Resolution to Approve Additional Agenda Items

Election of the Executive Committee for 2015-2016

Setting the Date of the 2016 Annual Meeting Of The Board

Resolution for Exclusion of Certain Directors and Officers — September 2015

Approval of the Gifts and Grants Report

2016-2022 State Six-Year Institutional Plan, Academic Division

Installation of Electrical Facilities on 11th Street

Acceptance of an Easement from the City Of Charlottesville for the Naming of the Karen S. Rheuban Center For Telehealth

Renaming the Ward K. Ensminger Distinguished Professorship in Geriatric Medicine the Ward K. Ensminger Distinguished Professorship in Medicine, Geriatric Medicine, and Palliative Care

State Operating Budget Amendments For The 2016-2018 Biennium for the Academic Division and the University of Virginia’s College at Wise and Revisions to the 2016-2018 Capital Program for the Academic Division

The University Of Virginia’s College at Wise Six-Year Plan

Revisions to the Bylaws of The University of Virginia’s College at Wise Board

Appointment to the University of Virginia’s College at Wise Board

Audit Department Charter

FY 2016 - FY 2017 Audit Department Resource Deployment Plan

Designation of the Chancellor as the Chief Executive Officer of the University of Virginia’s College at Wise

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Resolutions Not Requiring Action by the Full Board:

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  • Amended And Restated Bylaws Of The Clinical Staff Of The Medical Center 9898

Resolution approved by the Buildings and Grounds Committee on September 18, 2015
  • Concept, Site, and Design for Blandy Experimental Farm Greenhouse Replacement and Residential Housing Expansion Project 9898
The Board of Visitors of the University of Virginia met in open session at 12:40 p.m. on Friday, September 18, 2015, in the Auditorium of the Albert & Shirley Small Special Collections Library of the Harrison Institute. William H. Goodwin Jr., Rector, presided.


Also present were Teresa A. Sullivan, Patrick D. Hogan, Thomas C. Katsouleas, Richard P. Shannon, M.D., Eric M. Baumgartner, Susan G. Harris, Richard C. Kast, Pamela H. Sellers, Farnaz F. Thompson, Susan Carkeek, Donna P. Henry, Patricia M. Lampkin, Craig K. Littlepage, David W. Martel, Marcus L. Martin, M.D., Nancy A. Rivers, Roscoe C. Roberts, Colette Sheehy, Nina J. Solenski, M.D., Robert D. Sweeney, and Debra D. Rinker.

NCAA Certification

The Rector explained that Board members are boosters under the NCAA rules, and so annually, the Board is trained on NCAA compliance issues. He said the lesson here is, if in doubt, ask before you act. The rules are very complex and it would be quite easy inadvertently to cause a violation that would be detrimental to the athletics program. The Rector turned the session over to Eric Baumgartner, Associate Athletics Director for Compliance to provide the training. Mr. Baumgartner spoke about institutional control, stating that the President is responsible for the athletics program, and she has delegated day-to-day control to the Athletics Director and himself. He said a “representative of athletic interests” retains that definition forever, and Board members are such. A representative of athletic interests may not recruit student athletes. Prospective student athletes should be referred to the coaching staff. He said benefits provided to student athletes cannot be more than what is provided to others.

The Rector called on Ms. Fried to lead the Pledge of Allegiance. Rector Goodwin welcomed the newest Board Members present: Mark Bowles, Jimmy Reyes, Jeff Walker, Tammy Murphy, and the faculty.
representative Joe Garofalo. Mr. Goodwin said Whitt Clement could not be at the meeting because of a medical procedure; he wished Whitt Clement well in his procedure.

On motion, the Minutes of the Board meetings held on June 11-12, 2015, August 16-17, 2015 (BOV Retreat), August 27, 2015, and September 4, 2015 were approved.

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Resolution for Additions to the Agenda

On motion, the Board adopted the following resolution approving the consideration of addenda to the published agenda of the meeting:

RESOLUTION TO APPROVE ADDITIONAL AGENDA ITEMS

RESOLVED, the Board of Visitors approves the consideration of addenda to the published Agenda.

Election of the Executive Committee for 2015-2016

The Rector serves as the ex-officio chair of the executive committee, and he asked the Vice Rector, Frank M. Conner III, who is also an ex-officio member of the committee, to serve as the vice chair. The Rector proposed a slate of five additional members: Frank B. Atkinson, L.D. Britt, M.D., Kevin J. Fay, John A. Griffin, and Victoria Harker. He also proposed adding three advisors to the Executive Committee: Barbara J. Fried, Frank E. Genovese, and John G. Macfarlane III. On motion, the Board adopted the following resolution:

ELECTION OF THE EXECUTIVE COMMITTEE FOR 2015-2016

RESOLVED, in addition to the Rector and the Vice Rector, Frank B. Atkinson, L.D. Britt, M.D., Kevin J. Fay, John A. Griffin, and Victoria D. Harker are elected to the Executive Committee for the 2015-2016 year. Barbara J. Fried, Frank E. Genovese and John G. Macfarlane III are also elected as advisors.

Appointment of Standing Committees

Rector Goodwin reminded the Board they have already received the list of standing committees and their membership.

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Setting the Date of the 2016 Annual Meeting of the Board

On motion, the Board adopted the following resolution:
SETTING THE DATE OF THE 2016 ANNUAL MEETING OF THE BOARD

RESOLVED, the first meeting of the Board of Visitors in the fall of 2016 will be designated the 2016 Annual Meeting of the Board.

Resolution for Exclusion of Certain Directors and Officers – September 2015

On motion, the Board adopted the following resolution:

RESOLUTION FOR EXCLUSION OF CERTAIN DIRECTORS AND OFFICERS – SEPTEMBER 2015

WHEREAS, current Department of Defense Regulations contain a provision making it mandatory that the Chair of the Board, a Senior Management Official, and a Facility Security Officer meet the requirements for eligibility for access to classified information established for a contractor facility security clearance; and

WHEREAS, said Department of Defense Regulations permit the exclusion from the personnel of the requirements for access to classified information of certain members of the Board of Directors and other officers, provided that this action is recorded in the public Minutes;

RESOLVED, the Rector as Chair of the Board, Senior Management Official, and Facility Security Officer at the present time do possess, or will be processed for, the required eligibility for access to classified information; and

RESOLVED FURTHER, in the future, when any individual enters upon any duties as Rector of the Board, Senior Management Official, and Facility Security Officer, such individual shall immediately make application for the required eligibility for access to classified information; and

RESOLVED FURTHER, the following members of the Board of Visitors and other officers shall not require, shall not have, and can be effectively and formally excluded from access to all CLASSIFIED information disclosed to the University and shall not affect adversely Board and University policies or practices in the performance of classified contracts for the Department of Defense or the Government contracting activities (User Agencies) of the National Industrial Security Program.

<table>
<thead>
<tr>
<th>Frank B. Atkinson</th>
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<td>Mark T. Bowles</td>
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L.D. Britt, M.D. | Member, University of Virginia Board of Visitors
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Frank M. Conner III | Member, University of Virginia Board of Visitors
Helen E. Dragas | Member, University of Virginia Board of Visitors
Kevin J. Fay | Member, University of Virginia Board of Visitors
Barbara J. Fried | Member, University of Virginia Board of Visitors
Frank E. Genovese | Member, University of Virginia Board of Visitors
William H. Goodwin Jr. | Member, University of Virginia Board of Visitors
John A. Griffin | Member, University of Virginia Board of Visitors
Victoria D. Harker | Member, University of Virginia Board of Visitors
Bobbie G. Kilberg | Member, University of Virginia Board of Visitors
John G. Macfarlane III | Member, University of Virginia Board of Visitors
Tammy S. Murphy | Member, University of Virginia Board of Visitors
James V. Reyes | Member, University of Virginia Board of Visitors
Jeffrey C. Walker | Member, University of Virginia Board of Visitors
Roscoe C. Roberts | General Counsel to the University of Virginia
Susan G. Harris | Special Assistant to the President and Secretary to the Board of Visitors
Patrick D. Hogan | Executive Vice President and Chief Operating Officer
Thomas C. Katsouleas | Executive Vice President and Provost
Richard P. Shannon, M.D. | Executive Vice President for Health Affairs

**ACC Certification**

Every year, the Rector and the President are required to certify to the Atlantic Coast Conference (ACC) that Board members understand the President is responsible for the athletics program and has full authority from the Board to run the program. The certification was distributed to the Board.
Remarks by the Rector

The Rector asked Dr. Britt to give a brief report on the actions at the Medical Center Operating Board meeting the day before. This committee report can be found at: http://www.virginia.edu/bov/meetings/15Sep/15%20SEPT%20REPORT%20FROM%20MCOB%20MEETINGS%20FOR%20BOV.pdf

Rector Goodwin reminded Visitors to let the Board Office know if they are able to attend Fall Convocation on October 23. He then turned the meeting over to President Sullivan to give her report.

Report by the President

President Sullivan gave a report on the Cornerstone Plan (the Plan) implementation one year into the timeline. She passed around a written report, and she articulated the 8 principles for implementation: 1) ensure our actions conform to our values; 2) maintain our commitment to access and affordability; 3) seek opportunities to serve the Commonwealth; 4) leverage technology for maximum gain; 5) pursue continuous improvement as the source of ongoing excellence; 6) make collaboration an institutional hallmark; 7) seek opportunities to enhance our global perspective and presence; and 8) align resources with aspirations. She highlighted some areas of progress over the past year.

President Sullivan reviewed expenditures for the Plan. She said internal money was redirected to the Plan and there was some significant philanthropy.

She said the Residential Culture initiative has been active, including increasing “COLA” seminars from 45 sections to 66 sections, and ramping up career services including a “bootcamp” for graduates. There has been great enthusiasm from alumni around engaging with students, including serving as mentors.

On the Research initiative, the Licensing and Ventures Group had the best year ever supporting faculty research. The Data Science Institute is fully deployed and other institutes and affiliations are underway including a partnership with the Max Planck Institute focusing on alternative energy. Online materials were greatly expanded and there is increased undergraduate student engagement in research.

Student engagement also is apparent in the increased numbers of students studying abroad. In 2014-15, 2,468 undergraduate students studied abroad. Global activities are so strong that the University was recognized with the Paul Simon Award for Campus Internationalization.
Assembling and Supporting a Distinguishing Faculty activities include making interdisciplinary hiring possible, and streamlining the faculty search process in a number of ways.

Savings have been identified in a number of areas so resources can be redeployed to support academic excellence and affordable access. Ms. Sullivan identified where and how these savings are being redeployed.

The full power point presentation is available in the materials for the meeting.

Comments by the Student Member

Mr. Judge made the following comments:

To start the academic year, I’ve decided I want to use this student report to highlight many of the positive advances being made by students across grounds. In order to do this, I’ve engaged with around fifty student organizations, all of which are specifically working on early semester initiatives. However, please keep in mind that this is just a brief snapshot of everything happening.

It’s important to note that some of these initiatives are a direct response to events from last year, while others are entirely proactive. And that a number of these initiatives have received strong administrative support. This support comes in many forms like resource allocation, collaborative planning, and even simple recognition. In fact, initiatives that receive administrative support have seen a large increase in impact and success.

The first group I’ll talk about is the Sexual Violence Prevention Coalition (or SVPC). The Sexual Violence Prevention Coalition is the umbrella organization that coordinates prevention efforts between One in Four, One Less, Feminism is For Everyone, ADAPT, and Peer Health Educators. This year they have seen unprecedented increases in both awareness and activism regarding sexual violence prevention. Every student has now taken a mandatory online module, most have engaged with the Green Dot training program (either through training or an overview talk), and the Sexual Violence Prevention Coalition has received an outpouring of engagement with the Hoo's Got Your Back Campaign.

Also new this year, every first year student will have a conversation with a member of One in Four or One Less via a program entitled "Dorm Norms." In partnership with Housing and Residence Life, the University's peer education groups led discussions on bystander intervention, survivor support, and the
culture of the University. Advocacy groups designed the discussions to humanize prevention messaging and provide a space for students to engage with their peers on the topic during the end of the Red Zone period. For many, Dorm Norms provided proof that sexual violence prevention extended beyond administrative mandates. The SVPC is currently putting together a structure to allow any student to engage as an advocate for prevention.

The University Programs Council is a second example of an organization making a cultural impact on grounds. Their new initiative, "After Hours" is the product of input coming from students within the University Programs Council and from President Sullivan's group on climate and culture. "After Hours" is a series of alternative weekend programming that consist of 6 events per week, running in the late night time frame. Their events typically start around 7:00 p.m. and run until 2:00 in the morning. They have also helped create a program called "Newcomb Late Night." This allows students to use Newcomb Dining Hall and select restaurants until 2:00 in the morning every Thursday through Saturday. So far, these events have been very successful and have provided much needed alternative programing for students on weekends. The University programs Council’s goal is to continue expanding the program as they begin to see a distinct shift in late night culture.

Another organization, PULSE (an acronym that stands for Perspective, Understanding, Leadership, Sustained, Exchange) is a college retreat designed to explore identity, leadership and inclusion. It is the latest addition to Sustained Dialogue's work to shape lifelong leaders and activists who will help build a more inclusive campus environment. At the PULSE retreat, participants have the opportunity to build relationships with students from across grounds while sharing experiences on topics such as mental health, sexual orientation, race, socioeconomic status, and more. They recently received a $19,000 grant from the Jefferson Trust to fund four more retreats over the span of the next two years. This will establish a student-run tradition for first and second years to experience a space for self-exploration and multicultural awareness.

Next, I'd like to discuss advances in advising. The University Peer Advising Link (or ULink), a group which has previously presented in front of the Board, has more than doubled their operation in the last year. This year, ULink is advising 1,207 first-year students throughout the College, Engineering, Nursing, and Curry Schools. Advising topics frequently range from living situations, to internships, to major selection, truly creating a total advising experience. The Black Student Alliance has also increased its advising impact, by creating the Black Book, which I have here with me. This booklet provides first-year students with helpful information regarding lingo and traditions, restaurants to try,
tips for success, and many other subjects. This is easily one of the most innovative and accurate examples of how we should think about total advising from a student perspective.

I’d also like to take a minute to acknowledge the efforts implemented by Student Council. Student Council has changed its recruitment process this year in an attempt to create a more inclusive and effective organization. They will no longer deny any applicants. Instead, they will accept every student who applies and is willing to work towards the organization’s mission. This open model gives every student the opportunity to engage in the University’s affairs.

And finally, I would like to mention some of the recent initiatives supporting mental health. The week of September 7th through 11th was National Suicide Prevention Week. Students around grounds, including our local chapter of To Write Love on Her Arms, have worked collaboratively with faculty and administration to create awareness for mental health. This is one of the most significant issues in our community and all college communities for that matter. I would like to add that CAPS, Student Affairs, and Director Tim Davis have all been incredible resources and advocates for the student body. Mental Health is a primary focus for all students at the University and I can best demonstrate this through a brief anecdote. The other week I was asked to speak to a group of first-year students and give them advice from the perspective of a fourth-year. It didn’t take long to realize I had no idea what to say. So I started asking friends and strangers what they would want a first-year to know. Across the board, fourth-years wanted new students to know about mental health. They want them to know how to ask for help, when to ask for help, when to help others, and most importantly they want to get rid of any stigma surrounding seeking help. This is a unified issue and one our community is working on as a whole.

So, this concludes my brief snapshot. And, my underlying point is that the student body is more engaged and proactive than I’ve ever seen. I really mean that. If you take one thing away from this report, please know that great advancements are being made by students and the more support of any form they receive from the Board, faculty, and administration, the more of an impact they’ll be able to leave. And the better this institution will become.

Thank you.

Mr. Katsouleas commended Mr. Judge on a fantastic report. He said it was a hallmark of a very good university when students come and leave changed in a positive way, but it’s a hallmark of a great university that as a result of those students it remains changed in a
positive way. Rector Goodwin encouraged Mr. Judge to mention student concerns in future reports.

Mr. Griffin encouraged Mr. Judge to speak briefly about the open forum he is planning. He said it would take place either in late October or early November; Board members would be invited to hear from students. Mr. Judge said the organizers are considering a theme that would focus on the University in the next century. Mr. Griffin said they would apprise Visitors of the date once it has been decided, and he thanked Mr. Judge for his work on this initiative.

Comments by the Faculty Senate Chair

Rector Goodwin introduced Dr. Nina Solenski, chair of the Faculty Senate. She said there are a total of 82 faculty senators who are either appointed by the deans or voted in by their peers. There are a total of nine Faculty Senate committees that meet quarterly or more frequently, depending on their agendas.

Dr. Solenski said communication and engagement will be a theme for the year, including communicating with students, the General Faculty Council, the College at Wise Faculty Senate, and the state Faculty Senate.

Dr. Solenski spoke about the Faculty Survey from 2012. There were about 2100 respondents throughout all the schools. The most positive items highlighted from this survey were faculty collegiality — they like who they work with; faculty are committed to the institution; and faculty are satisfied with benefits. Areas to improve include faculty salaries; service (parking concerns); and transparency and communication. The faculty want the evaluative process to be transparent, consistent, and annual. They are also concerned about the financial revenue streams and understanding the transparency of this — how does this work, where does it go? Dr. Solenski said the new Responsibility Centered Management (RCM) model will do a good job of providing that much needed transparency.

Mr. Goodwin commented that he was surprised the annual review process was not consistent. Dr. Solenski said it is school-specific and department-specific and they all have not been consistent in the past. Mr. Garofalo said he believes this process is better now than when the survey was taken. The President reminded the Board in 2012 she mandated an annual review in order to receive a merit increase. She said they are making good progress but there is still room for improvement. President Sullivan said the Annual Faculty Report is not standardized and there has been strong resistance to standardizing it, which makes the IT application a little more challenging. The Provost Office has had a task force working on this for a couple of years. Rector Goodwin said on behalf of the Board he would like to state that this is not acceptable; it should not take a couple of years to have an annual review form in place. He said he wanted the faculty members to know
that the Board does not like this. He asked the Provost to bring them up-to-date at the next meeting on how much longer it will take to have a good review system in place. Mr. Goodwin also said the Faculty Senate prepares well in advance for the briefing to the Board on important issues and he wants faculty to know the Board is listening.

Dr. Solenski concluded her presentation by reviewing faculty recruitment and retention concerns. She said the faculty would like to see sustained competitive salaries; benefits expansion to include tuition, wellness, parking, and a childcare subsidy; more promotion of the Charlottesville environs; spousal hires; professional growth opportunities; an emphasis on core values; and faculty governance and autonomy.

Gifts and Grants Report

President Sullivan gave the following Gifts and Grants report:

Summary of Fiscal Year-To-Date through August 31, 2015

Philanthropic cash flow to the University of Virginia and its related foundations is $22,117,880 through August 31, 2015, with an additional $6,250,300 pledged.

Gifts to the following schools and units saw increases over the same time period last year: College of Arts & Sciences, Blandy Farm, Darden School of Business, Curry School of Education, Batten School of Leadership & Public Policy, School of Medicine, Athletics, Jefferson Scholars Foundation, Miller Center of Public Affairs, Jeffersonian Grounds, Fralin Museum of Art, Women’s Center, and the UVa Alumni Association

Significant Gifts Received Since The Last Meeting

The following are significant gifts received since the last Board meeting:

Bill and Melinda Gates Foundation private grant of $1,499,700 to the School of Medicine for an assessment of community transmission of Sabin type 2 virus in Bangladesh, as well as a private grant of $723,600 to the Batten School of Leadership & Public Policy for a study of the economic value of cognitive benefits from improved breast-feeding;

Robert Wood Johnson Foundation private grant of $1,200,000 to the School of Medicine for the Green Building and Public Health Innovation Partnership;

Mr. Steven C. Voorhees and Mrs. Celia Voorhees pledge payment of $1,000,000 to the Darden School of Business for the Robert F. Bruner Dean’s Fund for Faculty Excellence;
Mr. John Griffin pledge payment of $1,000,000 to the Blue Ridge Scholarships;

Mrs. Amy Mitchell Griffin and Mr. John Griffin pledge payment of $950,000 to Athletics for volleyball capital improvements;

Mrs. Donna D. Sullivan and Mr. William B. Sullivan deferred gift of $890,800 to the Alumni Association for the William B. and Donna D. Sullivan Scholarship Fund and the William B. and Donna D. Sullivan Theta Chi Fund;

American Chemical Society private grant of $792,000 to the School of Medicine for research on molecular determinants of small-cell lung cancer development;

Owens Family Foundation gift of $750,000 to the College of Arts & Sciences for the Owens Innovation Fund for Faculty Research; and

Mr. Bradley E. Singer gifts of $500,000 to support the University’s partnership with the Posse Foundation, and $150,000 for need-based scholarships.

**Significant Pledges Received Since The Last Meeting**

The following are significant pledges received since the last Board meeting:

Jack Miller Center pledge of $2,000,000 to the College of Arts & Sciences for the Program on Constitutionalism and Democracy;

Mrs. Barbara J. Fried pledge of $1,000,000 to the Virginia Foundation for the Humanities in support of the Encyclopedia of Virginia project;

Mr. Lane M. Bess and Mrs. Leticia L. Bess commitment, through the National Philanthropic Trust, of $750,000 to the School of Medicine to support LGL leukemia research;

Mr. H. Eugene Lockhart, Jr., and Mrs. Terry J. Lockhart pledge of $500,000 to the Miller Center of Public Affairs for The First Year: POTUS 2017;

Mr. Bruce R. Thompson pledge of $500,000 to the Darden School of Business for the Robert F. Bruner Dean’s Fund for Faculty Excellence; and

Anonymous pledge of $500,000 to Athletics for an endowed football scholarship fund.

Upon the President’s recommendation, the Board approved the Gifts and Grants Report. The Full Board meeting concluded at 2:30 p.m.
Executive Session, Friday, September 18, 2015

After adopting the following motion, the voting members present plus Daniel Judge, Teresa Sullivan, Patrick Hogan, Susan Harris, Roscoe Roberts, Debra Rinker, Farnaz Thompson, Richard Kast, Christina Morell, Patricia Lampkin, Sarah Schultz Robinson, Gabe Gates, Kelly Hodge, Gina Smith, and Nancy Deustch went into closed session at 2:30 p.m.:

That the Board of Visitors go into closed session to hear a litigation report and to discuss other legal matters requiring the provision of legal advice, and to discuss a personnel matter regarding an administrative appointment as permitted by the Code of Virginia sections 2.2-3711 (A)(1) and (7).

At 4:00 p.m., the Board left closed session and, on motion, adopted the following resolution certifying that the deliberations in closed session had been conducted in accordance with the exemptions permitted by the Virginia Freedom of Information Act:

That we vote on and record our certification that, to the best of each member's knowledge, only public business matters lawfully exempted from open meeting requirements and which were identified in the motion authorizing the closed session, were heard, discussed or considered in closed session.

Final Session, Friday, September 18, 2015

The Board was called to order at 4:05 p.m. for the Final Session. All voting members, save Mr. Clement and Ms. Harker, were present.

The following resolutions were adopted unanimously except Ms. Dragas voted against the first item in the consent agenda: 2016-2022 State Six-Year Institutional Plan, Academic Division.

CONSENT ITEMS

2016-2022 STATE SIX-YEAR INSTITUTIONAL PLAN, ACADEMIC DIVISION
(approved by the Finance Committee on September 17, 2015 - see Six-Year Plan in Attachment 1)

WHEREAS, § 23-38.87:17 of the Code of Virginia requires the governing boards of all public institutions of higher education to develop and adopt biennially an institutional six-year plan and submit that plan to the State Council of Higher Education (SCHEV), the Governor, and the Chairs of the House Committee on Appropriations and the Senate Committee on Finance; and
WHEREAS, the University submitted its preliminary plan for the Academic Division as required on July 1, outlining general strategies to advance the objectives of the Statewide Strategic Plan and the Higher Education Opportunity Act and to enhance teaching, research, and service consistent with the strategies of the Cornerstone Plan; and

WHEREAS, final institutional plans must be approved by the Board of Visitors and submitted to SCHEV, the Governor, and the Chairs of the House Committee on Appropriations and the Senate Committee on Finance no later than October 1;

RESOLVED, the Board of Visitors approves the 2016-2022 six-year institutional plan for the Academic Division; and

RESOLVED FURTHER, the President is authorized to transmit the six-year plan to SCHEV, the Governor, and the Chairs of the House Committee on Appropriations and the Senate Committee on Finance.

ACCEPTANCE OF AN EASEMENT FROM THE CITY OF CHARLOTTESVILLE FOR THE INSTALLATION OF ELECTRICAL FACILITIES ON 11TH STREET (approved by the Buildings & Grounds Committee on September 18, 2015)

RESOLVED, the acceptance of an easement from the City of Charlottesville to facilitate the installation of electrical infrastructure required for the relocation of an emergency generator is approved; and

RESOLVED FURTHER, that the Executive Vice President and Chief Operating Officer is authorized, on behalf of the University, to approve and execute a deed of easement and related documents, to approve revisions to the route (including, without limitation, revisions to change the location of the permanent easement), to incur reasonable and customary expenses, and to take such other actions as deemed necessary and appropriate to obtain such permanent easement; and

RESOLVED FURTHER, that all prior acts performed by the Executive Vice President and Chief Operating Officer, and other officers and agents of the University, in connection with the request for, and acceptance of, such permanent easement, are in all respects approved, ratified, and confirmed.

ACTION ITEMS

NAMING OF THE KAREN S. RHEUBAN CENTER FOR TELEHEALTH (approved by the Academic & Student Life Committee on September 17, 2015)

WHEREAS, Dr. Karen Schulder Rheuban serves as Professor of Pediatrics, Senior Associate Dean for Continuing Medical Education and External Affairs, and Director of the University of Virginia Center for Telehealth; and
WHEREAS, Dr. Rheuban co-founded the University of Virginia Center for Telehealth and its programs based on the idea that advances in medical and telecommunications technology could give health professionals the ability to bridge the miles between patients and the care they need; and

WHEREAS, since its founding, the Center has established a network of 152 sites in Virginia and has conducted more than 48,000 encounters, sparing the burden of travel for patients amounting to over 16 million miles, and has positively impacted the well-being of communities at the margins of the healthcare system; and

WHEREAS, through her renowned leadership at the University and with organizations around the globe, Dr. Rheuban has helped define a field that now touches thousands of lives each day;

RESOLVED, the Board of Visitors names the Center for Telehealth the Karen S. Rheuban Center for Telehealth.

RENNING THE WARD K. ENSMINGER DISTINGUISHED PROFESSORSHIP IN GERIATRIC MEDICINE THE WARD K. ENSMINGER DISTINGUISHED PROFESSORSHIP IN MEDICINE, GERIATRIC MEDICINE, AND PALLIATIVE CARE (approved by the Academic & Student Life Committee on September 17, 2015)

WHEREAS, on February 25, 2000, the Board of Visitors established the Ward K. Ensminger Distinguished Professorship in Geriatric Medicine; and

WHEREAS, the School of Medicine wishes to expand the purpose of the professorship to include the areas of general medicine and palliative care, while continuing to give preference to geriatric medicine, in order to facilitate the recruitment of chair holders; and

WHEREAS, these changes will allow the School of Medicine to utilize the funds and nominate an outstanding candidate in general medicine, palliative care, or geriatric medicine, while continuing to honor the spirit of the gift and the donor’s intent;

RESOLVED, the Board of Visitors renames the Ward K. Ensminger Distinguished Professorship in Geriatric Medicine the Ward K. Ensminger Distinguished Professorship in Medicine, Geriatric Medicine, and Palliative Care.

STATE OPERATING BUDGET AMENDMENTS FOR THE 2016-2018 BIENNIAL FOR THE ACADEMIC DIVISION AND THE UNIVERSITY OF VIRGINIA’S COLLEGE AT WISE AND REVISIONS TO THE 2016-2018 CAPITAL PROGRAM FOR THE ACADEMIC DIVISION (approved by the Finance Committee on September 17, 2015 - see State Operating Budget Amendments in Attachment 4)

WHEREAS, the proposed biennial budget requests represent the highest priority initiatives and are aligned with the six-year plan submitted to the Commonwealth on July 1, 2015;
RESOLVED, the Board of Visitors of the University of Virginia approves the 2016-2018 biennial budget general fund requests and the revisions to the 2016-2018 Capital Program; and

RESOLVED FURTHER, the Board of Visitors understands that to the extent these initiatives are not included in the Governor’s 2016-2018 biennial budget, the University may want to pursue similar requests to the General Assembly; and

RESOLVED FURTHER, the President or her designee is authorized to transmit to the General Assembly any request not funded by the Governor as long as there are no material differences from the items already endorsed by the Board of Visitors.

THE UNIVERSITY OF VIRGINIA’S COLLEGE AT WISE SIX-YEAR PLAN
(approved by the Committee on The University of Virginia’s College at Wise on September 18, 2015 - see Six-Year Plan in Attachment 2)

WHEREAS, all Virginia higher education institutions are required under state law to submit a six-year plan every two years to the State Council of Higher Education for Virginia; and

WHEREAS, the College is committed to continuing strategies and priorities outlined in previous plans that will improve the educational outcomes for students and create jobs in the region; and

WHEREAS, the Six-Year Plan meets the goals outlined in Virginia’s Higher Education Opportunity Act and the College’s Envisioning 2020 strategic plan;

RESOLVED, the Board of Visitors approves the 2015 Six-Year Plan as presented.

REVISIONS TO THE BYLAWS OF THE UNIVERSITY OF VIRGINIA’S COLLEGE AT WISE BOARD
(approved by the Committee on The University of Virginia’s College at Wise on September 18, 2015-see Revisions to the Bylaws in Attachment 3)

RESOLVED that the revisions to the Bylaws of The University of Virginia’s College at Wise Board are approved as presented.

APPOINTMENT TO THE UNIVERSITY OF VIRGINIA’S COLLEGE AT WISE BOARD
(approved by the Committee on The University of Virginia’s College at Wise on September 18, 2015)

RESOLVED, Katheryn B. Curtis is appointed to The University of Virginia's College at Wise Board for a four-year term ending June 30, 2019.
AUDIT DEPARTMENT CHARTER
(approved by the Audit, Compliance, and Risk Committee on September 18, 2015 - see Charter in Attachment 4)

RESOLVED, the updated Audit Department Charter, dated September 18, 2015, is approved as recommended by the Audit, Compliance, and Risk Committee.

FY 2016 - FY 2017 AUDIT DEPARTMENT RESOURCE DEPLOYMENT PLAN
(approved by the Audit, Compliance, and Risk Committee on September 18, 2015)

RESOLVED, the FY 2016 - FY 2017 Audit Department Resource Deployment Plan is approved as recommended by the Audit, Compliance, and Risk Committee.

DESIGNATION OF THE CHANCELLOR AS THE CHIEF EXECUTIVE OFFICER OF THE UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE
(approved by the Executive Committee on September 18, 2015)

WHEREAS, Section 2.4 of the Manual of the Board of Visitors of the University of Virginia (the Manual) refers to the Chancellor of the University of Virginia’s College at Wise as the “local chief executive officer”; and

WHEREAS, the College at Wise has been informed by SACSCOC that the head of an accredited college should be designated the chief executive officer; and

WHEREAS, the College at Wise is a separate state agency of the Commonwealth of Virginia and the Chancellor is the chief executive of the state agency;

RESOLVED, section 2.4 paragraph 24 of the Manual of the Board of Visitors of the University of Virginia is amended to designate the Chancellor of the University of Virginia’s College at Wise as the “chief executive officer” of the College at Wise; and

RESOLVED FURTHER, section 4.2 of the Manual of the Board of Visitors of the University of Virginia is amended to designate the President of the University as the “principal administrative officer” of the University of Virginia’s College at Wise.

AMENDMENTS TO SECTION THREE – THE COMMITTEE SYSTEM IN THE MANUAL OF THE BOARD OF VISITORS
(approved by the Executive Committee on September 18, 2015)

RESOLVED, in accordance with the provisions of Section 5.9 of the Manual of the Board of Visitors of the University of Virginia (the Manual) and the Code of Virginia Section 23-75, and upon recommendation of the Executive Committee, the committee charges in
Section 3 - The Committee System of the Manual of the Board of Visitors of the University of Virginia are amended as follows:

SECTION 3.1 EXECUTIVE COMMITTEE — At each Annual Meeting the Board shall elect from among its membership an Executive Committee composed of seven members. These seven members shall consist of the Rector, who shall serve as chair, the Vice Rector, who shall serve as vice chair, and five Visitors to be elected by the Board. Nominations for these five positions on the Executive Committee may be made by any Visitor, and if there are more than five nominations, a vote shall be taken, and the results shall be announced jointly by the Rector and the Secretary. Any vacancy on the Executive Committee shall be filled for the unexpired term at the next regular meeting of the Board and by vote if there is more than one nomination.

The Executive Committee shall meet upon the call of the Rector. It shall consider all matters referred to it by the Rector, the Vice Rector, or the President and shall, in the interim between meetings of the Board, be vested with the powers and authority of the full Board and shall take such action on all matters that may be referred to it as in its judgment is required. All such actions taken by the Executive Committee in the interim between meetings of the Board shall require a two-thirds vote of the whole number of committee members, and their actions shall be reported to the Board at the next regular meeting and shall, if confirmation is required, be confirmed and approved by the Board at that time.

In addition to the above, the Executive Committee shall organize the working processes of the Board and recommend best practices for governance to the Board. More specifically, the Executive Committee shall:

1. Develop and recommend to the Board a statement of governance setting out the Board’s role;
2. Periodically review the Board’s bylaws and recommend amendments;
3. Provide advice to the Board on committee structure, appointments and meetings;
4. Develop an orientation and continuing education process for Visitors that includes training on the Virginia Freedom of Information Act;
5. Create, monitor, oversee, and review compliance with a code of ethics for Visitors; and
6. Develop a set of qualifications and competencies for membership on the Board for approval by the Board and recommendation to the Governor.

As part of its responsibilities, the Executive Committee shall work with the President to encourage and support an atmosphere at the University that ensures that diverse members of the University of Virginia and Charlottesville communities are treated equally and fairly. This is essential to creating an educational experience for students to prepare them for productive and responsible citizenship in
the world beyond the University community. This responsibility includes encouraging and supporting the attraction and retention of a diverse group of students, faculty, and staff. “Diverse” includes race and ethnicity, age, gender, disability status, sexual orientation, religion and national origin, socio-economic status, and other aspects of individual experience and identity.

On behalf of the Board, the Executive Committee shall be responsible for working with the University administration on communication strategies and messaging with respect to emerging and urgent issues including informing and educating policy makers and regulatory oversight organizations and bodies.

SECTION 3.2 STANDING COMMITTEES — The standing committees of the Board of Visitors shall consist of the Finance Committee, Buildings and Grounds Committee, Academic and Student Life Committee, Student Affairs and Athletics Committee, Educational Policy Committee, Advancement and Communications Committee, Audit, Compliance, and Risk Committee, Advancement Committee, Committee on The University of Virginia’s College at Wise, and the Medical Center Operating Board, and the Committee on Diversity and Inclusion. The number to be appointed to each standing committee shall be determined by the Rector at the time of appointment. However, no committee shall consist of fewer than three members.

The standing committees shall be appointed by the Rector at the Annual Meeting of each year, and at the time of appointment the Rector shall designate the chair of each committee. A vacancy on any committee shall be filled by the Rector for the unexpired term, and the Rector shall have the power to change the membership of any standing committee at any time. Each standing committee shall meet at the call of the chair, the Rector, the Vice Rector, or the President and shall consider such matters as may be referred to it by these officers or by members of the committee.

The Secretary shall prepare a docket for each committee meeting and shall attend the meeting.

In addition to the duties of the standing committees as listed below, each committee shall consider such other matters as may be referred to it by the Board, the Rector, the Vice Rector, the President, or the chair and shall make its report and recommendations as required to the Board, to the President, and, upon the request of the Rector, to the Executive Committee. No standing committee has power or authority to commit the Board to any policy or action unless specifically granted such power or authority by the Board. In such cases, a report of final action by any committee shall be made at the next regular meeting of the Board and, if confirmation is required, shall be confirmed and approved by the Board at that time.

On motion of any member, any grant to a committee of power or authority to commit the Board shall be reviewed by the Board, at which
time it may be modified or rescinded by majority vote of the members present without complying with the requirements for amending this Manual.

SECTION 3.21 FINANCE COMMITTEE — The Finance Committee shall be responsible in all matters relating to the University's financial affairs and business operations. It shall review and approve the annual budget and the setting of tuition rates, student fees, and other student charges for recommendation to the Board. On behalf of the Board, it shall establish metrics and monitor programs for organizational excellence, approve the investment of endowment and other funds and the purchase of real and personal property, and the making of loans to faculty members, and it shall make progress reports to the Board on its actions.

The committee shall maintain liaison with the University of Virginia Investment Management Company, a nonprofit, nonstock corporation organized under Virginia law to provide investment and investment management and related services to the University of Virginia, and shall monitor and review periodically the performance of the Company.

The Finance Committee shall be responsible for all matters relating to funding research programs and partnerships of the University. The scope shall include all forms of research funding: external and internal sources of research support, startup packages for faculty, and commercialization activities and translational research. The committee may offer guidance on such issues as strategic investments in research, the infrastructure for research, strategic partnerships that enhance research capability and impact, and intellectual property policies.

SECTION 3.22 BUILDINGS AND GROUNDS COMMITTEE — The Buildings and Grounds Committee shall have responsibility in matters relating to land use and the physical plant and equipment. It shall be responsible for land use planning and acquisition policy as well as exercising oversight over the use of space and the care, maintenance, and security of the University's buildings and grounds including furnishings and equipment; the selection of architects and engineers and the siting, construction, and naming of new buildings; the care and preservation of all furnishing and equipment; and such other matters relating to the buildings and grounds of the University as may come before it. On behalf of the Board, it shall approve the siting location and design of new buildings and shall make progress reports to the Board on its actions.

SECTION 3.23 ACADEMIC AND STUDENT LIFE COMMITTEE — The Academic and Student Life Committee shall have oversight of matters relating to athletics, culture and safety, educational policy, and research programs. The Committee shall oversee matters relating to student conduct, residential and social life, extracurricular activities, food services, health, and such other matters relating to student affairs
as may be brought to its attention; and athletic policy and programs, both intramural and intercollegiate.

In exercising its responsibilities for educational policy and research programs, the committee shall have responsibility in all matters relating to educational and research policies and programs except for those matters subject to the oversight of the Medical Center Operating Board. The committee shall exercise oversight over the proposal of new degrees and educational programs by the President, the conditions affecting the recruitment and retention of faculty members, the adequacy of instructional and research facilities, and such other matters relating to the educational policies and programs as may be brought before it by the President or Provost or referred to it by the Board.

SECTION 3.24 AUDIT, COMPLIANCE, AND RISK COMMITTEE — The Audit, Compliance, and Risk Committee shall have oversight responsibility for internal audit, compliance, and enterprise risk management programs for the academic and medical center divisions, as it relates to financial, operational, compliance, strategic, and reputational risks. The committee shall have direct access to internal and external auditors to assess performance, the scope of audit activities, and the adequacy of internal accounting controls. The committee shall review, at least annually, the institution’s risk governance framework including the risk assessment and mitigation strategies. The committee also shall receive periodic reports on other such audit, compliance, and risk matters from the State auditor, senior management, and the institution’s internal audit, compliance, and enterprise risk management leaders. Such leaders shall also have direct access to the board.

SECTION 3.25 ADVANCEMENT AND COMMUNICATIONS COMMITTEE — The Advancement and Communications Committee shall have responsibility in all matters pertaining to University development, alumni affairs, and public communications. This responsibility shall include the oversight of University capital campaigns, branding efforts, commemorations, and all other programs that promote the University publicly and with alumni and friends. Private donations to and alumni support of the University. As part of this responsibility, the committee’s oversight will include the University-related foundations and their activities to raise funds on behalf of the University.

SECTION 3.26 THE COMMITTEE ON THE UNIVERSITY OF VIRGINIA’S COLLEGE AT WISE — The Committee on The University of Virginia’s College at Wise is charged with the oversight of the College and the advancement of its mission and with bringing its needs and concerns to the attention of the Board of Visitors. The committee will assist the Chancellor in carrying out the Chancellor’s duties and will further the goals of The University of Virginia’s College at Wise.

SECTION 3.27 THE MEDICAL CENTER OPERATING BOARD — The Medical Center Operating Board shall be the governing board of the Medical Center and
the Transitional Care Hospital for Joint Commission on Accreditation of Hospital Organization purposes, responsible to oversee and direct the operations of the Medical Center and the Transitional Care Hospital as delegated by the Board of Visitors.

The Rector shall serve as a voting member, and he shall appoint five other members of the Board of Visitors, including the chair, to serve as voting members of the Medical Center Operating Board; one of these members shall be the chair of the Finance Committee and one of these members shall be a physician with administrative and clinical experience in an academic medical center. The Board of Visitors may appoint no more than six public non-voting members of the Medical Center Operating Board to serve for initial terms not to exceed four years. The President of the University, the Executive Vice President and Provost of the University, the Executive Vice President and Chief Operating Officer of the University, the Executive Vice President for Health Affairs, the Chief Executive Officer of the Medical Center, the Dean of the School of Medicine, the Dean of the School of Nursing, and the President of the Clinical Staff of the Medical Center shall serve as non-voting advisory members.

RESOLUTION COMMENDING ALLISON CRYOR DINARDO

WHEREAS, Allison Cryor DiNardo took a Bachelor of Arts degree in English from the University of Virginia in 1982 and a MBA degree from the Darden Graduate School of Business in 1988; and

WHEREAS, Ms. Cryor DiNardo is the President of King Street Wireless, which offers 4G LTE wireless service in partnership with U.S. Cellular. From 1993-1998, Ms. Cryor DiNardo was Managing Director of the University of Virginia’s athletics capital campaign at the Virginia Student Aid Foundation, and from 1989-1993, she worked for President George H.W. Bush as Deputy Associate Director of Presidential Personnel; and

WHEREAS, Ms.Cryor DiNardo has served the University in many volunteer roles including the Jefferson Scholars Foundation’s regional and national selection committees and capital campaign committee, and the Darden Alumni Association Board. She co-chaired her undergraduate reunion planning committees in 2002 and 2007, and in 2011, she was appointed the Board of Visitors representative to the Alumni Association Board of Managers. Ms. Cryor DiNardo is a member of the prestigious Raven Society; and

WHEREAS, Ms. Cryor DiNardo has held numerous leadership roles in Alexandria, Virginia. In 2013, she was recognized as Alexandria’s Board Leader of the Year at the Business Philanthropy Summit. She was honored by Greater DC Cares as a “rising star in philanthropy and leading the charge for social change in the DC region” and by the Washington Business Journal as “A Woman Who Means Business.” She received the Barat Medal from the Stone Ridge School of the Sacred
WHEREAS, Ms. Cryor DiNardo was appointed to the Board of Visitors by Governor McDonnell in 2011; and

WHEREAS, Ms. Cryor DiNardo ably served the Board of Visitors as Chair and Co-Chair of the Diversity and Inclusion Committee and Chair and Co-Chair of the Student Affairs and Athletics Committee; and

WHEREAS, as a member of the Board of Visitors, Ms. Cryor DiNardo has worked tirelessly to improve the experience of students on Grounds. Among her many contributions, Ms. Dinardo participated in the President's Ad Hoc Group on University Climate and Culture, developing a broad range of measures to improve and sustain a safe and welcoming environment for all students at the University; and

WHEREAS, Ms. Cryor DiNardo completed her term on the Board of Visitors on June 30, 2015;

RESOLVED, the Board of Visitors thanks Allison Cryor DiNardo for her exemplary service to the University, and considers her a dear friend and a respected colleague; and

RESOLVED FURTHER, the Board wishes Allison and Robert DiNardo continued success and happiness in all of their future endeavors.

RESOLUTION COMMENDING STEPHEN P. LONG, M.D.

WHEREAS, Stephen P. Long took his Bachelor of Arts degree in English from Randolph-Macon College in 1982 and a Doctor of Medicine degree from Virginia Commonwealth University's School of Medicine in 1986; and

WHEREAS, Dr. Long completed his internship in general surgery and his residency and fellowship in Anesthesiology and Pain Medicine at the Medical College of Virginia Hospitals in 1991 and served on the faculty as an Associate Professor until 1998 when he formed his private practice, Commonwealth Pain Specialists. Dr. Long is currently an Associate Clinical Professor of anesthesiology at Virginia Commonwealth University; and

WHEREAS, Dr. Long's participation in civic and professional organizations includes the American Society of Anesthesiologists, the Virginia Society of Anesthesiologists, the Vestry of St. Stephen's Episcopal Church, the Fellowship of Christian Athletes, the Fellowship of Christians in Universities and Schools, and the Children's Museum of Richmond; and

WHEREAS, Dr. Long has received numerous honors, including Richmond Magazine's Top Pain Specialist. He was recognized as one of US News and World Report's Top Pain Specialists in 2011 and 2012 and
was presented with the Distinguished Alumnus Award by Randolph Macon's Society of Alumni in 2011; and

WHEREAS, Dr. Long currently serves on the Board of Trustees of Randolph-Macon College and has served as the chair of the Committee on Trustees. Dr. Long has also served on the Virginia Commonwealth University Board of Visitors and the Virginia Commonwealth University Health System board; and

WHEREAS, Dr. Long has lectured extensively throughout the world on topics pertaining to acute, chronic, and cancer pain as well as legal and regulatory issues involving pain management. Additionally, he has multiple publications on pain management; and

WHEREAS, Dr. Long was appointed to the Board of Visitors by Governor McDonnell in 2011; and

WHEREAS, Dr. Long was both Chair of the Educational Policy Committee and Co-Chair of the Medical Center Operating Board; and

WHEREAS, Dr. Long has been a tireless advocate for the academic and health missions of the University, an interested and supportive role model to many students and faculty, and an active participant in many University events and activities; and

WHEREAS, Dr. Long completed his term on the Board of Visitors on June 30, 2015;

RESOLVED, the Board thanks Stephen P. Long, M.D. for his devoted service to the University, and considers him a great friend and colleague; and

RESOLVED FURTHER, the Board wishes Steve and Georganne Long continued success and happiness.

RESOLUTION COMMENDING GEORGE KEITH MARTIN

WHEREAS, George Keith Martin took a Bachelor of Arts degree from the University of Virginia in 1975 and a Juris Doctor degree from Howard University School of Law in 1978, where he was the number two editor on the law review; and

WHEREAS, Mr. Martin is the managing partner of the Richmond office of McGuireWoods LLP, the firm’s largest office. He is a member of the firm’s pension committee and advisory board. For many years he served on the firm’s recruiting committee; and

WHEREAS, Mr. Martin’s practice includes construction, commercial real estate, real estate finance, and local government law. He has represented public and private entities on numerous real estate projects, including public private partnerships; and
WHEREAS, Mr. Martin has been recognized by Best Lawyers in America and Virginia’s Legal Elite. He is an affiliate member of the American Institute of Architects, a member of the National Association of College and University Attorneys, and a member of his firm’s education law team. Mr. Martin has lectured nationally on construction and real estate topics; and

WHEREAS, Mr. Martin has served on numerous boards and commissions, including the Virginia Board of Bar Examiners, James Madison University Board of Visitors, and the Governor’s Blue Ribbon Commission on Higher Education. Mr. Martin serves on the Board of Visitors at Regent University School of Law and on the Board of Directors of the Housing and Development Law Institute in Washington, DC; and

WHEREAS, Mr. Martin was the recipient of the 2011 Trailblazer Award from the Richmond UVA Club/Walter Ridley Scholarship Fund; and

WHEREAS, Mr. Martin was appointed to the Board of Visitors by Governor McDonnell in 2011; and

WHEREAS, Mr. Martin was elected Vice Rector in 2012, and became Rector of the University in 2013; and

WHEREAS, The Board and the University benefited from his sharp legal mind, calm demeanor, and confident presence; and

WHEREAS, Mr. Martin’s tenure as Rector was marked by change and innovation that will profoundly impact the University for many years to come, most notably approval by the Board of the Cornerstone strategic plan, a revised Mission Statement, and the addition of a non-voting faculty representative; and

WHEREAS, Mr. Martin led the Board on a number of important issues that examined board governance; developed a financially sound plan for funding academic initiatives while lowering administrative costs; and promoted faculty and student interactions with members of the Board; and

WHEREAS, Mr. Martin’s approach was always positive, looking for ways to bring people with diverse views together to find common ground. Mr. Martin was never afraid to confront contentious issues and to work through them; and

WHEREAS, Mr. Martin completed his term on the Board of Visitors on June 30, 2015;

RESOLVED, the Board thanks George Keith Martin for his thoughtful and principled leadership on behalf of his beloved alma mater; and
RESOLVED FURTHER, the Board wishes George and Anita Martin continued success and happiness in all of their future endeavors.

RESOLUTION COMMENDING EDWARD D. MILLER, M.D.

WHEREAS, Edward D. Miller took a Bachelor of Arts degree from Ohio Wesleyan University and a M.D. degree from the University of Rochester School of Medicine and Dentistry; and

WHEREAS, Dr. Miller was named Chief Executive Officer of Johns Hopkins Medicine, the 13th Dean of The Johns Hopkins University School of Medicine, and Vice President for Medicine of Johns Hopkins University in January 1997, and served in this position until June 2012. He was the first-ever Chief Executive Officer of Johns Hopkins Medicine, a new organization that formally integrated operations and planning of the School of Medicine with the Johns Hopkins Health System and Hospital; and

WHEREAS, Dr. Miller joined Johns Hopkins in 1994 as Professor and Director of the Department of Anesthesiology and Critical Care Medicine and was named Interim Dean of the School of Medicine in 1996. He came to Johns Hopkins after eight years at Columbia University, where he served as Professor and Chairman of the Department of Anesthesiology, and eleven years at the University of Virginia; and

WHEREAS, Dr. Miller's research has focused on the cardiovascular effects of anesthetic drugs and vascular smooth muscle relaxation. Among many other honors and awards, he received the National Institutes of Health's Career Research Development Award; and

WHEREAS, Dr. Miller is a member of the Institute of Medicine of the National Academy of Sciences and a fellow of the Royal College of Physicians and the Royal College of Anesthetists; and

WHEREAS, Dr. Miller has authored or co-authored more than 150 scientific papers, abstracts, and book chapters; and

WHEREAS, Dr. Miller was appointed as an advisory member to the Board of Visitors by Governor McDonnell in 2011, and was then appointed as a voting board member by Governor McDonnell in 2012; and

WHEREAS, Dr. Miller served the Board of Visitors as Chair and Co-Chair of the Medical Center Operating Board and Chair of the Special Committee on Research; and

WHEREAS, as a member of the Board of Visitors, Dr. Miller worked to strengthen the University's Health System and research programs; and

WHEREAS, Dr. Miller completed his term on the Board of Visitors on June 30, 2015;
RESOLVED, the Board thanks Edward D. Miller, M.D. for sharing his immense knowledge and expertise in the area of academic medicine for the benefit of the University, and considers him a valued friend and colleague; and

RESOLVED FURTHER, the Board wishes Ed and Lynne Miller continued success and happiness in all of their future endeavors.

RESOLUTION COMMENDING JOHN L. NAU III

WHEREAS, John L. Nau III took a Bachelor of Arts degree in History from the University of Virginia in 1968; and

WHEREAS, Mr. Nau is President and Chief Executive Officer of Silver Eagle Distributors, L.P.; and

WHEREAS, Mr. Nau has been and continues to be actively involved in the University community. He established the John L. Nau III Professorship in History of the American Civil War and a Jefferson Scholars Graduate Fellowship in Civil War Studies. Mr. Nau and his wife, Bobbie, funded the John L. Nau III Center for Civil War History and were major contributors to the South Lawn. He was instrumental in obtaining two gifts from Anheuser-Busch Companies in 1999, the first to support a program aimed at reducing risky drinking behaviors among students and the second for the Environmental Sciences Department, which helped fund the University’s Anheuser-Busch Coastal Research Center; and

WHEREAS, Mr. Nau is the former Chairman of the Council of Foundations and served as Vice Chairman of the UVA Capital Campaign; and

WHEREAS, Mr. Nau’s commitment to service is apparent through his participation in civic, community, and philanthropic organizations in Houston and throughout the country, including the National Parks Foundation Board of Directors, past president of the Texas State Historical Association, Civil War Trust Board of Trustees, Baylor College of Medicine Board of Trustees, and many other organizations. He is founder and President of The Nau Foundation; and

WHEREAS, Mr. Nau’s lifelong study of American history provided him with the knowledge to serve as chairman of the National Advisory Council on Historic Preservation from 2001 to 2010, a position appointed by the President of the United States. He also served as chairman of the Texas Historical Commission from 1995 to 2009, a position appointed by the Governor of Texas; and

WHEREAS, Mr. Nau was appointed to the Board of Visitors by Governor McDonnell in 2011; and
WHEREAS, Mr. Nau served the Board of Visitors as Chair of the Advancement and Communications Committee and Co-Chair of the Governance and Engagement Committee; and

WHEREAS, as a member of the Board of Visitors, Mr. Nau led efforts to enhance University communications and Board governance; and

WHEREAS, Mr. Nau completed his term on the Board of Visitors on June 30, 2015;

RESOLVED, the Board thanks John L. Nau for all that he has done for the University over many years including in his role as a Visitor, and considers him a valued friend and trusted colleague; and

RESOLVED FURTHER, the Board wishes John and Bobbie Nau continued success and happiness in all of their future endeavors.

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On motion, the Board approved the following faculty personnel actions:

**FACULTY PERSONNEL ACTIONS**

**ELECTIONS**

RESOLVED, the following persons were elected to the faculty:

Dr. Vaia T. Abatzis, as Assistant Professor of Anesthesiology, for three years, effective July 1, 2015, at an annual salary of $100,000.

Mr. Herve F. Agaisse, as Associate Professor of Microbiology, Immunology, and Cancer Biology, for three years, effective July 1, 2015, at an annual salary of $135,000.

[t] Mr. Jeffrey R. Allen, as Professor of English, effective August 25, 2015, at an academic year salary of $127,000.

Dr. Joseph Amalfitano, as Assistant Professor of Physical Medicine and Rehabilitation, for two years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Lalin Anik, as Assistant Professor of Business Administration, for three academic years, effective August 25, 2015, at an academic year salary of $162,000.

Dr. Christopher J. Arnold, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.
Mr. Gaurab Aryal, as Assistant Professor of Economics, for four academic years, effective August 25, 2015, at an academic year salary of $130,000.

Dr. Nina C. Baker, as Assistant Professor of Physical Medicine and Rehabilitation, for two years, effective June 15, 2015, at an annual salary of $100,000.

Mr. Bhupal Ban, as Assistant Professor of Research in Cell Biology, for three years, effective August 1, 2015, at an annual salary of $85,000.

Mr. Nicholas A. Barone, as Assistant Professor of Education, for three academic years, effective August 25, 2015, at an academic salary of $70,000.

Mr. Peter R. Belmi V, as Assistant Professor of Business Administration, for three academic years, effective August 25, 2015, at an academic year salary of $158,000.

Mr. Alan O. Bergland, as Assistant Professor of Biology, for the period January 25, 2016 through May 24, 2020, at an academic year salary of $79,000.

Mr. Zachary A. Bethune, as Assistant Professor of Economics, for four academic years, effective August 25, 2015, at an academic year salary of $130,000.

Mr. Nicola Bezzo, as Assistant Professor of Systems and Information Engineering, for the period January 10, 2016 through May 24, 2019, at an annual salary of $123,000.

Ms. Sanchita Bhatnagar, as Assistant Professor of Biochemistry & Molecular Genetics, for three years, effective August 25, 2015, at an annual salary of $95,000.

Mr. Jeffrey P. Boichuk, as Assistant Professor of Commerce, for three academic years, effective August 25, 2015, at an academic year salary of $155,000.

Dr. Heather A. Borek, as Assistant Professor of Emergency Medicine, for three years, effective August 1, 2015, at an annual salary of $100,000.

[t] Mr. Erik C. Braun, as Associate Professor of Religious Studies, effective August 25, 2015, at an academic year salary of $95,000.

Mr. Enrique Campos Nanez, as Assistant Professor of Research in Psychiatry and Neurobehavioral Sciences, for one year, effective May 1, 2015, at an annual salary of $100,000.
Dr. Stephanie D. Cardella, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Tong D. Chen, as Assistant Professor of Civil and Environmental Engineering, for three years, effective August 13, 2015, at an annual salary of $118,700.

Mr. Gia-Wei Chern, as Assistant Professor of Physics, for four academic years, effective August 25, 2015, at an academic year salary of $88,000.

Dr. Tushar Chopra, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Mr. Mete Civelek, as Assistant Professor of Biomedical Engineering, for one year, effective August 25, 2015, at an annual salary of $125,000.

Dr. Andrew Copland, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Margaret K. Crook, as Assistant Professor of Medicine, for three years, effective August 1, 2015, at an annual salary of $100,000.

Dr. Katharine C. DeGeorge, as Assistant Professor of Family Medicine, for two years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Isabelle Derre, as Assistant Professor of Microbiology, Immunology, and Cancer Biology, for three years, effective July 1, 2015, at an annual salary of $95,000.

Ms. Deborah L. Dillon, as Assistant Professor of Nursing, for one academic year, effective August 25, 2015, at an academic year salary of $80,000.

Dr. Lauren K. Dunn, as Assistant Professor of Anesthesiology, for the period July 13, 2015 through July 31, 2016, at an annual salary of $100,000.

Dr. Katherine Fedder, as Assistant Professor of Otolaryngology, for three years, effective August 17, 2015, at an annual salary of $100,000.

Ms. Nichole M. Flores, as Assistant Professor of Religious Studies, for four academic years, effective August 25, 2015, at an academic year salary of $68,000.
Ms. Ana L. Fostel, as Associate Professor of Economics, effective August 25, 2015, at an academic year salary of $180,000.

Dr. Laahn H. Foster, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Mr. Guarav Giri, as Assistant Professor of Chemical Engineering, for the period December 25, 2015 through May 24, 2019, at an annual salary of $126,700.

Mr. Jorge A. Giron, as Associate Professor of Pediatrics, for three years, effective August 1, 2015, at an annual salary of $79,400.

Ms. Jennifer L. Givens, as Assistant Professor of Law for the period August 10, 2015 through June 30, 2018, at an annual salary of $108,000.

Dr. Jeffrey R. Golen, as Assistant Professor of Ophthalmology, for three years, effective August 3, 2015, at an annual salary of $100,000.

Dr. Diana C. Gomez Manjarres, as Assistant Professor of Medicine, for three years, effective August 1, 2015, at an annual salary of $100,000.

Ms. Rose E. Gonzalez, as Associate Professor of Pediatrics, for three years, effective July 1, 2015, at an annual salary of $108,000.

Dr. Alejandro A. Gru, as Assistant Professor of Pathology, for three years, effective August 1, 2015, at an annual salary of $100,000.

Mr. Michael J. Guertin, as Assistant Professor of Biochemistry & Molecular Genetics, for three years, effective August 1, 2015, at an annual salary of $95,000.

Dr. Surovi Hazarika, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Zachary Henry, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Harry R. Holt, as Assistant Professor of Family Medicine, for two years, effective July 13, 2015, at an annual salary of $100,000.

Ms. Ashley R. Hurst, as Assistant Professor of Nursing, for one academic year, effective August 25, 2015, at an academic year salary of $82,000.

Mr. Joseph G. Hylton, as Professor of Law, for three academic years, effective August 25, 2015, at an annual salary of $153,000.
Mr. Murad Idris, as Assistant Professor of Politics, for four academic years, effective August 25, 2015, at an academic year salary of $78,500.

Dr. Vishal Jain, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Kristina G. Johnson, as Assistant Professor of Family Medicine, for two years, effective August 1, 2015, at an annual salary of $100,000.

Mr. Steven L. Johnson, as Associate Professor of Commerce, for three years, effective August 25, 2015, at an academic year salary of $185,000.

Mr. Sonam Kachru, as Assistant Professor of Religious Studies, for four academic years, effective August 25, 2015, at an academic year salary of $66,000.

Ms. Hyojung Kang, as Research Assistant Professor of Systems and Information Engineering, for two years, effective August 25, 2015, at an annual salary of $80,000.

Ms. Jennifer C. Kastello, as Assistant Professor of Nursing, for one academic year, effective August 25, 2015, at an academic year salary of $80,000.

Ms. Samira M. Khan, as Assistant Professor of Computer Science, for three years, effective September 25, 2015, at an annual salary of $140,000.

Dr. Sarah K. Kilbourne, as Assistant Professor of Medicine, for three years, effective July 13, 2015, at an annual salary of $100,000.

Mr. Inki Kim, as Assistant Professor of Systems and Information Engineering, for three years, effective August 25, 2015, at an annual salary of $123,000.

Mr. Brent M. Kitchens, as Assistant Professor of Commerce, for three academic years, effective August 25, 2015, at an academic year salary of $160,000.

Dr. Amanda M. Kleiman, as Assistant Professor of Anesthesiology, for two years, effective June 25, 2015, at an annual salary of $100,000.

Mr. Thomas M. Koberda, as Assistant Professor of Mathematics, for four academic years, effective August 25, 2015, at an academic year salary of $80,000.
Dr. Rachel H. Kon, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Richard R. Kronfol, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Younghoon Kwon, as Assistant Professor of Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Kisha Lashley, as Assistant Professor of Commerce, for three academic years, effective August 25, 2015, at an academic year salary of $162,000.

Ms. Virginia T. LeBaron, as Assistant Professor of Nursing, for three academic years, effective August 25, 2015, at an academic year salary of $88,000.

Dr. Simon J. Lehtinen, as Assistant Professor of Medicine, for three years, effective August 17, 2015, at an annual salary of $100,000.

Mr. Noel J. Lobley, as Assistant Professor of Music, for four academic years, effective August 25, 2015, at an academic year salary of $65,000.

Dr. Christopher D. Lunsford, as Assistant Professor of Physical Medicine and Rehabilitation, for two years, effective August 3, 2015, at an annual salary of $100,000.

Dr. Kelly B. Mahaney, as Assistant Professor of Neurosurgery, for three years, effective July 15, 2015, at an annual salary of $100,000.

Dr. Goutham Malempati, as Assistant Professor of Medicine, for three years, effective June 29, 2015, at an annual salary of $100,000.

Dr. David McCollum, as Assistant Professor of Neurology, for three years, effective August 17, 2015, at an annual salary of $100,000.

Dr. William P. McCullough Jr, as Assistant Professor of Pediatric Imaging, for three years, effective July 1, 2015, at an annual salary of $100,000.

Mr. Akshaya Meher, as Assistant Professor of Research in Pharmacology, for one year, effective September 1, 2015, at an annual salary of $66,000.

Ms. Maureen J. Metzger, as Assistant Professor of Nursing, for three academic years, effective August 25, 2015, at an academic year salary of $87,000.
Dr. Anne M. Mills, as Assistant Professor of Pathology, for three years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Christina F. Mobley, as Assistant Professor of History, for four academic years, effective August 25, 2015, at an academic year salary of $70,000.

Dr. Lavika Mor, as Assistant Professor of Dentistry, for two years, effective July 1, 2015, at an annual salary of $100,000.

Mr. Luis G. Pancorbo Crespo, as Assistant Professor of Architecture, for four academic years, effective August 25, 2015, at an academic year salary of $74,000.

Dr. Tessy K. Paul, as Assistant Professor of Medicine, for three years, effective August 1, 2015, at an annual salary of $100,000.

Ms. Jennifer S. Pease, as Assistant Professor of Education, for three academic years, effective August 25, 2015, at an academic salary of $61,000.

Mr. Yoav Peled, as Visiting Professor in Israel Studies, for one academic year, effective August 25, 2015, at an academic year salary of $105,000.

Dr. Kate E. Pettit, as Assistant Professor of Obstetrics and Gynecology, for the period August 1, 2015 through June 30, 2018, at an annual salary of $100,000.

Dr. Jose J. Provencio, as Associate Professor of Neurology, for three years, effective August 15, 2015, at an annual salary of $100,000.

Ms. Kristin C. Roush, as Assistant Professor of Education, for three years, effective August 17, 2015, at an annual salary of $82,000.

Dr. Steven H. Rybicki, as Assistant Professor of Medicine, for three years, effective August 25, 2015, at an annual salary of $100,000.

Dr. Reza Salajegheh, as Assistant Professor of Anesthesiology, for three years, effective July 13, 2015, at an annual salary of $100,000.

Ms. Morgan D. Salmon, as Assistant Professor of Research in Surgery, for three years, effective July 1, 2015, at an annual salary of $64,800.

Dr. Kathleen Schwarz, as Assistant Professor of Medicine, for three years, effective July 15, 2015, at an annual salary of $100,000.
Ms. Laura Shaffer, as Associate Professor of Pediatrics, for three years, effective June 1, 2015, at an annual salary of $100,000.

Mr. Jogender Singh, as Assistant Professor in Biochemistry and Molecular Genetics, for three years, effective August 25, 2015, at an annual salary of $85,000.

Mr. Swapnil K. Sonkusare, as Assistant Professor of Molecular Physiology & Biological Physics, for three years, effective August 1, 2015, at an annual salary of $110,000.

Mr. Gregg Strauss, as Associate Professor of Law, for five years, effective August 25, 2015, at an annual salary of $168,000.

Dr. Heather T. Streich, as Assistant Professor of Emergency Medicine, for three years, effective July 1, 2015, at an annual salary of $100,000.

Ms. Mami Taniuchi, as Assistant Professor of Research in Medicine, for two years, effective April 20, 2015, at an annual salary of $86,086.

Dr. Julia F. Taylor, as Assistant Professor of Pediatrics, for three years, effective July 1, 2015, at an annual salary of $100,000.

Dr. Katarina Topchyan, as Assistant Professor of Medicine, for three years, effective August 1, 2015, at an annual salary of $100,000.

Dr. Anubha Tripathi, as Assistant Professor of Medicine, for three years, effective July 25, 2015, at an annual salary of $100,000.

Ms. Marija Vucelja, as Assistant Professor of Physics, for four academic years, effective August 25, 2015, at an academic year salary of $85,000.

Ms. Yuenan Wang, as Assistant Professor of Radiation Oncology, for three years, effective June 15, 2015, at an annual salary of $155,000.

Ms. Clareen A. Wiencek, as Associate Professor of Nursing, for three years, effective June 25, 2015, at an annual salary of $155,000.

Dr. Matthew J. Wolf, as Associate Professor of Medicine, for three years, effective June 1, 2015, at an annual salary of $100,000.

Ms. Caitlin D. Wylie, as Assistant Professor of Engineering and Society, for three academic years, effective August 25, 2015, at an academic year salary of $65,000.
Mr. Nengliang Yao, as Assistant Professor of Public Health Sciences, for three years, effective June 25, 2015, at an annual salary of $95,000.

Dr. Jeanne M. Young, as Assistant Professor of Dermatology, for three years, effective August 1, 2015, at an annual salary of $100,000.

Mr. Eli Zunder, as Assistant Professor of Biomedical Engineering, for the period January 4, 2016 through May 24, 2019, at an annual salary of $122,000.

ACTIONS RELATING TO CHAIRHOLDERS

RESOLVED, the actions relating to the Chairholders were approved as shown below:

Election of Chairholders

[t] Dr. Mark W. Anderson, as Harrison Distinguished Teaching Professor of Radiology, for five years, effective April 25, 2015.

[t] Ms. Margo A. Bagley, as Joseph C. Carter, Jr., Research Professor of Law, for three academic years, effective August 25, 2015. Ms. Bagley will continue as Hardy Cross Dillard Professor of Law, without term.

[t] Mr. Brian H. Balogh, as Dorothy Danforth Compton Professor in the White Burkett Miller Center of Public Affairs, for three years, effective June 25, 2015. Mr. Balogh will continue as Professor History, without term.

Mr. Scott C. Beardsley, as Charles C. Abbott Professor of Business Administration, for five years, effective July 25, 2015, at an annual salary of $520,000.

[t] Mr. Craig H. Benson, as Janet Scott Hamilton and John Downman Hamilton Professor of Civil Engineering, and Professor of Civil Engineering, effective July 1, 2015.

[t] Mr. Albert H. Choi, as Albert C. BeVier Research Professor of Law, effective August 25, 2015. Mr. Choi will continue as Professor of Law, without term.

[t] Mr. Martin N. Davidson, as Johnson and Higgins Professor of Business Administration, effective August 25, 2015. Mr. Davidson will continue as Professor of Business Administration, without term.
Mr. Gregory B. Fairchild, as Bigelow Research Associate Professor of Business Administration, for three years, effective August 25, 2015. Mr. Fairchild will continue as Professor of Business Administration, without term.

Ms. Kimberly K. Ferzan, as Harrison Robertson Professor of Law, effective August 25, 2015, at an academic year salary of $239,600. Ms. Ferzan will continue as Professor of Law, without term.

Mr. Brandon L. Garrett, as Justice Thurgood Marshall Distinguished Professor of Law, for three academic years, effective August 25, 2015, at an academic year salary of $223,500. Mr. Garrett will continue as Professor of Law, without term.

Mr. Michael D. Gilbert, as Sullivan and Cromwell Professor of Law, for three academic years, effective August 25, 2015, at an academic year salary of $201,000. Mr. Gilbert will continue as Professor of Law, without term.

Mr. Jared D. Harris, as Samuel L. Slover Research Associate Professor, for three years, effective August 25, 2015. Mr. Harris will continue as Associate Professor of Business Administration, without term.

Mr. Toby J. Heytens, as David H. Ibbeken '71 Research Professor of Law, for three academic years, effective August 25, 2015. Mr. Heytens will continue as Professor of Law, without term.

Mr. Thomas C. Katsouleas, as Robert C. Taylor Professor of Electrical and Computer Engineering, without term, and Professor of Physics, for three years, effective August 17, 2015, at an annual salary of $406,900.

Mr. James P. Landers, as Commonwealth Professor of Chemistry, effective August 25, 2015. Mr. Landers will continue as Professor of Chemistry, without term.

Mr. Michael J. Lenox, as Taylor Murphy Professor of Business Administration, for five years, effective August 25, 2015. Mr. Lenox will continue as Professor of Business Administration, without term.

Mr. Kenneth C. Lichtendahl, Jr., as Eleanor F. and Philip G. Rust Professor of Business Administration, for three years, effective August 25, 2015. Mr. Lichtendahl will continue as Professor of Business Administration, without term.

Mr. Zongli Lin, as Ferman W. Perry Professor in the School of Engineering and Applied Science, effective August 25, 2015. Mr. Lin will continue as Professor of Engineering and Applied Science, without term.
Mr. Marc L. Lipson, as Robert F. Vandell Research Professor, for three years, effective August 25, 2015. Mr. Lipson will continue as Professor of Business Administration, without term.

Mr. John T. Monahan, as Joel B. Piassick Research Professor of Law, for three academic years, effective August 25, 2015. Mr. Piassick will continue as John S. Shannon Distinguished Professor of Law, without term.

Ms. Barbara A. Perry, as White Burkett Miller Center of Public Affairs Professor of Ethics and Institutions, for three years, effective August 25, 2015. Ms. Perry will continue as Professor, General Faculty until August 25, 2015.

Ms. Jennifer J. Roe, as Mary Irene DeShong Professor of Design and Health in the School of Architecture, and Professor of Urban and Environmental Planning, effective August 25, 2015, at an academic year salary of $110,000.

Mr. George A. Rutherglen, as Barron F. Black Research Professor of Law, for three academic years, effective August 25, 2015. Mr. Rutherglen will continue as John Barbee Minor Distinguished Professor of Law, without term.

Ms. Saras Sarasvathy, as Isidore Horween Research Professor in the Colgate Darden Graduate School of Business Administration, for three years, effective August 25, 2015. Ms. Sarasvathy will continue as Professor of Business Administration, without term.

Dr. Robert G. Sawyer, as C. Bruce Morton Professor of Surgery, for five years, effective August 1, 2015.

Mr. Kevin Skadron, Harry Douglas Forsyth Professor of Engineering and Applied Science, effective August 25, 2015, at an annual salary of $221,300.

Mr. Rajkumar Venkatesan, as Bank of America Research Associate Professor of Business Administration, for three years, effective August 25, 2015. Mr. Venkatesan will continue as Professor of Business Administration, without term.

Mr. Pierre-Hugues Verdier, as E. James Kelly, Jr., Research Professor of Law, for three academic years, effective August 25, 2015. Mr. Verdier will continue as Professor of Law, without term.

Ms. Barbra M. Wall, as Thomas A. Saunders, III, Family Professor of Nursing and Professor of Nursing, effective August 25, 2015.

Dr. David Wilkes, as James Carroll Flippin Professor of Medical Science, for five years, and Professor of Medicine, without term, effective September 15, 2015, at an annual salary of $600,000.
Mr. Brantly Womack, as C. K. Yen Professor in the White Burkett Miller Center for Public Affairs, for three years, effective August 25, 2015. Mr. Womack will continue as Professor of Politics, without term.

Ms. Nettie A. Woolhandler, as Class of 1966 Research Professor of Law, for three academic years, effective August 25, 2015, at an academic year salary of $256,500. Ms. Woolhandler will continue as William Monor Lile Professor of Law, without term.

Change of Title of Chairholders

Dr. Thomas J. Braciale, from Beirne B. Carter Professor of Immunology, to Alumni Professor of Pathology, for five years, effective July 1, 2015. Dr. Braciale will continue as Professor Pathology, without term.

Mr. Victor H. Engelhard, from Harrison Distinguished Teaching Professor of Microbiology to Beirne B. Carter Professor of Immunology, for five years, effective July 1, 2015. Mr. Engelhard will continue as Professor of Immunology, without term.

Special Salary Action of Chairholders

Mr. Douglas W. Desimone, Ivy Foundation Pratt Distinguished Professor of Morphogenesis, effective June 1, 2015, from $177,300 to an annual salary of $253,000.

Ms. Margaret A. Shupnik, Gerald D. Aurbach Professor of Endocrinology, effective June 25, 2015, from $226,900 to an annual salary of $282,000.

Mr. Michael J. Weber, Marion McNulty Weaver and Malvin C. Weaver Professor of Oncology, effective August 15, 2015, from $218,400 to an annual salary of $172,300.

Resignations of Chairholders

Dr. Daryl R. Gress, Louise Nerancy Associate Professor of Neurology, effective July 31, 2015, to accept another position.

Mr. Ming Li, Jean and Ronald Butcher, M.D., Eminent Scholars Professor of Behavioral Medicine and Psychiatry, effective December 31, 2015, for personal reasons.

Retirement of Chairholder

Mr. Barry M. Gumbiner, Harrison Distinguished Teaching Professor of Cell Biology, effective July 1, 2015. Mr. Gumbiner has been a member of the faculty since June 4, 2002.
PROMOTIONS

RESOLVED, the following persons were promoted:

Ms. Ruth G. Bernheim, from Associate Professor of Public Health Sciences, and Associate Professor of Medicine, and Associate Professor of Family Medicine, to Professor of Public Health Sciences, and Professor of Medicine, and Professor of Family Medicine, for three years, effective August 25, 2015.

[t] Mr. Norbert Leitinger, from Associate Professor of Pharmacology, to Professor of Pharmacology, effective August 25, 2015.

SPECIAL SALARY ACTIONS

RESOLVED, the following persons shall receive the salary indicated:

Ms. Janet V. Cross, Associate Professor of Pathology, effective July 1, 2015, from $94,600 to an annual salary of $104,100.

Mr. Bijoy Kundu, Assistant Professor of Radiology, effective June 25, 2015, from $74,500 to an annual salary of $69,300.

[t] Mr. Peter L. Sheras, Professor of Education, effective July 1, 2015, from $128,700 to an annual salary of $138,700.

[t] Mr. Peter T. Stukenberg, Professor of Biochemistry and Molecular Genetics, effective March 25, 2015, from $133,000 to an annual salary of $150,000.

RESIGNATIONS

The President announced the following resignations:

Ms. Monica L. Banyi, Assistant Professor of Commerce, effective May 24, 2015, to accept another position.

Ms. Diane E. Boyer, Assistant Professor of Nursing, General Nursing Faculty, effective May 24, 2015, to accept another position.

Ms. Reba M. Childress, Assistant Professor, General Nursing Faculty, effective June 21, 2015, to accept another position.

Dr. Scott Commins, Associate Professor of Medicine, effective September 30, 2015, for personal reasons.

Dr. Andrea U. Courtney, Associate Professor of Family Medicine, effective October 16, 2015, to accept another position.
Dr. Thao Dang, Associate Professor of Medicine, effective August 1, 2015, for personal reasons.

Mr. Daniel R. Foltz, Associate Professor of Biochemistry & Molecular Genetics, effective June 30, 2015, to accept another position.

Dr. Elizabeth Gay, Associate Professor of Medicine, effective November 30, 2015, to accept another position.

Ms. Bridget S. Graves, Assistant Professor of Research in Public Health Sciences, effective July 3, 2015, to accept another position.

Dr. Jennifer A. Hanner, Assistant Professor of Psychiatry and Neurobehavioral Sciences, effective January 15, 2016, for personal reasons.

[t] Mr. Michael A. Hill, Associate Professor of Mathematics, effective July 31, 2015, to accept another position.

Ms. Deena R. Hurwitz, Professor of Law, General Faculty, effective July 31, 2015, for personal reasons.

Ms. Jennifer M. Knippen, Assistant Professor of Commerce, effective May 24, 2015, to accept another position.

Dr. Laura K. Knox, Assistant Professor of Plastic Surgery, effective August 19, 2015, to accept another position.

Mr. Chien Li, Associate Professor of Pharmacology, effective June 12, 2015, to accept another position.

[t] Mr. Ming Li, Professor of Psychiatry and Neurobehavioral Sciences, effective December 31, 2015, for personal reasons.

Ms. Barbara L. Maling, Assistant Professor of Nursing, effective July 19, 2015, to accept another position.

Mr. Akshaya Meher, Assistant Professor of Research in Surgery, effective August 30, 2015, to accept another position.

Ms. Karen M. Moran, Professor of Law, General Faculty, effective June 24, 2015, for personal reasons.

Mr. Craig S. Nunemaker, Associate Professor of Medicine, effective August 14, 2015, to accept another position.

Mr. Deric M. Park, Assistant Professor of Neurosurgery, effective June 1, 2015, to accept another position.

Dr. Jeffrey A. Potter, Assistant Professor of Clinical Rheumatology, effective February 26, 2016, for personal reasons.
Ms. Sophia A. Rosenfeld, Professor of History, effective May 24, 2015, to accept another position.

Mr. Michael R. Shirts, Associate Professor of Chemical Engineering, effective December 31, 2015, to accept another position.

Mr. John D. Simon, Robert C. Taylor Professor of Chemistry, effective June 30, 2015, to accept another position.

Ms. Tina Stanton-Chapman, Associate Professor of Education, effective May 24, 2015, to accept another position.

Ms. Heather D. Wathington, Research Assistant Professor of Education, effective May 24, 2015, to accept another position.

RETIREMENTS

The President announced the following retirements:

Mr. Billy K. Cannaday Jr., Professor, General Faculty, effective August 24, 2015. Mr. Cannaday has been a member of the faculty since July 1, 2006.

Mr. Vigen Guroian, Professor of Religious Studies, effective May 24, 2015. Mr. Guroian has been a member of the faculty since August 25, 2008.

Dr. Aliaa A. Khidr, Assistant Professor of Education, effective May 24, 2015. Dr. Khidr has been a member of the faculty since August 25, 1997.

Mr. Richard R. McGuire, Associate Professor, General Faculty, effective June 24, 2015. Mr. McGuire has been a member of the faculty since August 15, 1983.

Ms. Ophelia M. Payne, Assistant Librarian, General Faculty, Alderman Library, effective July 26, 2015. Ms. Payne has been a member of the faculty since February 1, 1980.

Ms. Ellen S. Pentz, Assistant Professor of Research in Pediatrics, effective June 12, 2015. Ms. Pentz has been a member of the faculty since September 1, 1983.

Mr. Joseph J. Wynne, Assistant Professor, General Faculty, effective July 26, 2015. Mr. Wynne has been a member of the faculty since November 1, 1978.

APPOINTMENTS

The President announced the following appointments:
Mr. Scott C. Beardsley, as Dean of the Darden School of Business Administration, for five years, effective July 25, 2015.

Mr. Craig H. Benson, as Dean of the School of Engineering and Applied Science, for five years, effective July 1, 2015.

Mr. Steven E. Laymon, as Interim Dean of the School of Continuing and Professional Studies, for two years or until a new Dean is appointed, whichever comes first, effective August 25, 2015.

Ms. Alice J. Raucher, as University Architect, for five years, effective September 14, 2015.

Dr. David Wilkes, as Dean of the School of Medicine, for five years, effective September 15, 2015.

RE-APPOINTMENT

The President announced the following re-appointment:

Mr. Jody K. Kielbasa, as Vice Provost for the Arts, for five years, effective July 1, 2015

ELECTION OF MR. THOMAS C. KATSOULEAS AS EXECUTIVE VICE PRESIDENT AND PROVOST

RESOLVED, Mr. Thomas C. Katsouleas is elected as Executive Vice President and Provost, for five years, effective August 17, 2015.

ELECTION OF VICE PRESIDENT RONALD R. HUTCHINS

RESOLVED, Mr. Ronald R. Hutchins is elected as Vice President of Information Technology, for five years, effective August 1, 2015.

ELECTION OF PROFESSOR EMERITI

RESOLVED, the following persons were elected Professor Emeritus:

Ms. Phyllis K. Leffler, Professor, General Faculty, effective May 25, 2015.

DEATHS

The president announced the following deaths:

Mr. Raul A. Baragiola, Alice and Guy A. Wilson Professor of Engineering and Professor of Engineering Physics and Materials Science, died July 25, 2015. Mr. Baragiola had been a member of the faculty since April 17, 2004.
Mr. Martin C. Battestin, William R. Kenan Jr. Professor Emeritus of English, died May 15, 2015. Mr. Battestin had been a member of the faculty since September 1, 1961 until retiring May 24, 1998.

Mr. Horace J. Bond, Professor Emeritus of History, died August 15, 2015. Mr. Bond had been a member of the faculty since January 16, 1993 until retiring August 25, 2012.

Mr. Theodore Caplow, Commonwealth Professor Emeritus of Sociology, died July 4, 2015. Mr. Caplow had been a member of the faculty since September 1, 1970 until retiring May 24, 2005.

Dr. Margarete di Benedetto, Professor Emeritus of Physical Medicine and Rehabilitation, effective July 25, 2015. Dr. di Benedetto had been a member of the faculty since October 15, 1989 until retiring December 31, 2003.

UNIVERSITY OF VIRGINIA AT WISE

ELECTIONS

RESOLVED, the following persons were elected to the faculty:

Mr. Ronald Floridia Jr, as Assistant Professor of Administration of Justice, The University of Virginia’s College at Wise, for one academic year, effective August 25, 2015, at an academic year salary of $62,500.

Ms. Jennifer L. Holm, as Assistant Professor of French, The University of Virginia’s College at Wise, for one academic year, effective August 25, 2015, at an academic year salary of $53,000.

Mr. Ryan D. Huish, as Assistant Professor of Biology, The University of Virginia’s College at Wise, for one academic year, effective August 25, 2015, at an academic year salary of $54,500.

Ms. Alexandria M. Reynolds, as Assistant Professor of Psychology, The University of Virginia’s College at Wise, for one academic year, effective August 25, 2015, at an academic year salary of $53,000.

Ms. Hannah W. Ryan, as Assistant Professor of Music, The University of Virginia’s College at Wise, for one academic year, effective August 25, 2015, at an academic year salary of $50,000.

RESIGNATIONS

The President announced the following resignations:
Ms. Ashley L. Dickinson, Assistant Professor of Administration of Justice, The University of Virginia's College at Wise, effective August 24, 2015, for personal reasons.

Ms. Christy Lee, Assistant Professor of Music, The University of Virginia's College at Wise, effective August 24, 2015, for personal reasons.

[t] Mr. Christopher J. Scalia, Associate Professor of English, The University of Virginia's College at Wise, effective August 24, 2015, for personal reasons.

APPOINTMENTS

The President announced the following appointments:

Ms. Shannon R. Blevins, as Associate Vice Chancellor for Economic Development and Engagement, The University of Virginia's College at Wise, for the period August 25, 2015 through June 24, 2020.

Mr. Robert S. Bragg, as Vice Chancellor for Development and College Relations, The University of Virginia's College at Wise, for five years, effective June 25, 2015.

CORRECTION TO THE RE-APPOINTMENT OF MR. JOHN S. HUGUENIN

RESOLVED, the re-appointment of Mr. John S. Huguenin, as Provost and Vice President of Academic Affairs, The University of Virginia's College at Wise, for five years, effective July 1, 2015, as shown in the Minutes of the meeting of the Board of Visitors dated June 12, 2015, is corrected to read as follows:

[t] Mr. John S. Huguenin, as Provost and Vice Chancellor for Academic Affairs, The University of Virginia's College at Wise, for five years, effective July 1, 2015.

Executive Session

After adopting the following motion, the voting members present plus Daniel Judge and Joe Garofalo went into closed session at 4:20 p.m.:

That the Board of Visitors go into closed session to discuss a personnel matter regarding an administrative appointment as permitted by the Code of Virginia section 2.2-3711 (A)(1).

At 5:20 p.m. the Board left closed session and, on motion, adopted the following resolution certifying that the deliberations in
closed session had been conducted in accordance with the exemptions permitted by the Virginia Freedom of Information Act:

That we vote on and record our certification that, to the best of each member’s knowledge, only public business matters lawfully exempted from open meeting requirements and which were identified in the motion authorizing the closed session, were heard, discussed or considered in closed session.

The Rector adjourned the meeting at 5:20 p.m.

Respectfully submitted,

Susan G. Harris
Secretary

SGH:ddr
These minutes have been posted to the University of Virginia’s Board of Visitors website.
http://www.virginia.edu/bov/publicminutes.html
CERTIFICATION OF EXECUTIVE MEETING

The Board of Visitors, sitting in Open Session, unanimously adopted a resolution certifying that while meeting in Executive Session – as permitted by the relevant provisions of the Code of Virginia – only public business authorized by its motion and lawfully exempted from consideration were discussed in closed session.

Respectfully submitted,

Susan G. Harris
Secretary
RESOLUTIONS NOT REQUIRING ACTION BY THE FULL BOARD

The following resolutions were adopted in Board committees and do not require approval by the full Board; they are enumerated below as a matter of record.

MEDICAL CENTER OPERATING BOARD – SEPTEMBER 17, 2015

Resolutions approved by the Medical Center Operating Board and reported to the full Board.

AMENDED AND RESTATED BYLAWS OF THE CLINICAL STAFF OF THE TRANSITIONAL CARE HOSPITAL

RESOLVED, the Medical Center Operating Board approves the Amended and Restated Bylaws of the Clinical Staff of the Transitional Care Hospital. These amendments, which are appended to this resolution as an Attachment, shall be effective as of September 17, 2015.

AMENDED AND RESTATED BYLAWS OF THE CLINICAL STAFF OF THE MEDICAL CENTER

RESOLVED, the Medical Center Operating Board approves the Amended and Restated Bylaws of the Clinical Staff of the Medical Center. These amendments, which are appended to this resolution as an Attachment, shall be effective as of September 17, 2015.

BUILDINGS AND GROUNDS COMMITTEE – September 18, 2015

Resolution approved by the Buildings and Grounds Committee and reported to the full Board.

CONCEPT, SITE, AND DESIGN FOR BLANDY EXPERIMENTAL FARM GREENHOUSE REPLACEMENT AND RESIDENTIAL HOUSING EXPANSION PROJECT

RESOLVED, the concept, site, and design for the greenhouse replacement and residential housing expansion at Blandy Experimental Farm are approved for further development and construction.
ATTACHMENTS
## ACADEMIC AND SUPPORT SERVICE STRATEGIES FOR SIX-YEAR PERIOD (2016-2022)

<table>
<thead>
<tr>
<th>Priority Ranking</th>
<th>Strategies (Short Title)</th>
<th>SSP Goal</th>
<th>2016-2017</th>
<th>2017-2018</th>
<th>Cost: Incremental, Savings, Reallocation</th>
<th>Strategies</th>
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<td>Total Amount</td>
<td>Amount From Tuition Revenue</td>
<td>Total Amount</td>
<td>Amount From Tuition Revenue</td>
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<td>1</td>
<td>Enrollment Growth</td>
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<td>Faculty Recruitment and Retention (See Note A, Note B)</td>
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<td>Incremental</td>
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<tr>
<td></td>
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<td></td>
<td>Reallocation</td>
<td>$0</td>
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<td>$0</td>
</tr>
<tr>
<td>3</td>
<td>Staff Development (See Note B)</td>
<td>3</td>
<td>Incremental</td>
<td>$4,256,000</td>
<td>$2,618,000</td>
<td>$6,174,000</td>
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<td></td>
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<td>$0</td>
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<tr>
<td>4</td>
<td>Faculty Start-Up Packages (See Note B)</td>
<td>2, 3, 4</td>
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<td>$22,318,000</td>
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<tr>
<td>5</td>
<td>Affordable Excellence: Undergraduate Student Financial Aid (AccessUVa)</td>
<td>1, 2</td>
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<td>see below</td>
<td>see below</td>
<td>see below</td>
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<tr>
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<td>6</td>
<td>Student Success: Total Advising</td>
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<tr>
<td>7</td>
<td>Research &amp; Economic Development: Pan-University Research Priorities (See Note B)</td>
<td>3, 4</td>
<td>Incremental</td>
<td>$2,152,500</td>
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<td>Reallocation</td>
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<td>8</td>
<td>Research &amp; Economic Development: Medical Translational Research</td>
<td>4</td>
<td>Incremental</td>
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<td>9</td>
<td>Research &amp; Economic Development: Innovation Ecosystem</td>
<td>3, 4</td>
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<td>$1,804,000</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>10</td>
<td>Quality Enhancement: Self-Supporting Programs</td>
<td>4</td>
<td>Incremental</td>
<td>$251,000</td>
<td>$0</td>
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<td>11</td>
<td>Student Success: High-Impact Educational Experiences (see Note B)</td>
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<td>Incremental</td>
<td>$99,000</td>
<td>$74,000</td>
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<td>Reallocation</td>
<td>$0</td>
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**Note:** See Note A, Note B for more details.
### ACADEMIC AND SUPPORT SERVICE STRATEGIES FOR SIX-YEAR PERIOD (2016-2022)

#### Biennium 2016-2018 (7/1/16-6/30/18)

<table>
<thead>
<tr>
<th>Strategies (Short Title)</th>
<th>SSP Goal</th>
<th>Cost: Incremental, Savings, Reallocation</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-2020</th>
<th>2020-2022</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Amount</td>
<td>Amount From Tuition Revenue</td>
<td>Total Amount</td>
<td>Amount From Tuition Revenue</td>
<td>Total Amount</td>
</tr>
<tr>
<td>Institutional Collaboration: The Virginia Community College System (VCCS)</td>
<td>1, 2, 3, 4</td>
<td>Incremental</td>
<td>$19,000</td>
<td>$19,000</td>
<td>$53,000</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Reallocation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Organizational Excellence – Resource Alignment and Optimization</td>
<td>3</td>
<td>Incremental</td>
<td>$3,700,000</td>
<td>$0</td>
<td>$4,864,000</td>
<td>$4,864,000</td>
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<tr>
<td></td>
<td></td>
<td>Savings</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
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<td></td>
<td></td>
<td>Reallocation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Research &amp; Economic Development: Southwest Virginia Economic Development Partnership (Appalachian Prosperity Project)</td>
<td>4</td>
<td>Incremental</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Reallocation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Student Success: Serving Virginia’s Veterans and Military through Collaboration</td>
<td>2, 3, 4</td>
<td>Incremental</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reallocation</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</tbody>
</table>

#### Total 2016-2018 Costs

<table>
<thead>
<tr>
<th>Item</th>
<th>Incremental (Included in Financial Plan line 70)</th>
<th>Savings</th>
<th>Reallocation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$54,471,500</td>
<td>$15,692,000</td>
<td>$90,105,000</td>
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</tbody>
</table>

#### Six-Year Financial Plan for Educational and General Programs, Incremental Operating Budget Need

<table>
<thead>
<tr>
<th>Items</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Amount</td>
<td>Amount From Tuition Revenue</td>
<td>Total Amount</td>
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<tr>
<td>Total Incremental Cost from Academic Plan</td>
<td>$54,471,500</td>
<td>$15,692,000</td>
<td>$90,105,000</td>
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<tr>
<td>Increase T&amp;R Faculty Salaries</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>T&amp;R Faculty Salary Increase Rate</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Increase Admin. Faculty Salaries</td>
<td>$743,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Admin. Faculty Salary Increase Rate</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Increase Classified Staff Salaries</td>
<td>$2,146,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Classified Salary Increase Rate</td>
<td>2%+Compression Adjustment</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Increase University Staff Salaries</td>
<td>$2,043,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>University Staff Salary Increase Rate</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Increase Number of Full-Time T&amp;R Faculty</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increase Number of Full-Time T&amp;R Faculty (FTE)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increase Number of Full-Time Admin. Faculty</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increase Number of Full-Time Admin. Faculty (FTE)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increase Number of Part-Time Faculty</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Increase Number of Part-Time Faculty (FTE)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Notes:**

- Note C: Amount From Tuition Revenue.
### ACADEMIC AND SUPPORT SERVICE STRATEGIES FOR SIX-YEAR PERIOD (2016-2022)

#### Biennium 2016-2018 (7/1/16-6/30/18)

<table>
<thead>
<tr>
<th>Strategies (Short Title)</th>
<th>SSP Goal</th>
<th>Cost: Incremental, Savings, Reallocation</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2016-17 Total Amount</td>
<td>2017-2018 Total Amount</td>
</tr>
<tr>
<td>Library Enhancement($)</td>
<td>1,300,000</td>
<td>$1,300,000</td>
<td>$2,600,000</td>
</tr>
<tr>
<td>Library Enhancement(FTE)</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Technology Enhancement($)</td>
<td>1,850,000</td>
<td>$0</td>
<td>$1,750,000</td>
</tr>
<tr>
<td>Technology Enhancement(FTE)</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>O&amp;M for New Facilities($)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>O&amp;M for New Facilities(FTE)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Utility Cost Increase</td>
<td>1,267,000</td>
<td>$1,267,000</td>
<td>$2,577,000</td>
</tr>
<tr>
<td>NGF share of state authorized salary increase/bonus</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Fringe/health insurance benefits increase</td>
<td>$4,630,000</td>
<td>$2,778,000</td>
<td>$9,893,000</td>
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<tr>
<td>VRS increase</td>
<td>$500,000</td>
<td>$300,000</td>
<td>$1,000,000</td>
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<tr>
<td>Additional In-State Student Financial Aid From Tuition Revenue</td>
<td>$2,328,000</td>
<td>$2,328,000</td>
<td>$5,428,000</td>
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<tr>
<td>Others (Specify, insert lines below)</td>
<td>$0</td>
<td>$0</td>
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</tbody>
</table>

**Total Additional Funding Need** = $66,346,500

### SCHEV Notes

1. Please ensure that these items are not double counted if they are already included in the incremental cost of the academic plan.
2. If planned, enter the cost of any institution-wide increase.
3. Enter planned annual faculty salary increase rate. Any salary increase entered here will be counted when calculating the gap to reach the 60th percentile in the future.
4. Enter number of FTE change over the FY2016 level in appropriate columns.

### UVa Notes

Note A: Faculty Recruitment and Retention includes salary increases for existing faculty and estimated costs of generational turnover (i.e., new faculty)
Note B: Amounts listed as "Reallocation" are funded, in-whole or in-part, from private sources
Note C: Percentage increase reflect strategic institutional increase above state authorized increase of 2%. Dollar amounts reflect portion of state authorized increase funded from institutional sources (tuition revenue).
Note D: Classified staff increase for FY2015-16 includes 2% base pay increase and compression adjustment ($1.34 million).
### University of Virginia

**Six-Year Financial Plan for Tuition and Fee Increases and Nongeneral Fund Revenue Estimates**


#### Items

<table>
<thead>
<tr>
<th>Items</th>
<th>2014-2015 (Estimated)</th>
<th>2015-2016 (Estimated)</th>
<th>2016-2017 (Planned)</th>
<th>2017-2018 (Planned)</th>
</tr>
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<tbody>
<tr>
<td>E&amp;G Programs</td>
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</tr>
<tr>
<td>Undergraduate, In-State</td>
<td>$16,932</td>
<td>$122,134,315</td>
<td>$11,577</td>
<td>$150,303,845</td>
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<td>Undergraduate, Out-of-State</td>
<td>$40,119</td>
<td>$196,871,260</td>
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<td>$221,928,630</td>
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<td>Graduate, In-State</td>
<td>$14,692</td>
<td>$32,531,222</td>
<td>$15,847</td>
<td>$37,705,644</td>
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<tr>
<td>Graduate, Out-of-State</td>
<td>$24,698</td>
<td>$70,193,933</td>
<td>$75,985,868</td>
<td>$81,397,961</td>
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<tr>
<td>Law, In-State</td>
<td>$49,694</td>
<td>$13,968,392</td>
<td>$15,311</td>
<td>$14,554,583</td>
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<tr>
<td>Law, Out-of-State</td>
<td>$52,694</td>
<td>$38,823,760</td>
<td>$25,425</td>
<td>$41,002,949</td>
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<td>Medicine, In-State</td>
<td>$43,416</td>
<td>$17,569,856</td>
<td>$19,301</td>
<td>$18,085,447</td>
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<tr>
<td>Medicine, Out-of-State</td>
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<td>$38,276,692</td>
<td>$26,315</td>
<td>$38,705,644</td>
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<tr>
<td>Dentistry, In-State</td>
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<td>$0</td>
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<tr>
<td>Dentistry, Out-of-State</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PharmD, In-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PharmD, Out-of-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Veterinary Medicine, In-State</td>
<td>$0</td>
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<tr>
<td>Veterinary Medicine, Out-of-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Other NGF</td>
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<td>$37,210</td>
<td>$38,140,839</td>
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<td>Total E&amp;G Revenue - Gross</td>
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<td>$572,164,733</td>
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<td>$621,201,673</td>
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<td>Total E&amp;G Revenue - Net of Financial Aid</td>
<td>$450,857,687</td>
<td>$488,126,406</td>
<td>$507,083</td>
<td>$535,083,083</td>
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<td>E&amp;G Revenue Used for Faculty Salary Increases</td>
<td>$3,041,343</td>
<td>$6,707,343</td>
<td>$11,074</td>
<td>$13,969,343</td>
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<tr>
<td>Average T&amp;R Faculty Salary Increase Rate</td>
<td>4.75%</td>
<td>4.50%</td>
<td>4.75%</td>
<td>3.00%</td>
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<tr>
<td>I Mandatory Non-E&amp;G Fees</td>
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<tr>
<td>Undergraduate</td>
<td>$2,066</td>
<td>$2,121</td>
<td>$2,174</td>
<td>$2,228</td>
</tr>
<tr>
<td>Graduate</td>
<td>$2,066</td>
<td>$2,121</td>
<td>$2,174</td>
<td>$2,228</td>
</tr>
<tr>
<td>Law</td>
<td>$2,066</td>
<td>$2,121</td>
<td>$2,174</td>
<td>$2,228</td>
</tr>
<tr>
<td>Medicine</td>
<td>$2,066</td>
<td>$2,121</td>
<td>$2,174</td>
<td>$2,228</td>
</tr>
<tr>
<td>Dentistry</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PharmD</td>
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<td>$0</td>
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<tr>
<td>Veterinary Medicine</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
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<tr>
<td>Total Auxiliary Revenue (ALL including room and board)</td>
<td>$192,244,000</td>
<td>$209,475,777</td>
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<td>Total Tuition and Fees</td>
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<tr>
<td>Undergraduate, In-State</td>
<td>$12,998</td>
<td>$13,698</td>
<td>$14,594</td>
<td>$15,353</td>
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<tr>
<td>Undergraduate, Out-of-State</td>
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<td>Graduate, In-State</td>
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<td>Graduate, Out-of-State</td>
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<td>$27,546</td>
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<tr>
<td>Law, In-State</td>
<td>$51,760</td>
<td>$53,960</td>
<td>$55,827</td>
<td>$57,760</td>
</tr>
<tr>
<td>Law, Out-of-State</td>
<td>$54,760</td>
<td>$56,960</td>
<td>$58,932</td>
<td>$60,973</td>
</tr>
<tr>
<td>Medicine, In-State</td>
<td>$45,482</td>
<td>$46,404</td>
<td>$47,343</td>
<td>$48,300</td>
</tr>
<tr>
<td>Medicine, Out-of-State</td>
<td>$56,090</td>
<td>$57,210</td>
<td>$58,365</td>
<td>$59,543</td>
</tr>
<tr>
<td>Dentistry</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Dentistry, Out-of-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PharmD, In-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>PharmD, Out-of-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Veterinary Medicine, In-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Veterinary Medicine, Out-of-State</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Student Financial Aid (Program 108)</td>
<td>$91,549,088</td>
<td>$102,172,097</td>
<td>$108,070,601</td>
<td>$114,118,590</td>
</tr>
<tr>
<td>Sponsored Programs (Program 110)</td>
<td>$276,512,000</td>
<td>$280,961,000</td>
<td>$285,440,000</td>
<td>$289,210,000</td>
</tr>
<tr>
<td>Unique Military Activities</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Last Revised: 9/3/2015
## Allocation of Tuition Revenue Used for Student Financial Aid

### 2015-16 (Actual)

<table>
<thead>
<tr>
<th>T&amp;F Used for Financial Aid</th>
<th>Gross Tuition Revenue</th>
<th>Tuition Revenue for Financial Aid (Program 108)</th>
<th>% Revenue for Financial Aid</th>
<th>Distribution of Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate, In-State</strong></td>
<td>$109,816,710</td>
<td>$14,770,521</td>
<td>13.5%</td>
<td>Note A, Note C</td>
</tr>
<tr>
<td><strong>Graduate, In-State</strong></td>
<td>$206,552,968</td>
<td>$27,562,848</td>
<td>13.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Graduate, Out-of-State</strong></td>
<td>$53,722,724</td>
<td>$5,495,431</td>
<td>12.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, In-State</strong></td>
<td>$3,347,492</td>
<td>$1,763,630</td>
<td>52.5%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, Out-of-State</strong></td>
<td>$54,177,340</td>
<td>$4,676,561</td>
<td>8.6%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$167,336,374</td>
<td>$32,264,786</td>
<td>19.5%</td>
<td>Note B</td>
</tr>
</tbody>
</table>

### 2014-15 (Estimated)

<table>
<thead>
<tr>
<th>T&amp;F Used for Financial Aid</th>
<th>Gross Tuition Revenue</th>
<th>Tuition Revenue for Financial Aid (Program 108)</th>
<th>% Revenue for Financial Aid</th>
<th>Distribution of Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate, In-State</strong></td>
<td>$122,134,315</td>
<td>$16,452,360</td>
<td>13.5%</td>
<td>Note A, Note C</td>
</tr>
<tr>
<td><strong>Graduate, Out-of-State</strong></td>
<td>$70,193,323</td>
<td>$5,347,209</td>
<td>7.6%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, In-State</strong></td>
<td>$25,389,309</td>
<td>$1,872,752</td>
<td>7.4%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, Out-of-State</strong></td>
<td>$56,393,616</td>
<td>$5,820,779</td>
<td>10.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$213,916,250</td>
<td>$28,042,388</td>
<td>13.0%</td>
<td>Note B</td>
</tr>
</tbody>
</table>

### 2015-16 (Planned)

<table>
<thead>
<tr>
<th>T&amp;F Used for Financial Aid</th>
<th>Gross Tuition Revenue</th>
<th>Tuition Revenue for Financial Aid (Program 108)</th>
<th>% Revenue for Financial Aid</th>
<th>Distribution of Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate, In-State</strong></td>
<td>$130,762,991</td>
<td>$25,021,315</td>
<td>18.1%</td>
<td>Note A, Note C</td>
</tr>
<tr>
<td><strong>Graduate, Out-of-State</strong></td>
<td>$75,985,686</td>
<td>$15,338,854</td>
<td>20.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, In-State</strong></td>
<td>$32,548,769</td>
<td>$6,527,435</td>
<td>20.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, Out-of-State</strong></td>
<td>$57,577,704</td>
<td>$6,011,735</td>
<td>10.5%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$236,684,330</td>
<td>$36,517,924</td>
<td>15.4%</td>
<td>Note B</td>
</tr>
</tbody>
</table>

### 2016-17 (Planned)

<table>
<thead>
<tr>
<th>T&amp;F Used for Financial Aid</th>
<th>Gross Tuition Revenue</th>
<th>Tuition Revenue for Financial Aid (Program 108)</th>
<th>% Revenue for Financial Aid</th>
<th>Distribution of Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate, In-State</strong></td>
<td>$140,288,968</td>
<td>$27,287,005</td>
<td>19.5%</td>
<td>Note A, Note C</td>
</tr>
<tr>
<td><strong>Graduate, Out-of-State</strong></td>
<td>$78,645,373</td>
<td>$15,397,161</td>
<td>19.6%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, In-State</strong></td>
<td>$36,893,074</td>
<td>$6,161,921</td>
<td>17.0%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, Out-of-State</strong></td>
<td>$55,303,408</td>
<td>$6,142,199</td>
<td>11.6%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$266,587,889</td>
<td>$38,846,355</td>
<td>14.5%</td>
<td>Note B</td>
</tr>
</tbody>
</table>

### 2017-18 (Planned)

<table>
<thead>
<tr>
<th>T&amp;F Used for Financial Aid</th>
<th>Gross Tuition Revenue</th>
<th>Tuition Revenue for Financial Aid (Program 108)</th>
<th>% Revenue for Financial Aid</th>
<th>Distribution of Financial Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undergraduate, In-State</strong></td>
<td>$159,303,845</td>
<td>$30,531,665</td>
<td>19.0%</td>
<td>Note A, Note C</td>
</tr>
<tr>
<td><strong>Graduate, Out-of-State</strong></td>
<td>$81,397,961</td>
<td>$6,154,580</td>
<td>15.0%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, In-State</strong></td>
<td>$32,548,769</td>
<td>$2,045,320</td>
<td>6.3%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>First Professional, Out-of-State</strong></td>
<td>$61,083,722</td>
<td>$6,357,145</td>
<td>10.4%</td>
<td>Note B</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$330,086,843</td>
<td>$36,846,355</td>
<td>11.2%</td>
<td>Note B</td>
</tr>
</tbody>
</table>

**Note A:** Tuition revenue is used for financial aid, however, the University does not separately track a tuition dollar paid to where it is expended. All undergraduate tuition revenue is collected into a $030 revenue project, then the amount required for financial aid is transferred to program 108. The University is committed to the principle that in-state undergraduates will pay for in-state undergraduate financial aid, while out-of-state undergraduates will pay for out-of-state undergraduate financial aid.

**Note B:** The actual allocation of financial aid to in-state and out-of-state undergraduates from tuition is dependent on other sources available for undergraduate financial aid. Total financial aid allocated to undergraduates through AccessUVa did NOT decline, just the portion that was required to be funded from tuition revenues. We maximize all other sources funded financial aid.

**Note C:** If you do not have actual amounts for Tuition Revenue for Financial Aid by student category, please provide an estimate. If values are not distributed for Tuition Revenue for Financial Aid, a distribution may be calculated for your institution.

University of Virginia

INTELLECTUAL PROPERTY ASSIGNMENTS AND EXTERNALLY SPONSORED RESEARCH

Background

The intellectual property (IP) worksheet captures report information for the most recently ended fiscal year as required by § 23-4.4 (B) of the Code of Virginia. Assignment of IP interests to persons or nongovernmental entities and the value of funds from persons or nongovernmental entities to support IP research are captured by the worksheet. Information is sought on research that yields IP regardless of the project’s intent. Information is sought about IP transferred as a result of either basic or applied research. The worksheet is structured to capture separate aggregate data on entities that have a principal place of business in Virginia and those with a principal place of business outside of Virginia.

Data Collection

Special Note: The information requested below pertains to the institution as well as any affiliated entity.

<table>
<thead>
<tr>
<th>FY 2014-2015</th>
<th>Principal Place of Business in VA</th>
<th>Principal Place of Business outside VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of assignments of intellectual property interests to persons or nongovernmental entities</td>
<td>16</td>
<td>55</td>
</tr>
<tr>
<td>Value of funds from persons or nongovernmental entities to support intellectual property research</td>
<td>$6,430,745</td>
<td>$61,614,778</td>
</tr>
<tr>
<td>Number of patents (by type) developed in whole or part from external projects funded by persons or nongovernmental entities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patent Type - Design</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patent Type - Plant</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patent Type - Utility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Definitions

**Assignment:** A transfer of ownership of Intellectual Property from one entity to another, including exclusive and royalty bearing licenses.

**Design Patent:** A patent that may be granted to anyone who invents a new, original, and ornamental design for an article of manufacture.

**Intellectual Property:** Creations of the mind – creative works or ideas embodied in a form that can be shared or can enable others to recreate, emulate, or manufacture them.

**Nongovernmental Entities:** An entity not associated with any federal, national or local government.

**Patent:** A property right granted by the Government of the United States of America to an inventor “to exclude others from making, using, offering for sale, or selling the invention throughout the United States or importing the invention into the United States” for a limited time in exchange for public disclosure of the invention when the patent is granted.

**Plant Patent:** A patent that may be granted to anyone who invents or discovers and asexually reproduces any distinct and new variety of plant.

**Sponsored Research:** Research that is supported and compensated by a sponsoring agency.

**Utility Patent:** A patent that may be granted to anyone who invents or discovers any new, useful, and nonobvious process, machine, article of manufacture, or composition of matter, or any new and useful improvement thereof.

**Value of Funds:** Total value of all monetary and in-kind support provided by an external sponsor of Intellectual Property research.
A. Institutional Mission

The University of Virginia’s mission is reflected in its Mission Statement that was revised in 2013. SCHEV approved the mission statement on January 24, 2014, to be effective 30 days following adjournment of the 2014 General Assembly.

The University of Virginia is a public institution of higher learning guided by a founding vision of discovery, innovation, and development of the full potential of talented students from all walks of life. It serves the Commonwealth of Virginia, the nation, and the world by developing responsible citizen leaders and professionals; advancing, preserving, and disseminating knowledge; and providing world-class patient care.

We are defined by:
• Our enduring commitment to a vibrant and unique residential learning environment marked by the free and collegial exchange of ideas;
• Our unwavering support of a collaborative, diverse community bound together by distinctive foundational values of honor, integrity, trust, and respect;
• Our universal dedication to excellence and affordable access.
B. Strategies

The University of Virginia’s current strategic plan, the Cornerstone Plan, was approved in November 2013 and implemented starting in the 2014-2015 academic year. The Cornerstone Plan identifies five “pillars” that provide strategic direction for the University and further the goals of the Statewide Strategic Plan and the Virginia Higher Education Opportunity Act (HEOA). These five “pillars” are:

1) Enrich and strengthen the University’s distinctive residential culture.
2) Strengthen the University’s capacity to advance knowledge and serve the Commonwealth of Virginia, the nation, and the world through research, scholarship, creative arts, and innovation.
3) Provide educational experiences that deliver new levels of student engagement.
4) Assemble and support a distinguishing faculty.
5) Steward the University’s resources to promote academic excellence and affordable access.

Over the last several years, U.Va. has worked to align various planning efforts into a multi-year planning process that will be updated regularly. The 16 key strategies/priorities outlined in the Six-Year Plan align directly with the University’s Cornerstone Plan and multi-year financial plan; advance the priorities of the Commonwealth, primarily the objectives of the Virginia Higher Education Opportunity Act and the goals and strategies of the Statewide Strategic Plan; and will enhance the quality of education, research, and service at the University.

SIX-YEAR PLAN STRATEGIES

Priority 1 – Enrollment Growth
To increase enrollment of Virginia students, implement Board of Visitors approved plan for enrollment growth with approximately 33 to 40 percent of growth targeted in STEM-H disciplines. Undergraduate on-Grounds enrollment growth targets are 200 in 2016-17 (over 2015-16) and 88 in 2017-18 (over 2016-17) for a total growth of 288 students over the 2016-18 biennium. Because of an unexpectedly high yield rate among first-year students in fall 2014, the University exceeded its first-year target by 139 students that year. As a result, the University’s current undergraduate enrollment growth plan, scheduled to reach completion in 2018-19, will be fulfilled one year early (in 2017-18). For 2016-18, the on-Grounds graduate and professional enrollment growth is estimated to be 159 students.

Note: The University's enrollment growth plan is contingent upon receiving the appropriate state share of funding per Virginia student.

STATE GOALS: 2, 4
TJ21 OBJECTIVES: E1, E6
CORNERSTONE PLAN Pillars: 1
Priority 2 – Faculty Recruitment and Retention
To increase quality and enhance recruitment and retention, implement Board of Visitors’ four-year plan to address the competitiveness of faculty salaries. The University, along with other institutions of higher learning, faces a dramatic generational turnover in faculty during the coming decade. To approach the generational turnover from a position of strength, the University will improve the average faculty salary at each rank to the 20th position of its Association of American Universities (AAU) peers. We have not made as much progress as we anticipated, increasing our overall rank to 27 from 34 in 2013-14, but falling one spot to 28 in 2014-15. The Board has asked the administration to re-examine what it will take to reach our goal.

STATE GOALS: 3
TJ21 OBJECTIVES: D
CORNERSTONE PLAN PILLARS: 4

Priority 3 – Staff Development
To increase quality and enhance recruitment and retention, improve compensation for University and classified staff. The long-term plan is to move to competitive ranges for all University staff. Total incremental costs assume no state-authorized salary increase for classified staff since instructions direct institutions to assume no incremental general funds. A three percent Board of Visitors authorized merit increase pool for University staff and administrative/professional faculty is included in the budget for the two-year period. In addition, we will continue our focus on building staff leadership at all levels by offering more opportunities for experiential learning assignments, coaching, career advising, and training for leaders across the University. Supporting initiatives include, but are not limited to:

- Succession Development Program — Year-long program that prepares employees for possible future leadership roles and provides opportunities for personal development.
- Executive Onboarding Program — Six-month program to integrate new senior-level managers and executives to U.Va.
- Exceptional Assistants’ Seminar Series — Program designed to enhance administrative skills, broaden understanding of the University culture and to introduce program graduates to a network that focuses on personal development, mentoring, and community service.
- Leadership Essentials — Program designed to give new managers the basic knowledge, skills, and abilities needed to succeed at U.Va.
- Leadership Strategies — Explores a variety of topical issues relating to both the mission of the University and the leadership competence of its managers.
- Grounds for Success — Comprehensive, three-step orientation experience: (1) in-person program; (2) e-learning modules to be completed within two weeks of the in-person component; and (3) follow-up checklist to assist new employees in their transition to the University and in jumpstarting a successful career at the University.
Priority 4 – Faculty Start-Up Packages
To increase degree production in STEM-H disciplines, implement plan to provide sufficient start-up packages and space to accommodate new STEM-H faculty associated with enrollment growth and retirement turnover.

At a research university such as U.Va., the costs associated with the recruitment of STEM-H faculty go beyond salary and fringe benefits. Such faculty require start-up packages to support the renovation of laboratories, purchase of equipment, hiring of research staff, and training of graduate students, among others, while the research program is being established. It is the expectation that, within a few years, extramural funding will provide support for ongoing costs. Start-up packages do not include base salary support for faculty.

Based on expected retirements and new hiring we estimate the need for 54 start-up packages in over the 2016-18 biennium. The projected payouts are $32.87 in FY2016-17 and $47.12 in FY2017-18. Start-up packages are normally paid out over three years.

Priority 5 – Affordable Excellence: Undergraduate Student Financial Aid (AccessUVa)
The University of Virginia’s Board of Visitors authorized AccessUVa in February 2004 to ensure that an undergraduate education at the University would be available to all students regardless of their financial circumstances. The program has been successful in increasing socioeconomic diversity, reducing student loan debt and meeting 100 percent of need for all of the University’s undergraduate students. This program continues to bring the University significant recognition as the premier need-based aid program for a public institution in the United States.

In 2014-15, the University’s Board of Visitors charged a subcommittee to recommend strategies to further improve affordability and predictability for Virginians with financial need. As a result, in March 2015, the Board of Visitors approved a plan that will reduce the maximum need-based indebtedness for Virginians by $10,000: maximum loans will decrease from $14,000 to $4,000 for low-income Virginians and from $28,000 to $18,000 for all other Virginians who demonstrate financial need. In addition, the University will offer to Virginia students who enroll in Fall 2015 or later, the option of a four-year, fixed-price base tuition at a reasonable premium. In the initial offering 170 students have selected the guaranteed option.
Section C includes additional information on the structure of AccessUVa and how aid is distributed to families of different income levels.

Note: Incremental costs for in-state students are included in the “Additional In-State Student Financial Aid From Tuition Revenue - UGrad and Grad” line item in the “Academic and Financial Plan.” Incremental costs for out-of-state students are included in the “Additional Out-of-State Student Financial Aid From Tuition Revenue - UGrad and Grad” line item in the “Academic and Financial Plan.”

STATE GOALS: 1, 2
TJ21 OBJECTIVES: A, E5
CORNERSTONE PLAN PILLARS: 5

Priority 6 – Student Success: Total Advising
To improve retention and graduation rates, the University will continue to pioneer “total advising,” a multidimensional process that combines high-quality academic advising, career advising, and coaching, includes an online portfolio, and capitalizes on relationships with U.Va. alumni.

Supporting initiatives include, but are not limited to:
- Continuing growth of the College Advising Fellows and College Advising Seminars (COLAs), concurrent with enrollment growth.
- Continuing development of a total advising center designed to enhance student access to and awareness of academically-related curricular and co-curricular interests.
- Expanding support to assist students in securing national and international scholarships and fellowships.
- Continuing implementation of a re-envisioning of the University’s approach to career advising and career development.

STATE GOALS: 2, 3, 4
TJ21 OBJECTIVES: D, E3, E5, E6, E8, E10, E12
CORNERSTONE PLAN PILLARS: 1, 3

Priority 7 – Research & Economic Development: Pan-University Research Priorities
To increase research, including regional and public-private collaboration, continue development of and support for pan-University research priorities: (1) systems bioscience, bioengineering, neuro and cognitive science; (2) computational systems science and modeling (i.e. “Data Science”, and automata computing); (3) environment, sustainability and resilience; and (4) energy systems. The University will also pursue additional pan-University or school-specific research priorities, not included above, when faculty expertise converges with opportunities presented by private enterprise, local and state government, the federal government, and/or other strategic initiatives.
Supporting initiatives include, but are not limited to:

- Increasing research support from large corporations, small businesses, NGOs, foundations, venture capitalists, state government, local government, and non-traditional federal agencies. Continuing and expanding partnerships with:
  - major companies through U.Va.’s Strategic Corporate Partner program;
  - the Commonwealth Center for Advanced Logistics Systems (CCALS).
  - the Commonwealth Center for Advanced Manufacturing (CCAM).

- Increasing library support for collaborative research, particularly with respect to “Data Science.”

- Leveraging the U.Va. Research Park to serve the local defense community, provide a transition zone for successful startup companies, and optimize space allocation for the University.

- Establishing a research resources center to better enable faculty (in particular new faculty hires) to have access to training and support for increased quality proposals to agencies and foundations, and support of multi-investigator interdisciplinary research proposals.

**STATE GOALS: 3, 4**
**TJ21 OBJECTIVES: E8, E10, E11, E13**
**CORNERSTONE PLAN PILLARS: 2, 3, 4**

**Priority 8 – Research & Economic Development: Medical Translational Research**
Increase research and expand medical translational research, including cancer clinical trials and focused ultrasound surgery, so that laboratory discoveries are converted into new methods to diagnose and treat illness and augment cancer outreach and prevention activities.

**STATE GOALS: 4**
**TJ21 OBJECTIVES: E8**
**CORNERSTONE PLAN PILLARS: 2, 4**

**Priority 9 – Research & Economic Development: Innovation Ecosystem**
To increase research and promote economic development, enhance the innovation ecosystem. Supporting initiatives include, but are not limited to:

- Continuing implementation of the U.Va. Economic Development Accelerator (UVEDA), designed to facilitate knowledge transfer and business development around University research and innovation, including a proof-of-concept seed fund.

- Continuing to work with the Licensing and Ventures Group to increase deal flow.

- Increasing the number of successful start-up companies generated from U.Va. research.
STATE GOALS: 3, 4
TJ21 OBJECTIVES: E8, E12
CORNERSTONE PLAN PILLARS: 2, 4, 5

**Priority 10 – Quality Enhancement: Self-Supporting Programs**
To maintain and enhance programmatic quality of self-supporting programs (business, data science, graduate commerce, and law), incremental revenue generated by these programs will be used to fund their respective increases in financial aid, utilities and facility maintenance, electronic library resources, and academic programs.

STATE GOALS: 4
TJ21 OBJECTIVES: E13
CORNERSTONE PLAN PILLARS: 1, 3, 4, 5

**Priority 11 – Student Success: High-Impact Educational Experiences**
As part of the University’s strategic plan, continue support for high-impact educational experiences that complement and enhance classroom learning and prepare students for life after graduation. High-impact educational experiences encompass a broad array of experiential learning opportunities including, but not limited to:

- Meaningful research with faculty;
- Community engagement and public service;
- Entrepreneurial experiences;
- Global experiences; and
- Internships and externships.

Specific initiatives for the 2016-18 biennium include expanded support for students seeking internships and increased financial support for undergraduate research opportunities.

STATE GOALS: 3
TJ21 OBJECTIVES: D
CORNERSTONE PLAN PILLARS: 1, 3, 4

**Priority 12 – Student Success: Technology-Enhanced Learning**
To increase access, continue growth and development of academic programs and coursework using technology-enhanced instruction. At present, the University offers 19 certificate programs and 21 degree programs that meet the distance education definition of the Southern Association of Colleges and Schools Commission on Colleges (SACSCOC). In 36 of these 40 programs, students may earn more than 50 percent of the program through distance education. In addition, the University is heavily focused on enhancing the use of technology in its residential curriculum.
Supporting initiatives include, but are not limited to:

- Continuing graduate program offerings through the Commonwealth Graduate Engineering Program (CGEP).
- Continuing implementation of the Bachelor of Professional Studies (B.P.S.) in Health Sciences Management, an online undergraduate degree program.
- Implementing expanded online graduate program offerings in (1) administration and supervision, (2) curriculum and instruction, and (3) special education, through the Curry School of Education.
- Continuing partnership with George Mason University, James Madison University, Old Dominion University, and Virginia Tech through the 4-VA course-sharing initiative using Cisco TelePresence technology.
- Continuing partnership with Duke University through a course-sharing initiative using Cisco TelePresence technology. Expansion of the partnership to Vanderbilt University in fall 2015.
- Developing new online certificate programs (such as federal acquisition) and continuing migration of existing certificate programs (such as accounting) to online formats.
- Continuing partnership with Coursera to offer massive open online courses (MOOCs), including expansion into specializations, professional development coursework for educators, and courses targeted towards University alumni.
- Investing in production facilities and classrooms required to place the University at the forefront of efforts that enrich traditional in-class activities with Web-based or digital technologies.
- Continuing the Course Redesign Institute, an interdisciplinary program in which faculty design or substantially redesign courses to promote significant, long-term learning.

STATE GOALS: 2, 3, 4
TJ21 OBJECTIVES: C, E1, E6, E10
CORNERSTONE PLAN PILLARS: 1, 3, 5

**Priority 13 – Institutional Collaboration: The Virginia Community College System (VCCS)**

To increase degree completion for Virginians with partial credit:

- Developing a guaranteed admission agreement (GAA) with the VCCS for the Bachelor of Interdisciplinary Studies (BIS) program.
- Continuing expansion of the BIS program to Thomas Nelson Community College (current sites include Charlottesville, Tidewater Community College, Northern Virginia Community College, and the Richmond Center).
- Continuing implementation of the Bachelor of Professional Studies in Health Sciences Management program, an online undergraduate degree program developed in cooperation with the VCCS.
- Continuing implementation of the GAA with the VCCS for the Bachelor of Professional Studies in Health Sciences Management program and for the RN to BSN program.
• Continuing implementation of the RN to BSN distance learning initiative with Germanna Community College (GCC).

STATE GOALS: 1, 2, 3, 4
TJ21 OBJECTIVES: E1, E2, E3, E4, E6, E7, E10, E13
CORNERSTONE PLAN PILLARS: 1, 3, 5

**Priority 14 – Organizational Excellence – Resource Alignment and Optimization**
As one of the nation’s premier public universities, the University of Virginia pursues innovation, quality and improvement leading to effective stewardship of its resources. Building upon the success of the institution’s improvement program established in 1994, a formal program of Organizational Excellence (OE) was established in August 2013 as part of the University’s Cornerstone Strategic Plan. The OE program seeks opportunities to enhance stewardship of resources — through resource optimization and resource alignment to support and advance institutional priorities and mission activities. Both the academic schools and administrative units contribute to the overall goals of organizational excellence.

The total estimated savings and reallocations for FY2016-17 are $20.4 million and for FY2017-18 are $21.6 million.

**Process and Service Delivery Improvements**
Service delivery improvements involve the optimization of resources through a variety of means including, but not limited to, consolidations, new delivery models, and discontinuation of obsolete or underutilized services. Other process improvements often result in effort savings, cost avoidance, and enhanced services and allow effort savings to be redirected to higher value activity.

*Examples:*
- Begin year one implementation of redesigned high-performing and efficient human resources service model across the enterprise, including academic division and medical center, to advance the University’s goals and aspirations.
- Consolidate servers and data centers for more efficient maintenance, higher quality services, cost-savings, and increased data security.
- Consolidate email systems to reduce infrastructure costs and enable faculty and staff to engage and communicate more efficiently, a savings of time and effort.
- Complete voice over IP deployment of 26,000 phone lines across the Medical Center and Academic Division.
- Implementation of formal service level agreements between administrative service providers and the schools (internal customers) that describe the services delivered, document service levels, and specify the responsibilities of the provider and the customer.
• Implement fully-integrated travel and expense solution to simplify travel processes for faculty and staff, enable enhanced duty of care reporting, and ensure better compliance with federal export control regulations, and negotiate contracts for cost savings.
• Restructure gift processing to consolidate operations, resulting in expedited, timely and accurate gift recording and receipting.
• Develop and implement a formal administrative review program to assess a unit’s quality, efficiency, and effectiveness of services; and to promote continuous improvement.
• Accrue savings on interest due to debt restructuring.
• Implement second phase of research administration technology support, including an on-line proposal form and budget tool to manage expenditures. Implement other identified research administration improvements.
• Continue strategic sourcing of additional commodities and services (e.g., in-bound freight, promotional products, lab supplies, computer hardware and peripherals).
• Implement an institutional-wide scholarship management system to reduce redundancies in process and enhance tracking.
• Continue with multi-faceted energy conservation program. New activities include participation in the Dominion Virginia Power Community Solar Power Program and leasing roofs on 2 buildings for solar generation.
• Continue to improve space optimization in both owned and leased space

Organizational Restructuring
Organizational Restructuring allows the University to realign its existing human resources and positions to meet the changing needs of the institution. By repurposing positions in lieu of new hiring, the University is able to continue to deliver quality service while avoiding the costs associated with new hires.

Examples:
• Implementation of Early Retirement Incentive Program in fall 2015 provides an opportunity to optimize staffing (approximately 800 staff are eligible).
• Continue efforts to address inefficient organizational structures (i.e., spans of control) through enhanced analytics, education, and consultation.
• Promote opportunities for more flexible staffing - job sharing, rotations, etc.
• Reduction in administrative staff in some areas as a result of discontinuing activities or redistribution of work among staff.

Organizational Capacity for Change
Organizational Capacity refers to targeted efforts to develop the institution’s readiness for change through the development of individuals and effective organizational practices and systems.

Examples:
• Continue to build the internal quality network, a community of practice, providing professional development and opportunities for sharing and scaling solutions across the University.
• Refine change leadership training and offer to additional cohorts.
• Facilitate increased academic-administrative collaborations through councils, advisory committees and other partnerships.
• Implement a decision support reporting tool to enhance data analytics and reporting capabilities, resulting in significant savings of effort to compile and manipulate data and enhancing access to meaningful information for decision-making.

STATE GOALS: 3
TJ21 OBJECTIVES: B, E9, E12
CORNERSTONE PLAN PILLARS: 5

Priority 15 – Research & Economic Development: Southwest Virginia Economic Development Partnership (Appalachian Prosperity Project)
Continue and enhance the University’s Southwest Virginia Economic Development Partnership, the Appalachian Prosperity Project, with a continued focus on (1) K-12 education support, (2) business support/entrepreneurship, and (3) access to healthcare. Recent focus has been on regional centers of excellence for advanced manufacturing workforce training, U.Va.’s Cancer Center Without Walls program, town planning assistance, creating new economic development opportunities related to the Clinch River, and the creation of a community and youth development center.

STATE GOALS: 4
TJ21 OBJECTIVES: E13
CORNERSTONE PLAN PILLARS: 2

Priority 16 – Student Success: Serving Virginia’s Veterans and Military through Collaboration
The University will continue to implement the Veterans Access, Choice and Accountability Act of 2014 ("Choice Act"). At this time, the costs associated with implementation are not known.

STATE GOALS: 2, 3, 4
TJ21 OBJECTIVES: E1, E2, E3, E6, E7, E10, E13
CORNERSTONE PLAN PILLARS: 1, 3, 5
C. Financial Aid

The University of Virginia’s Board of Visitors authorized AccessUVa in February 2004 to ensure that an undergraduate education at the University would be available to all students regardless of their financial circumstances. The program has been successful in increasing socioeconomic diversity, reducing student loan debt and meeting 100 percent of need for all of the University’s undergraduate students. This program continues to bring the University significant recognition as the premier need-based aid program for a public institution in the United States.

In 2014-15, the University’s Board of Visitors charged a subcommittee to recommend strategies to further improve affordability and predictability for Virginians with financial need. As a result, in March 2015, the Board of Visitors approved a plan that will reduce the maximum need-based indebtedness for Virginians by $10,000: maximum loans will decrease from $14,000 to $4,000 for low-income Virginians and from $28,000 to $18,000 for all other Virginians who demonstrate financial need. In addition, the University will offer to Virginia students who enroll in Fall 2015 or later, the option of a four-year, fixed-price base tuition at a reasonable premium. In the initial offering 170 students have selected the guaranteed option.

The following table highlights examples of how aid will be awarded to students in Fall 2016 through the AccessUVa program to students from families of different income levels (low = less than 200 percent of federal poverty guidelines; all others = greater than 200 percent of federal poverty guidelines):

<table>
<thead>
<tr>
<th></th>
<th>Low Income Family Income &lt; $47k 200% of Poverty or Less Example Income: $0k</th>
<th>Other Students with Need Family Income &gt; $47k 200% of Poverty or Greater Example Income: $70k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-State Total Cost of Attendance</strong></td>
<td>$28,932</td>
<td>$28,932</td>
</tr>
<tr>
<td><strong>Expected Family Contribution</strong></td>
<td>$1,600</td>
<td>$13,600</td>
</tr>
<tr>
<td><strong>Subsidized Loans</strong></td>
<td>$1,000</td>
<td>$3,500</td>
</tr>
<tr>
<td><strong>Work Study</strong></td>
<td>$3,000</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Grants (state, federal, private sources)</strong></td>
<td>$17,175</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Grants from tuition</strong></td>
<td>$6,157</td>
<td>$11,832</td>
</tr>
<tr>
<td><strong>Unmet Need</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

1 Subsidized loans for students with need from families with income greater than $47,000 range from $3,500 to $5,000 based on year and cap at $18,000 over four years.

2 Fund sources: Federal Pell Grant, $5,775; Federal Supplemental Educational Opportunity Grant (SEOG), $600; Virginia Guaranteed Assistance Program (VGAP), $10,800.

University of Virginia
July 1, 2015
The following chart shows the various sources of funding that comprise the AccessUVa budget, which reached approximately $105.5 million in 2014-15. Institutional grants comprise approximately $47 million of the budget and are taken from unrestricted institutional funds. The remainder of the funding comes from state, federal, and private funds, as well as athletics grants-in-aid.
D. Evaluation of Previous Six-Year Plan

Priority 1 – Enrollment Growth
The previous plan called for undergraduate enrollment growth of 256 in 2014-15 (over 2013-14). Due to an unexpectedly high yield rate for the first-year entering class in fall 2014 and slightly higher than normal retention rates, the actual growth was 512. The previous plan also called for additional growth of 280 undergraduates in fall 2015. The current plan calls for an additional 200 undergraduate students in fall 2015, on top of the growth of 512 the previous year. So the University’s current undergraduate enrollment growth plan, originally scheduled to reach completion in 2018-19, will be fulfilled one year early (in 2017-18).

For graduate and first-professional students, the improving economy has kept more students in the workforce and had a somewhat negative effect on our plans for very modest growth. The previous plan called for growth of 199 students in the 2014-16 biennium. Fall 2014 resulted in growth of only 36 such students and little growth is expected in fall 2015.

Priority 2 – Faculty Compensation
Beginning in 2013-14, the University began increasing faculty compensation in alignment with the Board of Visitors-approved four-year plan to address faculty salary competitiveness with the goal of being ranked at the 20th position among its Association of American University (AAU) peers. Average salary increases of 4.75% were awarded in both 2013-14 and 2014-15. Consequently, the University’s average faculty salary ranking increased from 32nd to 27th in 2013-2014. In 2014-2015, the University’s average faculty salary rank fell slightly to 28th and is $6,500 below the 20th ranked institution. The Board has asked the administration to re-examine how to achieve this goal in a timely manner.

Priority 3 – Staff Compensation
The University has an overall goal for staff salaries of reaching the median paid by our peer group (a combination of AAU institutions as well as private sector organizations). Classified staff are bound by state-authorized salary increases while the Board of Visitors has greater flexibility with regard to University staff salaries. In 2014-15 we distributed a three percent merit-based salary pool to University staff. U.Va.’s University staff salaries currently lag the median by 7% (classified staff are at 99% of the median). In 2015-16, the operating budget includes the two percent across-the-board salary increase for classified staff who “meet expectations” and the $65 per year of service compression adjustment. The budget includes an average two percent salary increase for University staff that will be awarded based on merit. As of June 2015 the University’s staff is 70 percent University staff and 30 percent classified staff.

Priority 4 – Faculty Start-Up Packages
The University is implementing its plan to provide sufficient start-up packages and space to accommodate new STEM-H faculty associated with enrollment growth and retirement turnover. Such faculty require start-up packages to support the renovation of laboratories,
purchase of equipment, hiring of research staff, and training of graduate students, among others, while the research program is being established. It is the expectation that, within a few years, extramural funding will provide support for ongoing costs. Start-up packages do not include base salary support for faculty. In March of 2015, the Board of Visitors approved a multi-year financial plan as part of the Affordable Excellence model that relies on a number of fund sources (e.g. state, private, F&A, Equipment Trust Fund) to address the cost of faculty start-up packages. In addition, the University is utilizing the $4 million general fund appropriation received in 2014 to renovate eleven labs in the College of Arts and Sciences, School of Engineering and Applied Science, and the School of Medicine.

Priority 5 – Affordable Access: Undergraduate Student Financial Aid (AccessUVa)
In 2014-15, the University’s Board of Visitors charged a subcommittee to recommend strategies to further improve affordability and predictability for Virginians with financial need. As a result, in March 2015, the Board of Visitors approved a plan that will reduce the maximum need-based indebtedness for Virginians by $10,000 over four years: from $14,000 to $4,000 for low-income Virginians and from $28,000 to $18,000 for all other Virginians who demonstrate financial need. In order to fund the additional grant aid required to reduce indebtedness the University raised 2015-16 tuition for entering undergraduate Virginians by $1,000 above the base tuition level. The plan calls for another increase of $1,000 for those Virginian students entering in the Fall of 2016. The plan will be fully implemented with all in-state students paying the same tuition rate after five years. The University has a goal to raise $1 billion in endowment for need-based financial aid which would fully fund the amount of grants funded by tuition today.

In addition, the University will offer to Virginia students who enroll in Fall 2015 or later, the option of a four-year, fixed-price base tuition at a reasonable premium. The price for students entering in the Fall of 2015 is $12,950. We have received applications from 162 students who selected the guaranteed option.

Priority 6 – Student Success: Total Advising
The University has retained BrightSpot, a consultancy that specializes in creating “strategies for spaces, services, organizations, and experiences.” BrightSpot is assisting the University with needs assessment to develop a total advising center in Clemons Library (renovation scheduled to begin in fall 2016). By working with the University’s undergraduate schools and students, the University has identified the following characteristics of total advising and the services provided in a total advising center:

- Consist of a blend of physical and digital resources and services.
- Both direct students to resources and actively help students address their needs and make informed decisions.
- Integrate across advising services to create connections, establish a network of advising services and providers, and increase convenience.
- Advisors will act as guides, helping students interact with services and make choices throughout their time at the University.
- Be flexible to support a variety of activities and needs, and provide students with choices in how they would like to receive support.
• Engage and empower students to design and follow their paths.

In fall 2013, the University completed a comprehensive review of undergraduate career services to better meet the career development needs of students. As part of its strategic plan, the University has focused on implementing the recommendations emerging from this review. Recent accomplishments include:

• Development of “career communities” focused on building networks between students and University alumni.
• Launching biannual “Fourth-Year Career Summit,” an intensive two-day program focused on career development and providing students with the skills to conduct a successful employment search.
• Launching Virginia Alumni Mentoring, a program that connects third-year students with alumni who have volunteered to provide insights about the process of choosing and starting a career in a specific field.
• Offering coursework focused on connecting the liberal arts with the world of work.

The University continues to support the expansion of College Advising Seminars (COLAs). COLAs are one-credit, graded seminars open to first-year students in the College of Arts and Sciences. Approximately 80 percent of course content is academic in nature with 20 percent of course content devoted to group advising. COLA instructors continue to serve as a student’s advisor until the selection of a major.

• The University increased COLA sections from 45 to more than 60 in 2014-15, with 83 planned for 2015-16.
• University Career Services (UCS) participated in 40 of these COLAs.
• The School of Engineering and Applied Science (SEAS) piloted a COLA-like course and plans to expand such offerings in subsequent academic years.

Priority 7 – Research & Economic Development: Pan-University Research Priorities
To increase research, including regional and public-private collaboration, continue development of and support for pan-University research priorities: (1) bioscience and engineering; (2) computational systems science and modeling (Data Science and Automata Computing); (3) environment, sustainability and resilience; and (4) energy systems prototyping, research, innovation and technology (ESPRIT). Pursue additional pan-University or school-specific research priorities, not included above, when faculty expertise converges with opportunities presented by private enterprise, local and state government, the federal government, and/or other strategic initiatives.

Bioscience
• Developing new interdisciplinary, cross-Grounds Neuro and Cognitive Science collaborative effort.
• Appointed new faculty leadership to oversee initiative.
• Organized meetings of faculty interested in cognitive science where threads have emerged.
- Youth-Nex in the education school is being expanded to be more interdisciplinary and have a broader participant group and focus.
- A core cognitive science group from Psychology, Biology, Education, and School of Medicine has emerged.

**Data Science Institute**
- Developed a plan for the Data Sciences Institute which gained approval from the Board of Visitors.
- Identified an inaugural director and developed academic curricula for the Institute.
- Developed a suite of facilities and services for data science that include Analytics and modeling; Data management; and Visualization.
- Designed and implemented Center for Data Ethics, Policy and Law.
- Catalyzed data science across the University through workshops and informative discussions.
- Raised $15M endowment gift plus an additional endowed professorship.
- Inaugural class of Master of Data Science conferred 40 M.S. degrees in May 2015.

**Automata Computing**
- U.Va. and Micron Technology, Inc. co-founded the Center for Automata Processing to catalyze the growth of an ecosystem around automata processing.
- Established projects through the Center in a variety of areas such as data analytics, natural language processing, bioinformatics, neuromorphic computing, and programming languages.
- Research resulted in two peer-reviewed publications with three manuscripts accepted for publication.
- Center received $525,000 in external funding, including grant from the CIT to develop new software tools. Another $100,000 award from the NSF is expected soon.

**Energy Systems (ESPRIT): Max Planck**
- Selected to join MAXNET Energy, a new initiative of Germany’s Max Planck Society (MPS). MAXNET Energy is comprised of seven Max Planck Institutes, and U.Va. joins Cardiff University as only external members.
- Partnership allows faculty/students to conduct collaborative research on new energy processes.
- Initially funded seed projects include solar process heat, photo electrocatalysis (sunlight to hydrogen and other fuels), and natural gas to liquid fuels.
- U.Va. and the MPS have committed ~$4M ($2M each) in seed funding over 5 years.
- Preparing externally-supported proposals based upon data gained from seed projects.

**Revolutionary Chip Cooling Technology**
- University funded groundbreaking research exploring thermal management as it impacts the microprocessor industry.
• Research has the potential to revolutionize the microprocessor industry and the University has a patent-pending for the cooling design of these high-performance computer chips.
• BluTherm is a spinout company based upon U.Va. intellectual property created through this research, which was sponsored by ESPRIT, CRCF and i6 award from Department of Commerce.

**Resilience**
• Appointed inaugural associate vice president for research, sustainability and the environment.
• Developed initial cross-Grounds inventory of strengths and opportunities.
• Established new collaborations on sustainability with external partners including the Brookings Institution and the Security and Sustainability Forum.
• Facilitated pan-University events on Global Water Day, Earth Day and faculty/staff forum.
• Secured $2.0 million multi-university NSF grant in Coastal Sustainability (U.Va. lead) and $1.5 million from U.S. Department of the Interior in multi-sector partnership to address Coastal Resilience in Virginia (Nature Conservancy lead, U.Va. co-lead).
• Created new Jefferson Trust graduate fellowships to develop future leaders in the major research area of environmental sustainability and resilience ($72,500).

**Increasing research support from large corporations, small businesses, NGOs, foundations, venture capitalists, state government, local government, and non-traditional federal agencies.**
• Formed partnership with MAXNET Energy, a new initiative of Germany’s Max Planck Society to advance research on new, renewable, environmentally friendly and economical energy sources on an exclusive $4 Million Partnership
• Joined Rolls-Royce University Technology Centers Network comprising research groups in world-class universities to develop long-term research and technology programs.
• Renewed corporate partnership with AstraZeneca for $4.5 million to greatly speed up the development of novel drugs to treat diseases in several targeted areas.
• Won five state CIT CRCF awards totaling $550,000 to advance science and technology-based research, development, and commercialization to drive economic growth in Virginia.

**Continuing and expanding partnerships with major companies through U.Va.’s Strategic Corporate Partner program.**
• Worked with partners to sign two additional industry organizing members to the Commonwealth Center for Advanced Manufacturing (CCAM) – Airbus and Alcoa. Each of these companies will fund a minimum of $400,000 per year in research to be conducted at CCAM and member universities (U.Va., VT, VCU, VSU and ODU).
• Altria’s support of University efforts expanded to include funding for need-based scholarships and for high school-based career/college counselors to be based in Richmond area schools through the Virginia college advising corps.
• Named a top university partner school by Northrop Grumman; increased offers for engineering interns and tripled the number of full-time offers.
• Successfully engaged international partners in Asia and identified opportunities for global student experiences, international internships, executive education, and research.

Continuing and expanding partnerships with national defense and intelligence communities through U.Va.’s Applied Research Institute
• Hired a dedicated project team.
• Constructed a Sensitive Compartmented Information Facility (SCIF).
• Hosting second annual conference on national defense and intelligence, bringing together academic, government, and industry partners to discuss topics of interest to the intelligence community.
• Signed an agreement with the Navy Air Warfare Center Aircraft Division to support a variety of research efforts, including work in the area of cyber security and big data analytics, and to provide executive education to military and civilian leaders working with the agency. The first project under the agreement provides $1 million to fund research in the laboratory of chemistry professor James Landers.

Continuing and expanding partnership with the Commonwealth Center for Advanced Logistics Systems (CCALS), whose members include Logistics Management Resources (LMR), Logistics Management Institute (LMI), U.S. Army Combined Arms Support Command (CASCOM) at Fort Lee, and The Port of Virginia
• Partnered with U.Va. Applied Research Institute (ARI) on the Naval Aviation Warfare Center Aircraft Division (NAWCAD) University Partnership contract award.
• CCALS with U.Va. SEAS as the lead, completed a cyber-physical attack research project for the LMI Research Institute
• CCALS with U.Va. School of Engineering and Applied Science (SEAS) as the lead, submitted two research projects for the Commonwealth Research Commercialization Fund (CRCF) FY 2015 Matching Funds Program.
• ORBIS America, Inc has signed a Letter of Intent (LOI) to join CCALS.
• Defense Logistics Agency Operations Research and Resource Analysis (DORRA) is reviewing a LOI to join CCALS as a Government Associate Member.
• Approved entering into a Cooperative Research and Development Agreement (CRADA) with the U.S. Army Research, Development and Engineering Command (RDECOM).

Increasing library support for collaborative research
• Developing new research opportunities in the mass digitization of the historical and cultural record.
• Exploring the growth in the ubiquity and scale of data and its potential to revolutionize the sciences, social sciences, humanities, and arts.
• Embracing cross-disciplinary collaboration to address complex problems; and emerging mandates and changing norms for publicly sharing the process and products of academic research.
• Creating new mechanisms to find and access information in all its forms, from literature and scholarship to data and specialized research materials.

**Leveraging the U.Va. Research Park to serve the local defense community, provide a transition zone for successful startup companies, and optimize space allocation for the University.**

• The University of Virginia Foundation (UVAF) upgraded the U.Va. ARI SCIF space so that it can contract directly with NGIC/DIA and other related defense agencies.
• The Foundation and ARI work with tenants in the Park to develop new business/research opportunities for U.Va. students and faculty as well as for the tenants.
• Opportunity under way exploring the development of a consortium of universities interested in a $25M multi-year contract

**Provide a transition zone for successful startup companies**

• The UVAF has several small laboratories in its Emerging Technology Center at the U.Va. Research Park. Two small startups are currently growing in these spaces.
• Additionally, the UVAF recently converted two different spaces into executive suite spaces called Workspaces 1.0 and 2.0. These spaces offer single suites that are totally furnished and offer Wi-Fi and printing services.
• U.Va. Innovation will move to the renovated Coca-Cola building on Preston Avenue.
• The UVAF/U.Va. Research Park plans to provide casework for the creation of a small laboratory that could accommodate as many as 4 small companies.

**Optimize space allocation for the University**

• By the end of this summer, the University will occupy approximately 140,000 SF of space in the U.Va. Research Park.
• The UVAF is permitted as many as 3.7 million square feet of development rights. Currently, the total built SF in the Park is 500,000 SF.

**Priority 8 – Research & Economic Development: Medical Translational Research**

• During the past year, the Health System’s strategic clinical plan included funds for continuing clinical research grants and infrastructure funding for genomics and clinical effectiveness/outcomes research.
• Funded projects included a Focused Ultrasound trial for Parkinson’s disease, a genomics trial for relapsed pediatric cancers, and a trial evaluating incidence and effects of potential traumatic brain injury (TBI) in young athletes.
• The Health System currently is conducting a protocol to evaluate transcranial MR-guided focused ultrasound of the subthalamic nucleus for the treatment of Parkinson's Disease.
• The NIH has initiated a multi-center national study, led by the U.Va. Department of Neurology, to determine the comparative effectiveness of three drugs against established status epilepticus.
• Cancer center subjects on trials increased 19% over the past year.
• Successful faculty searches were completed for Cancer Center Deputy Director and Associate Director for Clinical Research, Leader, Cancer Prevention and Control
Program, and for outcomes researchers in cancer and in neurosciences. Additional faculty searches are underway for outcomes researchers, including cancer prevention and control.

- The U.Va. Cancer Center is also an inaugural partner in ORIEN (Oncology Research Information Exchange Network) a unique research partnership among North America’s top cancer centers to leverage multiple data sources, including genomic information to match specific patients to targeted treatments – the backbone of precision medicine.
- Extramural funding for clinical research at the School of Medicine increased over 12% from the past year, and the research portfolio has increased translational/clinical focus in neurosciences and cancer.
- The goal of the “Cancer Center Without Walls” is to increase access for the citizens of the Tobacco Region to the revolutionary advances in cancer care including clinical research that are available only at NCI-designated cancer centers such as the University of Virginia Cancer Center. This project is working to build a healthy citizenry by enhancing access to the full spectrum of cutting-edge cancer prevention, risk management and treatment; and also helped build a healthy economy by expanding the health and IT workforce, investing in local healthcare delivery, and retaining clinical expenditures in the Tobacco Region.
  - The $1M grant began January 1, 2013 and lasts 36 months. To date, we have launched efforts in telemedicine (mobile mammography and telemedicine video colposcopy); partnered with the College at Wise to develop and deliver education sessions about clinical research for nurses in Southwest Virginia; conducted a needs assessment that reports the resources available and gaps remaining to build functional cancer research infrastructure in Southwest Virginia; and developed and trained a lay navigator network.
  - Efforts are now expanding to the development of a survivor network and research projects using telemedicine to reduce the travel burden for stem cell transplant patients, provide geriatric assessments, and reduce the risk of cancer recurrence through exercise and diet.

Priority 9 – Research & Economic Development: Innovation Ecosystem

To increase research and promote economic development, enhance the innovation ecosystem. Supporting initiatives include, but are not limited to:

- Continued implementation of the U.Va. Economic Development Accelerator (UVEDA), designed to facilitate knowledge transfer and business development around University research and innovation, including a proof-of-concept fund.
- Developing new funding opportunities for U.Va.-affiliated new venture/technology opportunities.
- Partnering with U.S. Department of Commerce, U.Va. led the Virginia Innovation Partnership (i6 Challenge, http://www.virginia.edu/vpr/i6/) that awarded 18 seed projects statewide, designed to accelerate innovation and economic growth through establishing new licensing deals, publications, research proposals, collaborations, start-up companies, and patent applications. Five of the 18 funded projects were from U.Va.:
  - Scalable synthesis of nano-structured oxides for thermal barrier coatings
- Improved Efficacy and Safety of Ischemic Stroke Therapy using Optimal tPA Delivery to Complement Mechanical Thrombectomy
- Effective Cooling Solutions for Very High Heat Flux Applications
- Laser Modification of Metallic Surfaces for Industrial Applications

- Continued implementation of a new relationship between U.Va. and the Licensing and Ventures Group to increase deal flow. Over the past two years, annual disclosures increased over 18% (148 to 176), patents over 40% (26 to 37), and start-up companies by 33% (6 to 8).
- Continued comprehensive outreach and networking efforts on Grounds designed to engage more faculty on subjects related to the commercialization process such as intellectual property, new venture creation and innovation.
- Executed first of its kind start-up funding and partnership with Pfizer Seed Fund for Neoantigenics.
- Supported Series A investment by New Enterprise Associates (NEA) in the U.Va. startup company PsiKick (Benton Calhoun, Ph.D. (SEAS)).
- Launched first “Entrepreneur-in-Residence” initiative, brought in a seasoned executive with experience in launching and securing funding for startup companies to work with high potential U.Va. projects and innovators to accelerate the development and launch of new companies to commercialize their discoveries.

**Priority 10 – Quality Enhancement: Self-Supporting Programs**
The University utilized incremental tuition revenue from self-supporting programs (graduate business, graduate commerce, and law) to maintain and enhance programmatic quality. Incremental tuition revenue was allocated to financial aid, utility and facilities maintenance, electronic library resources, and academic programs.

**Priority 11 – Student Success: Student-Faculty Engagement**
High-impact educational experiences are an important component of the University’s identity as a research-intensive institution with a strong residential culture focused on extensive interaction between faculty and students. High-impact educational experiences take many forms including, but not limited to, meaningful research with faculty, community engagement and public service, entrepreneurial experiences, and internships and externships. The following represent a sampling of programs that the University has launched, expanded, and/or continued to support as part of its strategic focus on high-impact educational experiences:

- **Harrison Undergraduate Research Awards:** This program funds outstanding undergraduate research projects to be carried out in the summer and subsequent academic year under the guidance of a faculty member.
- **Undergraduate Student Opportunities in Academic Research (USOAR):** This program provides rising first-year, second-year, and transfer students who do not have previous significant experience opportunities to participate in paid research opportunities with faculty members within their area of interest.
• **Community Based Undergraduate Research Grant (CBURG):** This program fosters collaborative partnerships between University researchers and the community by providing opportunities for students to develop research projects that apply their academic skills, experiences, and ideas to real world problems.

• **Double Hoo Award:** This program supports pairs of undergraduate and graduate scholars seeking to develop and pursue a research project with guidance from a faculty advisor.

• **Kenan Fellowship:** This program provides students summer grants to conduct research projects that increase public understanding of the Academical Village. These research projects may include architectural or field internships; development of exhibitions and other educational opportunities to inform and engage the public (of all ages) in the history, evolution, and restoration of this World Heritage site; preparation of materials on historic preservation for publication and public distribution; and other educational outreach initiatives.

• **Library of Congress Internships:** The Internship Center in University Career Services organizes student participation in the Library of Congress Knowledge Navigators Program, which provides internships opportunities at the library's Washington, D.C. and Culpeper, Virginia campuses.

• **University Internship Program:** This program combines academic instruction and work experience in an applied setting under the supervision of UIP liaisons, faculty members, and field supervisors which help students build on knowledge and skills learned from study in their major and in the social sciences generally.

• **Global Internship Program:** The Office of Global Internships works with alumni, university affiliates, and professional connections to offer a number of unique and exciting opportunities for students to participate in internships on four continents and in dozens of industries.

• **Center for Global Health Scholars:** The Center for Global Health organizes this program which allows students to conduct research projects in countries such as South Africa, Rwanda, Guatemala, Zambia and India, as well as the United States, Uganda, Tanzania, Peru and Nicaragua. This research can be conducted independently, on a team, or in partnership with external partners.

• **National Scholarships & Fellowships:** The Center for Undergraduate Excellence (CUE) supports the pursuit of nationally (and internationally) competitive awards that either support or provide high-impact educational experiences. Awards fund opportunities for domestic and international research, study, teaching, and community engagement.

**Priority 12 – Student Success: Technology-Enhanced Learning**

The University continued expanding its distance education offerings, as well as integrating technology into the residential curriculum. During the period of the previous Six-Year Plan, the University:

• Launched the Bachelor of Professional Studies in Health Sciences Management, an online undergraduate degree program.
• Launched the M.S.N. (Clinical Nurse Leader) in Southwest Virginia, offered through distance education and at the Southwest Virginia Higher Education Center.
• Converted existing degree programs in administration and supervision, curriculum and instruction, and special education to distance delivery (while retaining the residential formats for appropriate student audiences).
• Continued graduate program offerings through the Commonwealth Graduate Engineering Program (CGEP).
• Expanded the course-sharing initiative with Duke University to include Vanderbilt University.
• Continued the 4-VA course-sharing initiative with George Mason University, James Madison University, and Virginia Tech.
• Continued the University’s partnership with Coursera to offer massive open online courses (MOOCs), including the development of Coursera “specializations.”
• Hosted an “Innovation in Pedagogy Summit” with representation from institutions across the Commonwealth.

Priority 13 – Institutional Collaboration: The Virginia Community College System (VCCS)
The University continues to collaborate with the Virginia Community College System (VCCS) on a number of initiatives designed to facilitate degree completion and provide access to high-quality academic programs. Accomplishments include:

• Securing approval from the Southern Association of Colleges and Schools Commission on Colleges (SACSCOC) to expand the Bachelor of Interdisciplinary Studies (BIS) program to Thomas Nelson Community College (TNCC). The program will launch at TNCC effective fall 2015 (current sites include Charlottesville, Tidewater Community College, Northern Virginia Community College, and the Richmond Center). Projected enrollments of 6 FTE in FY2016-17 and 12 FTE in FY2017-18.
• After securing SCHEV approval, initiating the Bachelor of Professional Studies in Health Sciences Management (BPHM), an online degree program developed in cooperation with the VCCS. Projected enrollments of 25 FTE in FY2016-17 and 40 FTE in FY2017-18.
  o Negotiating a guaranteed admission agreement (GAA) with VCCS for the BPHM program, effective fall 2015.
• Implementing the guaranteed admission agreement (GAA) with the VCCS for the RN to BSN program.
• Implementing the RN to BSN distance learning initiative with Germanna Community College (GCC).

Priority 14 – Efficiency and Continuous Improvement
Through a variety of efforts, the University achieved approximately $19 million in savings and improvements in 2014-15. Below are examples of these savings and reallocations:

Process and Service Delivery Improvements
• Implemented ResearchUVA, a web-based system to document and track research proposals and awards using an easy to use faculty dashboard with “at a glance” review of proposal and award status.

• Automated several research administration and technology process improvements (e.g., rounding error, close-out checklist, grants and award tracker).

• Completed comprehensive review and analysis of strategic sourcing opportunities. Identified nine key commodities and created a roadmap for implementation. Participating in the recently established Virginia Higher Education Procurement Cooperative.

• Implemented strategic sourcing of office supplies. Consolidated spend with one vendor for volume discounting.

• Negotiated contract savings.

• Developed departmental spend dashboards to increase school and unit analysis of spend trends and opportunities for savings.

• Pre-purchasing foreign currency in the US rather than destination country.

• Implemented collections module for student accounts, yielding improved processing, time savings and increased collections from debtors.

• Transforming voice communications from soon to be end-of-life telephone system to a voice over IP system.

• Completed year one of a multi-year Managerial Reporting Project that will enhance the ability to make effective, data-driven decisions. Implementation of the Hyperion Profitability and Cost Management (HPCM) software forms the platform for the University Financial Model, an activity-based model that begins its first year of full implementation in 2015-16. Launched five data and process improvement teams.

• Continued comprehensive water and energy conservation program. In-sourced building automation installations on construction projects and dedicated power and light team.

• Restructured the Student Financial Services contact center for increased responsiveness.

• Developed formal service level agreements between administrative service providers and the schools (internal customers) that describe the services delivered, document service levels, and specify the responsibilities of the provider and the customer.

• Completed functional reviews in research administration, human resources, and internal communications to identify opportunities for greater effectiveness and efficiency.

• Participated in The Chronicle of Higher Education’s “Great Colleges To Work For” program to benchmark institutional workplace practices, policies, benefits, and culture.

• Completed process redesign of travel and expense management and began redesign of gift processing.

• Initiated server and email consolidation.

• Designed a future-state human resources model to better meet institutional needs and yield efficiencies.

• Improved safety in Facilities Management and reduced days out due to work-related accidents.

Organizational Restructure/Collaborations/Capacity
Increased consolidation and sharing of positions. For example, consolidated two outreach and training positions in the area of finance administration; sharing a position across Student Affairs and School of Engineering.

- Completed first cohort of Cornerstone Succession Planning program.
- Building a culture of quality: hosted state-wide forum; established an internal community of practice and recognition program; piloted change leadership training.

**Health Care**

- Revisions to spousal coverage; dependent audit and plan design changes.

**Priority 15 – Research & Economic Development: Southwest Virginia Economic Development Partnership (Appalachian Prosperity Project)**

The Appalachian Prosperity Project (APP) is a collaborative partnership among the University, U.Va.’s College at Wise, the Virginia Coalfield Coalition, the private sector, and the Commonwealth. This partnership uses a systems approach to simultaneously advance the inextricably linked fields of education (Appalachians Building Capacity), health (Healthy Appalachia Institute), and prosperity (Appalachian Ventures). The AAP FY14 Annual Report is available online at [http://tinyurl.com/FY14AAP](http://tinyurl.com/FY14AAP).

**Priority 16 – Student Success: Serving Virginia’s Veterans and Military through Collaboration**

In the previous Six-Year Plan, the University proposed to create and pilot a veteran and military friendly consortium for earning certificates in high-demand, professional fields and/or completing a bachelor’s degree through cross-institutional collaboration. The consortium did not receive the requested state funding and therefore did not proceed.
E. Capital Outlay

On June 12, the Board of Visitors approved the University’s 2016-22 Major Capital Plan. The Capital Plan which includes projects expected through fiscal year 2022 will be used as a planning tool and as support for state capital project funding priorities. The Capital Plan categorizes the projects into the near term (expected to be initiated by 2018) and long term (expected to begin after 2018). The projects included below represent the highest priorities of the Academic Division that will be initiated over the next several years.

Maintenance Reserve

Maintenance Reserve Funding is critical for the repair and replacement of plant, property and equipment to maintain or extend the useful life of the Academic Division’s Educational & General (E&G) facilities. Fiscal year 2014-15 represents the conclusion of the Board of Visitors’ ten-year program to improve the condition of the University’s facilities and reduce the deferred maintenance backlog. One metric used is the Facilities Condition Index (FCI). An FCI of 5 percent means the facilities are in good condition while anything over 10 percent means the facilities are in poor condition. When we began the program the University’s FCI was 10.6 percent. As of June 30, 2014, the FCI was 5.4 percent and we expect to reach 5 percent by June 30, 2015. Achieving this goal has required allocation of additional resources to the annual operating maintenance budget, renewal of whole buildings through renovation, and the careful use of the maintenance reserve appropriation. In order for the University to maintain the FCI at 5 percent the maintenance reserve appropriation plays a critical role and should keep pace with inflation in building costs.

Gilmer Hall and Chemistry Building Renovations ($180.0 million)

Student success in the STEM fields requires shifting teaching and lab instruction toward active learning, experiential learning, and team-based discovery. Renovating facilities to provide effective space for teaching, learning, and research will have a positive impact on current and incoming undergraduate and graduate learning outcomes and will make their work much safer and more sustainable.

The University conducted a comprehensive analysis and planning study of STEM facilities that considered space and infrastructure supply and demand, projected space needs, curriculum innovations, and building renewal needs for the STEM facilities on Grounds through 2025. The STEM study identified several buildings as outdated with deteriorated infrastructure including Gilmer Hall, the Chemistry Building, the Physics Building, and several others. Gilmer Hall and the Chemistry Building have housed the Biology, Psychology, and Chemistry Departments for more than 50 years. They continue to house classrooms, teaching laboratories, and research space for these departments, and provide learning space for undergraduate and graduate instruction for the STEM disciplines.

To address the challenges facing instructional and research facilities in STEM, we need interdisciplinary solutions that are adaptable and flexible to changes in technology and teaching pedagogies. The classrooms, class laboratories, and research laboratories in Gilmer/Chemistry...
suffer from a number of deficiencies. To address these deficiencies, the University is planning a comprehensive renewal of these buildings that will replace antiquated and inefficient systems with a modern, energy efficient, and adaptable infrastructure for each building. Renovation of over 350,000 GSF of instructional and research space will maximize space utilization through efficient and flexible teaching and research laboratory design. A new high performance exterior glazing and masonry system for Gilmer Hall will replace large portions of both north and south façades. This will provide a new watertight and energy efficient exterior envelope that is consistent with the building’s original design.

Preplanning authority of $1.8 million ($250,000 general funds, $1.55 million non-general funds) was authorized by the state in the 2012-2014 biennium with non-general funds advanced by the University to be reimbursed from general funds. Additional planning was authorized allowing the University to proceed to detailed planning with additional non-general funds to be reimbursed upon state approval of construction funding.

The University will submit its preliminary design package to the Bureau of Capital Outlay Management by August 2015. Timing of construction authorization is critical in order to maintain continuity with the architect and contractor teams already on board.

**Alderman Library Renewal ($160.5 million)**
Built in 1938 to relieve crowding in the University’s first library, the Rotunda, Alderman Library today holds 2.5 million volumes and hosts more than 750,000 public visits per year. While there have been cosmetic upgrades over 77 years, the building has original systems and significant health and safety issues. Half of its 300,000 square feet is devoted to book stacks that are non-code-compliant and are overly full and unsafe, especially in the event of fire. The HVAC system is 30 years old, costly to maintain, and produces fluctuating temperatures that accelerate the degradation of the books.

Project Drivers include:
- Heavy use, especially during exams (3,575 visits/day)
- Inadequate fire suppression and egress
- Poor “wayfinding” and security
- Lack of ADA compliance
- No filtration or humidity control in HVAC
- 34 mold and water-related incidents in last five years
- High energy and repair costs: AC and heating often running at the same time
- Opportunity to boost the University’s student experience and faculty recruiting/retention goals
- Chance to create iconic, sustainable centerpiece of learning

**Laboratory Renovations for New Faculty Hires ($8.0 million)**
As new faculty in STEM disciplines in Arts and Sciences, Engineering, and Medicine are hired over the next two year period it will be necessary to renovate lab space including lab
reconfigurations, new building systems distribution (HVAC, electrical, plumbing, telephone/data), finishes, and casework. An $8 million appropriation will provide funding to renovate nine wet labs and three dry labs. The ability to perform small lab renovations as new faculty are hired is critical to recruiting the high quality faculty we will need to replace those retiring.

**Physics Building Renewal ($35.0 million)**

This project was identified by the STEM study referenced above, and will renew nearly 135,000 GSF of research and instruction space in the Physics Building which is nearly 60 years old. Included in the proposed scope is renewing mechanical systems for improved energy performance; installing fire detection and suppression systems; repairing the exterior envelope and structure; and renewing interior systems, finishes, and furnishings.
F. Restructuring

Background
July 2015 marks the tenth anniversary of the enactment of the Restructuring Act. Restructuring has provided the University with important tools to assist institutions in managing the changing higher education environment, as well as the financial challenges presented by numerous economic downturns during the last decade which have resulted in a decline of 17.4% in the University of Virginia’s inflation adjusted unrestricted E&G appropriation per in-state student (from $10,590 in 2004-05 to $8,748 in 2014-15). In 2014-15 the general fund appropriation represents 9.4% of the operating budget for the Academic Division, compared to 13.4% in 2004-05.

Initiated during Governor Warner’s term in 2005, public institutions are now operating under the fourth gubernatorial administration since the passage of the Restructuring Act in 2005 and the Management Agreement in 2006 (for the first three Level 3 institutions). While there has been consistency among many staff in the executive and legislative branches throughout this ten-year period, leadership within the Administration among Cabinet Secretaries has changed with each gubernatorial election cycle. In addition, there are many new members in the legislature and new individuals in other key leadership positions. This has resulted in the need for continuous education by the institutions about the Restructuring Act, particularly around the additional authorities granted to Level 3 institutions, including the benefits realized over the years to both the various institutions and to the Commonwealth.

Opportunity for Enhancing and Expanding Restructuring Authorities
In the spring of 2014, institutional representatives met with several Cabinet Secretaries to review the principles of the Restructuring Act, the Virginia Higher Education Opportunity Act, and other related legislation. During this discussion, we shared four major areas in which we would like to collaborate with the Governor, the Administration, and the General Assembly to further the objectives of the Restructuring Act and the Management Agreements:

- Provide support to foster efficient business processes between higher education and central state agencies;
- Expand examination of efficiencies to include academic processes;
- Review Restructuring authority and explore options to expand; and
- Eliminate non-value added and duplicative reporting requirements.

We would like to engage in a conversation with appropriate representatives of the Administration and the General Assembly about not only options for expanding and enhancing the provisions of the Restructuring Act, but also more generally ways in which business and academic processes between central state agencies and institutions of higher education could be improved in order to enhance efficiency and effectiveness. We believe the outcome of these discussions would benefit both the institutions and the Commonwealth. Examples might include the following:
• Recognize the need for multi-year planning by developing a process for institutions to create operating and capital reserves in E&G, similar to auxiliary enterprises, that are not subject to reversion at the end of the fiscal year;
• Re-examine the applicability of state human resource policies (e.g. layoff, probation) to University staff;
• Simplify processes (e.g., data reporting, Equipment Trust Fund approvals, daily cash transfers, granting function between state agencies);
• Eliminate non-value added reports.

**Faculty Compensation**
In addition to these conversations, we would like to engage in a conversation about compensation practices for our faculty and our efforts to recruit and retain high-quality faculty. While we do not believe it was the intention of the 2015 General Assembly to restrict institutions’ ability to compete with their peers for top-rated faculty, especially given the looming generational turnover and intensifying competition for key faculty positions, U.Va.’s Board of Visitors recently reviewed data indicating that imposing a cap on faculty salary increases could impinge the University’s ability to achieve – using self-generated funds – the Board-approved goal of improving faculty salaries to the 20th position among AAU institutions (priority 2). Further, this may hamper the University’s ability to achieve this goal through merit-based awards that provide incentives for excellence in faculty performance and productivity. Again, we recognize that this was not the intent of the language included in the budget, and would like to work with the Administration and the General Assembly on the 2016-18 budget to include language providing the requisite flexibility for the University to meet the Board-established goal that is directly related to the quality, performance, and productivity of our faculty.

**Clarification of Existing Authority**
An area that warrants further conversation and/or clarification relates to instances when language included in the budget is inconsistent with authorities granted by the Restructuring Act and/or the Management Agreement. While we recognize that the budget supersedes both the Restructuring Act and the Management Agreement, language included in the budget often limits our ability to fully realize the benefits granted by Restructuring. It is sometimes unclear whether such actions are intended to address concerns about how institutions are operating, or whether they are intended to apply to other agencies and unintentionally include higher education. For example, on a number of occasions, the approved budget bill has included language limiting the ability of Level 3 institutions to take certain compensation actions approved by their respective Boards of Visitors in an effort to improve the competitive position in recruiting and retaining faculty and staff.

AGENCY 207 – Academic Division Operating Requests

**Fund Enrollment Growth** – ($5,099,100 GF in year one and $5,632,200 GF in year two) – Consistent with the undergraduate enrollment targets approved by the Board of Visitors, the University requests general fund support, at the base budget adequacy rate of $8,599 per student, based on projected in-state enrollment growth for both years in the biennium (140 additional Virginia students in Fall 2016 and 62 additional students in Fall 2017). UVa has received support from the Commonwealth since 2011 to fund enrollment growth, and the amount requested factors in the cumulative support received to date.

**Building Research Capacity** – ($21,750,000 GF in year one and $25,750,000 GF in year two) – As the University continues implementation of the Cornerstone Plan, we are developing several initiatives to enhance and expand research capacity. To expedite growth opportunities there are four compelling immediate funding needs to catalyze our research capabilities: faculty start-up packages; faculty retention; pan-University multidisciplinary research teams to address the increasingly integrated and complex societal challenges; and commercialization seed funds to more quickly move innovative ideas from the lab to the marketplace.

**Security Enhancement Program** – ($7,766,800 GF in year one and $5,236,300 GF in year two) – The ability to safely and reliably use information technology is at risk due to successful, high profile attacks on institutions of higher education, including the University. The University is developing a Security Enhancement Program to strengthen and expand IT security capabilities and enable the University to proactively monitor and address rapidly evolving cyber security threats.

**Human Resources Service Delivery Transformation Enabling Technology** – ($10,500,000 GF in year one and $6,500,000 GF in year two) – The University is requesting $17 million over the biennium to help fund the upgrade of the Human Resources technology platform across the Academic and Health System as part of a broader transformation of the Human Resources function. Upon completion of this multi-year project, the
University will have the Human Resources technology and processes needed to support the future needs of the institution and be able to deliver services with higher efficiency and more cost effectively.

**Blandy Experimental Farm preK-12 Outreach Efforts** – ($67,800 GF in year one and year two) – The preK-12 programs and teacher development opportunities offered through the State Arboretum at Blandy Farm represent significant regional, statewide, and national resources for STEM education. In order to sustain and expand the preK-12 program, two current part-time positions (.75 FTE each) need to be made full-time (1.0 FTE), requiring an additional $67,800 in funding each year.

**Virginia Foundation for the Humanities (VFH)** – ($500,000 GF in year one and year two) – The VFH has devoted 40 years of service to illuminating and documenting our communities’ histories, traditions, aspirations, and lived experiences in audio and video. More than 3,000 grants and directed projects have produced interviews, films, music, exhibits, and oral histories in various formats. VFH is seeking general fund support for Discovery Virginia, an online environment that will preserve these materials and make them publicly accessible.

**Modify Appropriation Act Language for Center for Politics** *(Language Only)* – The University proposes to eliminate from the current Appropriation Act the specific line item language related to the Center for Politics. This action, a request of the Center, will not change the overall appropriation.

**2016-2018 REVISIONS TO THE CAPITAL PROGRAM**

At the request of the Governor we have revisited our capital program for 2016-2018 to ensure that we have projects that are responsive to his call to advance the economy of the Commonwealth. As a result we have revised the Clean Room Renovation and added two research related projects – Center for Human Therapeutics and a renovation of Medical Research Building 4.

**Thornton Hall Clean Room Renovation**

*Approved by the Board of Visitors in June 2015, the scope of the project has been expanded to include the renovation of 10,000 gross square feet for the UVa Microfabrication Laboratories (UMVL), a 1980s clean room located in C wing of Thornton Hall requiring highly controlled, low contaminant environment. The project cost for the renovation of the lab and surrounding areas*
and upgrades to the building infrastructure and systems is $14,800,000; the equipment budget is $3,200,000 for replacement of five major pieces of equipment critical to the lab’s work.

**Center for Human Therapeutics**  
GF $9.0M  
The proposed Center for Human Therapeutics project will establish clinical manufacturing facilities to create and produce vehicles for translating basic discoveries into therapeutic options for the treatment of human disease. The Center will serve the research needs of the UVa translational research community, and will develop a commercial arm where the production of these therapeutic platforms will be sold to laboratories and interested commercial partners.

**Medical Research Building #4 (MR4) Renovation**  
GF $21.5M  
NGF $21.5M  
MR4 was designed and constructed in the late 1980s to support multiple research initiatives at the School of Medicine. While the structural components of MR4 are sound, various systems are outdated and have reached the end of their service life and must be replaced for MR4 to continue supporting both wet and computational research and to meet current research lab standards.

**Blandy Experimental Farm**  
NGF $1.57M  
To meet current and future research needs, Blandy Farm needs to replace an aging research greenhouse and construct two additional residential cottages. Both projects are consistent with Blandy’s 2011 Master Plan and project design guidelines. Application to the National Science Foundation for a grant to fund the greenhouse was recently awarded.

**AGENCY 246 – University of Virginia’s College at Wise**

**NMR for Chemistry Accreditation** – ($517,650 GF in year one) – The Natural Sciences are one of the strongest departments of the College. To enhance the program’s ability to place its students at higher levels within organizations such as Eastman Chemical whose corporate headquarters are 45 miles from campus the College needs to obtain accreditation from the American Chemical Society requiring the purchase of a new NMR.

**Enrollment Growth** – ($80,553 GF in year one and $159,300 in year two) – The College has established a plan to grow the freshman class to 400 qualified students by 2020, a 4.8 percent growth in new freshmen enrollment per year. With a declining high school
student population in southwest Virginia, the College will serve the region while also developing greater brand awareness across the Commonwealth for potential students who could benefit from the UVa-Wise experience.

Retention and Graduation – ($166,135 GF in year one and $186,472 in year two) – Three major efforts will assist the College at Wise in improving retention and graduation rates: (1) implementing a predictive model to better target retention strategies for students; (2) preparing and implementing a Quality Enhancement Plan (QEP) to satisfy the requirements for reaffirmation/accreditation by the Southern Association of Colleges and Schools; and (3) continuing efforts to better utilize summer offerings to retain students, increase enrollments, and promote degree completion.

STEM Early College Academy and High Need STEM-H Degrees – ($157,289 GF in year one and year two) – The College will continue to build the STEM Early College Academy program, established in Fall 2014 to provide college classes to high-performing high school seniors on the UVa-Wise campus. The College will also continue its investment in efforts to meet Commonwealth degree production goals, while increasing institutional efficiency by better matching capable students with challenging degree programs.

Federal Mandates – ($309,382 GF in year one and $352,388 in year two) – This request will assist the College at Wise in meeting the increasing accreditation requirements and federal mandates including but not limited to the Clery Act, Title IX, and the Violence against Women Act.

Outreach – ($39,808 GF in year one and year two) – Outreach efforts include providing programming to public schools through the Science Consortium; partnering with the Academic Division in the Appalachian Prosperity Project (APP); and improving K-12 teaching and learning through the Center for Teaching Excellence (CTE).

Undergraduate Research – ($25,084 GF in year one and year two) – The College will continue efforts to increase the number of undergraduate students presenting at academic conferences and publishing original faculty-mentored research; and will increase the number of summer undergraduate research fellowships, as well as funds to support student presentation.
### ACADEMIC AND SUPPORT SERVICE STRATEGIES FOR SIX-YEAR PERIOD (2016-2022)

<table>
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<th>Cost: Incremental, Savings, Reallocation</th>
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**Total 2016-18 Costs**

- Incremental (Included in Financial Plan line 61): $1,319,069
- Savings: $197,725
- Reallocation: $1,559,900

**Six-Year Financial Plan for Educational and General Programs, Incremental Operating Budget Need**

- 2016-2018 Biennium
- (Assuming No Additional General Fund)

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*Assess and modify senior/junior student search program as needed.*
*Assess and modify student orientation and Expedition programs as needed.*
*Continue to narrow and focus summer course offerings.*
*Continue to assess and modify compliance strategies based on federal mandates and Department of Education guidance.*
*Continued to access and modify staffing requirements.*
*Assess and modify program and modify as needed.*
*Sustain model to serve future students.*
*Continue to expand funding and philanthropic support.*
*Assess program and modify as needed.*
*Sustain model*
### Six-Year Financial Plan for Educational and General Programs, Incremental Operating Budget Need

#### 2016-2018 Biennium

(Assuming No Additional General Fund)

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<td>Admin. Faculty Salary Increase Rate</td>
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<td>Increase Classified Staff Salaries**</td>
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<td>Classified Salary Increase Rate**</td>
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<td>Increase University Staff Salaries**</td>
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<tr>
<td>University Staff Salary Increase Rate</td>
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<td>Increase Number of Full-Time T&amp;R Faculty** (FTE)</td>
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<td>Increase Number of Full-Time Admin. Faculty** ($)</td>
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<td>Increase Number of Full-Time Admin. Faculty** (FTE)</td>
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<td>Increase Number of Classified Staff** ($)</td>
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<td>Others (Specify, insert lines below)</td>
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<tr>
<td>Safety and Security Enhancement</td>
<td>$0</td>
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**Total Additional Funding Need**                                     | $1,986,716 | $2,244,263 | $707,376 |

Notes:
1. Please ensure that these items are not double counted if they are already included in the incremental cost of the academic plan.
2. If planned, enter the cost of any institution-wide increase.
3. Enter planned annual faculty salary increase rate. Any salary increase entered here will be counted when calculating the gap to the 60th percentile in the future.
4. Enter number of FTE change over the FY2016 level in appropriate columns.

*Library Enhancement - This number is $0 because any increases will be paid with endowment funds.  **O&M for New Facilities - These are the O&M costs associated with the new Library  ***Utility Cost Increase - This is for existing facilities. The new library utility costs are included in the O&M for New Facilities above.
BYLAWS
THE UNIVERSITY OF VIRGINIA'S COLLEGE AT WISE BOARD

I. Title

The name of this body is The University of Virginia's College at Wise Board. The University of Virginia's College at Wise Board exists to serve the Rector and Visitors of the University of Virginia in fulfilling its statutory authority over The University of Virginia's College at Wise.

II. Purpose and Duties

The purpose of The University of Virginia's College at Wise Board is to promote the sound development of the institution in accordance with policy, as set by the University's President and/or the Rector and Visitors. The University of Virginia's College at Wise Board also serves in an advisory capacity to the Chancellor of the College, the President of the University, and the Board of Visitors on matters pertaining to The University of Virginia's College at Wise.

Actions taken by the Board of Visitors, raised or proposed by the College, are preceded by deliberation of The University of Virginia's College at Wise Board. The Chancellor is responsible for assuring that there has been deliberation by The University of Virginia's College at Wise Board on matters brought forward to the Board of Visitors.

A. Chancellor Search Process

In the event of a vacancy in the chancellorship, the chair of The University of Virginia's College at Wise Board shall consult with and seek the advice of the University President, and make recommendations to the President of persons to serve on the search committee. The recommendations should include representatives of The University of Virginia's College at Wise Board, the faculty, the student body, and the alumni. Upon the establishment of the search committee, the President shall establish a budget, identify staff for the committee, and name a chair.

The search committee, through its chair, shall make a preliminary report to the President regarding the work of the committee at the time when the committee is beginning to develop a group of final candidates. After finalists have been interviewed, the search committee shall provide a report for The University of Virginia's College at Wise Board. The report should contain the names of not more than three candidates, who in the judgment of the search committee are fully qualified and have a continuing interest in the chancellorship.
The University of Virginia's College at Wise Board, following receipt of the report of the search committee, shall review the candidates and formally recommend, with its reasons, not more than three candidates from the search committee’s report for final consideration by the President. The President shall have responsibility for designating a nominee for the chancellorship, and making a recommendation for formal election by the Board of Visitors. On the operational level, the Chancellor is directly responsible to the President.

B. Naming of Campus Facilities

The University of Virginia's College at Wise Board shall develop its own policies regarding the naming of campus facilities, and submit them to the Rector and Visitors for approval. The Chancellor shall make recommendations to The University of Virginia's College at Wise Board regarding such actions as appropriate. The University of Virginia's College at Wise Board shall have responsibility and authority for the naming of major campus facilities in accordance with the policy approved by the Board of Visitors.

C. Establishment of Tuition Rates for Kentucky and Tennessee Residents

Section 23.7.4:2 (E) of the Code of Virginia provides that The University of Virginia's College at Wise Board and the Board of Visitors “may charge reduced tuition to any person enrolled at The University of Virginia's College at Wise who lives within a fifty-mile radius of the College, is domiciled in, and is entitled to in-state tuition charges in the institutions of the higher learning in Kentucky, if Kentucky has similar reciprocal provisions for persons domiciled in Virginia.”

In addition, the board of the University of Virginia's College at Wise and the board of visitors of the University of Virginia may charge reduced tuition to any person enrolled at the University of Virginia's College at Wise who lives within a 50-mile radius of the University of Virginia's College at Wise, is domiciled in, and is entitled to in-state tuition charges in the institutions of higher learning in Tennessee, if Tennessee has similar reciprocal provisions for persons domiciled in Virginia. The board of the University of Virginia's College at Wise and its partners or associates offering programs jointly at a regional off-campus center may also charge reduced tuition to any person enrolled in such joint programs who lives within a 50 mile radius of the University of Virginia's College at Wise, is domiciled in, and is entitled to in-state tuition charges in the institutions of higher learning in Tennessee, if Tennessee has similar reciprocal provisions for persons domiciled in Virginia. Any such respective partners or associates shall establish and charge separately tuition rates for their independent classes or programs at such regional centers."
It is the responsibility of the Chancellor or designee to develop, in consultation with the University's chief financial officer, a recommendation annually for tuition and fee rates for eligible Kentucky and Tennessee students that is presented for action to The University of Virginia's College at Wise Board and the Board of Visitors.

D. Other Duties:

The University of Virginia's College at Wise Board shall also be responsible for any tasks or other duties delegated to it by the Board of Visitors or the President of the University.

III. Composition and Appointment

The University of Virginia's College at Wise Board shall be composed of not less than nine, and not more than 20 persons, to be appointed by the Board of Visitors of the University of Virginia upon the recommendation of the President of the University. At least six members shall be residents of the Commonwealth of Virginia, and at least three shall be alumni of The University of Virginia's College at Wise. Members of the faculty or staff of The University of Virginia's College at Wise shall not be eligible for membership on The University of Virginia's College at Wise Board.

In addition, the Rector, the Chair of The University of Virginia's College at Wise Committee of the Board of Visitors, and the President of the University shall serve as voting ex-officio members of Board. A representative of The University of Virginia's College at Wise Alumni Association may serve a term as a voting ex-officio member of the Board. One member of the student body shall serve a one-year term as a non-voting member of The University of Virginia's College at Wise Board. No student will be eligible to serve more than one term. The student member shall be selected by the Executive Committee.

IV. Terms of Office

Members shall be appointed to serve terms of four years. Terms shall be staggered to provide continuity, up to five members being appointed each year by the Board of Visitors. The Board of Visitors may make appointments of fewer than four-year terms to fill un-expired vacancies and when changing the number of members of The University of Virginia's College at Wise Board.

Terms shall commence July 1, and end on June 30.

V. Officers, Organization, Executive Committee
Every two years, at its last regular meeting, The University of Virginia's College at Wise Board shall elect a chair, vice chair, secretary, and executive committee. The Chair, vice chair, secretary, and executive committee shall be elected for two-year terms. The executive committee shall consist of three at large voting Board members who shall be elected for a two-year term and shall serve with the immediate past chair, chair, vice chair, and secretary, assuming the past chair is still a member of the Board. The at-large members of the committee may not serve more than one term consecutively.

The chair shall call all meetings of the Board, and shall be the presiding officer. The chair shall have such powers and duties as may be assigned to her/him from time to time by the President and the Board of Visitors. The vice chair shall serve in the absence of the chair. The secretary shall have responsibility for working with the clerk to maintain a record of the proceedings of all meetings.

The executive committee shall meet upon the call of the chair, and between meetings of the Board, it shall be vested with the powers and duties of the full Board. All such actions taken by the executive committee between meetings of The University of Virginia's College at Wise Board shall be reported to the full Board at the next annual or regular meeting. If confirmation is required, the action shall be confirmed and approved by the Board at that time. The executive committee shall recommend a slate of officers to the Board.

The chair shall appoint a nominating committee consisting of four members of the Board who shall recommend names to be forwarded to the Board of Visitors for consideration as members of this Board.

Annually, The University of Virginia's College at Wise Board, upon recommendation of the Chancellor, shall elect a member of the College staff to serve as Clerk of the Board. The Clerk shall attend all meetings, and shall draft minutes of all proceedings. The Clerk shall work with The University of Virginia's College at Wise Board secretary in finalizing minutes of all proceedings for action by the full Board, and shall assist The University of Virginia's College at Wise Board in the discharge of its duties.

VI. Committees of The University of Virginia's College at Wise Board

The University of Virginia's College at Wise Board may establish and charge such committees as may be necessary, proper, or convenient to carry out its duties. Additionally, The University of Virginia's College at Wise Board may, upon the recommendation of the chancellor, establish advisory bodies to engage other citizens in support of the College, its mission, and its programs.

VII. Meetings
Meetings shall be of three kinds: an annual meeting, at least two regular meetings, and special meetings as called. The University of Virginia's College at Wise Board shall hold one annual meeting in each fiscal year on the campus of The University of Virginia's College at Wise at a time to be determined by the executive committee. At the annual meeting, The University of Virginia's College at Wise Board shall receive a report from the Chancellor of The University of Virginia's College at Wise on the state of the College and review and decide on such other matters as may come before it.

There shall be such regular meetings as The University of Virginia's College at Wise Board may determine. The executive committee shall determine the time, date, and place of such meetings. Special meetings may be called by the chair or upon the request of five voting members. A quorum of the Board for the conduct of business shall consist of eight voting members. For meetings of the executive committee a quorum shall consist of three voting members.

Notice of the annual meeting and all regular meetings of The University of Virginia's College at Wise Board shall be given at least 10 days in advance of the meeting. Notice of all special meetings shall be given at least five days in advance of such special meeting unless waived in writing by each member of the Board. Notice of meetings shall be provided by mail at the direction of the chair.

VIII. Compliance with the Commonwealth’s Freedom of Information Act

The University of Virginia's College at Wise Board is a public body and as a result must comply with the Commonwealth of Virginia’s Freedom of Information Act.

IX. Amendments to Bylaws

The Board of Visitors has the authority to effect changes in these Bylaws. Upon reasonable notice, recommendations for changes may come from The University of Virginia's College at Wise Board, or from the Board or Visitors. Recommendations from The University of Virginia's College at Wise Board for changes in the Bylaws must come as a result of the vote of two-thirds of the members in attendance at an annual or regular meeting of The University of Virginia's College At Wise.

X. Revocation of Previous Bylaws

All previous Bylaws are revoked upon the approval of these Bylaws by the Board of Visitors.

XI. Removal of Members
Any member who fails to perform the duties of his or her office for one year without sufficient cause shown to The University of Virginia's College at Wise Board, shall at their next meeting after the end of such year, cause the fact of such failure to be recorded in the minutes of their proceedings and certify the same to the Board of Visitors; and the office of such local board member shall be thereupon vacant.

Revisions approved by the College’s Board on May 12, 2000 and the Board of Visitors on June 17, 2000
Revisions approved by the College’s Board on September 14, 2001 and the Board of Visitors on October 18, 2001
Revisions approved by the College’s Board on May 16, 2003 and the Board of Visitors on May 29, 2003
Revisions approved by the College’s Board on December 6, 2006 and the Board of Visitors on February 9, 2007
Revisions approved by the College’s Board on May 18, 2007 and the Board of Visitors on June 8, 2007.
Revisions approved by the College’s Board on August 12, 2015
UNIVERSITY OF VIRGINIA AUDIT DEPARTMENT CHARTER

Introduction:
Internal Auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of the University of Virginia and the University of Virginia Health System (the University). Its mission is to enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight.

Role:
It is the policy of the University to establish and support the Audit Department to assist the University in accomplishing its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of the University’s governance, risk management, and internal controls. The internal audit activity’s responsibilities are defined by the Audit, Compliance, and Risk Committee (ACR Committee) of the Board of Visitors (Board) as part of its oversight role.

Professionalism:
The work of the Audit Department will be conducted in accordance with the Institute of Internal Auditors’ Definition of Internal Auditing, Code of Ethics, and International Standards for the Professional Practice of Internal Auditing (Standards). The Audit Department will adhere to the University’s relevant policies and procedures as well as the Generally Accepted Governmental Auditing Standards of the Government Accountability Office.

Authority:
The internal auditor, with strict accountability for confidentiality and safeguarding records and information, is authorized to have full, free, and unrestricted access to any and all of the University’s records, physical properties, and personnel pertinent to carrying out an engagement. All employees are requested to assist the Audit Department in fulfilling its roles and responsibilities. The internal audit activity will also have free and unrestricted access to the ACR Committee and its chairman.

Organization:
The Chief Audit Executive will report functionally to the ACR Committee chairman, and administratively (i.e. day to day operations) to the President of the University through her
delegate, the Executive Vice President and Chief Operating Officer.

The ACR Committee will:
• Approve the Audit Department charter.
• Approve the risk based audit plan.
• Approve the internal audit budget and resource plan.
• Receive communications from the Chief Audit Executive on the Audit Department’s performance relative to its plan and other matters.
• Approve decisions regarding the performance evaluation, appointment, or removal of the Chief Audit Executive
• Approve the remuneration of the Chief Audit Executive
• Make appropriate inquiries of management and the Chief Audit Executive to determine whether there is inappropriate scope or resource limitations.

The Chief Audit Executive will communicate and interact directly with the ACR Committee, including in executive sessions and between ACR Committee meetings as appropriate.

Independence and Objectivity:
The internal audit activity will remain free from interference by any element in the University, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of a necessary independent and objective function.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair internal auditors’ independence or judgment.

Internal auditors will exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors will make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgments.

The Chief Audit Executive will confirm to the ACR Committee annually the organizational independence of the Audit Department.
Responsibility:
The scope of Internal Auditing encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of the University’s governance, risk management, and internal controls as well as the quality of performance in carrying out assigned responsibilities to achieve the University’s stated goals and objectives. This includes:

- Evaluating the design, implementation, and effectiveness of the organization’s ethics-related objectives, programs, and activities.
- Evaluating risk exposure relating to achievement of the University’s strategic objectives.
- Assessing whether the information technology governance of the organization supports the organization’s strategies and objectives.
- Evaluating the reliability and integrity of information and the means used to identify, measure, classify, and report such information.
  - In order to enable this responsibility, the Audit Department will participate in the planning, development, implementation, and modification of major computer-based and manual systems to ensure that:
    - adequate controls are incorporated into the system;
    - thorough system testing is performed at appropriate stages;
    - system documentation is complete and accurate; and
    - the resultant system is a complete and accurate implementation of the system specifications.
- Evaluating the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on the University.
- Evaluating the means of safeguarding assets and, as appropriate, verifying the existence of such assets.
- Evaluating the effectiveness and efficiency of resource utilization.
- Evaluating operations or programs to ascertain whether results are consistent with established objectives and goals and whether the operations or programs are being carried out as planned.
- Assessing and making appropriate recommendations for improving the governance process in its accomplishment of the following objectives:
- Promoting appropriate ethics and values within the organization
- Ensuring effective organizational performance management and accountability
- Communicating risk and control information to appropriate areas of the organization
- Coordinating the activities of and communicating information among the board, external and internal auditors, and management.

- Monitoring and evaluating the effectiveness of the organization’s risk management processes.
- Performing consulting services related to governance, risk management, and control.
- Reporting significant risk exposures and control issues, including fraud risks, governance issues, and other matters needed or requested by the ACR Committee or management.
- Evaluating specific operations at the request of the ACR Committee or management, as appropriate.
- Reporting periodically on the Audit Department’s purpose, authority, responsibility and performance relative to its plan.

Internal Audit Plan:
At least annually, the Chief Audit Executive will submit to senior management and the ACR an internal audit plan for review and approval. The internal audit plan will consist of a work schedule as well as budget and resource requirements for the next year.

The Chief Audit Executive will communicate the impact of resource limitations and significant interim changes to senior management and the Board.

The internal audit plan will be developed based on a prioritization of the audit universe using a risk-based methodology, including input of senior management, the ACR, and Board.

The Chief Audit Executive will review and adjust the plan, as necessary, in response to changes in the organization’s business, risks, operations, programs, systems, and controls. Any significant deviation from the approved internal audit plan will be communicated to senior management and the ACR through periodic activity reports.
Special Projects:
The Chief Audit Executive is empowered to conduct special audit projects, reviews, advisory services, or investigations at the request of the Board, ACR Committee, President, General Counsel, EVP Provost, EVP Chief Operating Officer, EVP Health Affairs, or their designee, to assist management in meeting its objectives, promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in its programs and operations. The Audit Department may also provide consulting services, beyond the Audit Department’s assurance services, to assist management in meeting its objectives. Examples may include facilitation, process design, training, and advisory services.

Coordination with External Auditing Agencies:
The Chief Audit Executive, with the goal of avoiding duplication of work, will coordinate the department’s audit efforts with those of the Commonwealth of Virginia’s Auditor of Public Accounts, or other external auditing agencies as applicable, by participating in the planning and definition of the scope of proposed audits so the work of all auditing groups is complementary and their combined efforts provide comprehensive, cost-effective audit coverage for the University.

Reporting and Monitoring:
A written report will be prepared and issued by the Chief Audit Executive or designee following the conclusion of each internal audit engagement and will be distributed as appropriate. Internal audit results will be available for review by the ACR and Board of Visitors.

The internal audit report will include management’s response and corrective action taken or to be taken in regard to the specific findings and recommendations. Management's response to audit findings and recommendations should include a timetable for anticipated completion of action to be taken and an explanation for any corrective action that will not be implemented.

The Audit Department will be responsible for appropriate follow-up on its engagement findings and recommendations. All significant findings will remain in an open issues file until cleared. The ACR will receive periodic reporting from the Chief Audit Executive on the status of management’s action plan implementation.

The Chief Audit Executive will periodically report to senior management and the ACR on the internal audit activity’s purpose, authority, and responsibility, as well as performance relative
to its plan. Reporting will also include significant risk exposures and control issues, including fraud risks, governance issues, and other matters needed or requested by senior management, ACR, or the Board.

**Quality Assurance and Improvement Program:**
The internal audit activity will maintain a quality assurance and improvement program that covers all aspects of the internal audit activity. The program will include an evaluation of the internal audit activity’s conformance with the Definition of Internal Auditing and the Standards and an evaluation of whether internal auditors abide by the Code of Ethics. The program will also assess the efficiency and effectiveness of the internal audit activity and identify opportunities for improvement.

The Chief Audit Executive will communicate to senior management and the ACR on the internal audit activity’s quality assurance and improvement program, including results of ongoing internal assessments and external assessments conducted at least every five years.
AMENDED AND RESTATED

BYLAWS

OF THE CLINICAL STAFF

OF THE

UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

July 9, 2010

REVISED September 15, 2011

REVISED January 13, 2013

REVISED September 17, 2015
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AMENDED AND RESTATED
BYLAWS
OF THE CLINICAL STAFF
OF THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

PREAMBLE

WHEREAS, the University of Virginia Transitional Care Hospital is an integral part of the University of Virginia, which is a public corporation organized under the laws of the Commonwealth of Virginia and an agency of the Commonwealth; and

WHEREAS, the Transitional Care Hospital is a long term acute care in-patient hospital as designated by the Operating Board of the University of Virginia; and

WHEREAS, the Operating Board of the University of Virginia Medical Center is the governing body for the Transitional Care Hospital, as decreed by the University of Virginia Board of Visitors, and has delegated to the Clinical Staff the responsibility for the provision of the quality clinical care it provides throughout the Transitional Care Hospital; and

WHEREAS, these Bylaws set forth the requirements for membership on the Clinical Staff, including a mechanism for reviewing the qualifications of Applicants for Clinical Privileges and a process for their continuing review and evaluation, and provide for the internal governance of the Clinical Staff;

NOW, THEREFORE, these Bylaws are adopted by the Clinical Staff and approved by the Operating Board to accomplish the aims, goals, and purposes set forth in these Bylaws.
MISSION, VISION AND VALUES OF THE UNIVERSITY OF VIRGINIA HEALTH SYSTEM and TRANSITIONAL CARE HOSPITAL

Mission

To provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge within a culture that promotes equity, diversity and inclusiveness.

Vision

In all that we do, we work to benefit human health and improve the quality of life. We will be:

- Our local community’s provider of choice for health care needs.
- A national leader in quality, patient safety, service and compassionate care.
- The leading provider of technologically advanced, ground-breaking care throughout Virginia.
- Recognized for translating research discoveries into improvements in clinical care and patient outcomes.
- Fostering innovative care delivery and teaching/training models that respond to the evolving health environment.
- A leader in training students and faculty in providing healthcare free of disparity.

Values

This institution exists to serve others, and does so through the expression of our core values:

Respect: To recognize the dignity of every person.

Integrity: To be honest, fair and trustworthy.

Stewardship: To manage resources responsibly.

Excellence: To work at the highest level of performance, with a commitment to continuous improvement.

UVA Health System Goals:

- Become the safest place to receive care.
- Be the healthiest work environment.
- Provide exceptional clinical care.
- Generate biomedical discovery that betters the human condition.
- Train healthcare providers of the future to work in multi-disciplinary teams.
- Ensure value-driven and efficient stewardship of resources.
ARTICLE I
DEFINITIONS

“Active Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.1 of these Bylaws.

“Active Clinical Staff – Provisional” means those Members of the Clinical Staff who are in their first year of appointment as an Active Member of the Clinical Staff as described in Section 4.4.1 of the Bylaws.

“Adverse Action” means the reduction, restriction (including the requirement of prospective or concurrent consultation), suspension, revocation, or denial of Clinical Privileges of a Member that constitute grounds for a hearing as provided in Section 9.2 of these Bylaws. Adverse Action shall not include warnings, letters of admonition, letters of reprimand or recommendations or actions taken as a result of an individual’s failure to satisfy specified objective credentialing criteria that are applicable to all similarly situated individuals.

“Allied Health Professionals” means but are not limited to, Optometrists, Audiologists, Certified Substance Abuse Counselors, Licensed Professional Counselors, Licensed Clinical Social Workers, Nurse Practitioners, Physician Assistants, and Certified Registered Nurse Anesthetists.

“Allied Health Professionals Manual” means the Transitional Care Hospital Allied Health Professionals Staff Credentialing Manual, as such may be in effect from time to time. The Allied Health Professionals Manual is incorporated by reference into these Bylaws.

“Applicant” means a person who is applying for appointment or reappointment of Clinical Staff membership and may also mean a person who is applying for Clinical Privileges to practice within the University of Virginia Transitional Care Hospital, as the context requires.

“Attending Physician” means a Member of the Clinical Staff who is responsible for the care of a patient at the Transitional Care Hospital.

Be Safe” means to advance the University of Virginia Transitional Care Hospital’s status as the safest place to work and to receive care. The core belief is that patient and team member safety are preconditions to excellence in health care, and that collective system-wide focus on these areas will jointly improve outcomes and develop broad capacity to engage in organizational problem solving and continuous improvement. Based in Lean management principles, the Be Safe program emphasizes real-time root cause problem solving, the use of standard work as a basis for improvement, and rapid escalation of safety issues within a tiered chain of leadership support.

“Board Certified” means that a Practitioner, if a Physician, is certified as a specialist by a specialty board organization, recognized as such by the American Board of Medical Specialties, or the American Osteopathic Association’s Council for Graduate Medical Education; if an Oral Surgeon is specialty certified as such by the Virginia Board of Dentistry and the American Board
of Maxillo-Facial Surgery; if a Podiatrist is certified by the American Board of Podiatric Surgery; and if a Dentist, is certified by the American Board of Dentistry; and if a clinical pathologist is certified by a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“Board Qualified” means a Practitioner has met the educational, post-graduate training and skill qualifications, and is currently eligible to sit, within a specified amount of time, for a board certification examination of a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Dental Association or the American Podiatric Medical Association or a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“Board of Visitors” means the governing body of the University of Virginia as appointed by the Governor of Virginia.

“Bylaws” means these Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Transitional Care Hospital as amended from time to time.

“Case Review” means a full review and analysis of an event related to a single patient’s experience in the Transitional Care Hospital and may also mean a review of multiple patient cases involving a single procedure, as the context requires.

“Chief Executive Officer” or “CEO” means the individual appointed by the Board of Visitors or the Medical Center Operating Board, as applicable, to serve as its representative in the overall administration of the Transitional Care Hospital.

“Chief Medical Officer” means the Chief Medical Officer (CMO) of the University of Virginia Transitional Care Hospital. The Chief Medical Officer is an Active Member in good standing of the Clinical Staff, and is appointed by the CEO. The Chief Medical Officer is responsible for assisting the Clinical Staff in performing its assigned functions, in coordinating such functions with the responsibilities and programs of the Transitional Care Hospital, including compliance with all relevant policies concerning the operations of the Transitional Care Hospital, and the performance of other duties as may be necessary from time to time.

“Clinical Privileges” means the permission granted to a Member or Non-Member to render specific diagnostic, therapeutic, medical, dental, or surgical services for patients of the Transitional Care Hospital.

“Clinical Staff” or “Staff” means the formal organizations of all licensed Physicians, Dentists, Ph.D. Clinical Psychologists, Ph.D. Clinical Pathologists and Podiatrists who may practice independently and who are granted recognition as Members under the terms of these Bylaws.

“Clinical Staff Executive Committee” or “Executive Committee” or “CSEC” means the executive committee of the Clinical Staff as more particularly described in Article XI of these Bylaws.
“Clinical Staff Office” means the administrative office of the Medical Center, which through contractual arrangement is responsible for the administration of the Transitional Care Hospital Clinical Staff, including the process for membership, credentialing and the granting of Clinical Privileges.

“CMS” means the Center for Medicare and Medicaid Services.

“Code of Conduct” means the Code of Conduct for the Clinical Staff that is described in Transitional Care Hospital Policy 0291 (“Clinical Staff Code of Conduct”).

“Committees” means those Standing Committees of the Clinical Staff as described in Article XIII of these Bylaws.

“Complete Application” means an application for either initial appointment or reappointment to the Clinical Staff, or an application for clinical privileges that has been determined by the applicable Chair (or the Chair’s designee), the Credentials Committee, the Clinical Staff Executive Committee (CSEC), and the MCOB to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete, the application must be submitted on a form approved by CSEC and MCOB, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

“Compliance Code of Conduct” means the Transitional Care Hospital Compliance Code of Conduct that is described in Transitional Care Hospital Policy 0235 (“Compliance Code of Conduct”).

“Consultative Clinical Staff” means, those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.2 of these Bylaws.

“Contract Physician” means, those Non-Members of the Clinical Staff with Privileges who meet the criteria set forth in Section 4.5.2 of these Bylaws.

“Credentialing” means the process of verifying the authenticity and adequacy of a Practitioner’s educational, training, and work history in order to determine whether the individual meets predefined criteria for membership and/or privileges.

“Credentials Manual” means the Clinical Staff and Resource Manual as such may be in effect from time to time. The Credentials Manual is an associate manual to these Bylaws.

“DEA” means the Federal Drug Enforcement Agency, or any successor agency.

“Dean” means the Dean of the School of Medicine of the University of Virginia.

“Dentist” means any individual who has received a degree in and is currently licensed to practice dentistry in the Commonwealth of Virginia.
“Department” means a clinical department within the University of Virginia School of Medicine.

“Department Chair” or “Chair” means the Active Member, appointed by the Dean of the School of Medicine, who has the responsibility for overseeing his or her Department; all Department Chairs are Active Members of the Clinical Staff of the University of Virginia Transitional Care Hospital.

“Disaster Privileges” means those Clinical Privileges granted during a declared disaster as more specifically provided in Section 6.9 of these Bylaws.

“Division” means a subdivision of a Department.

“Emergency Privileges” means those Clinical Privileges granted already existing Practitioners to provide emergency treatment outside the scope of their existing privileges in order to save the life, limb, or organ of a patient, as provided in Section 6.8 of these Bylaws.

“Executive Vice President for Health Affairs (“EVP”) means an individual appointed by the Board of Visitors with operational, financial and strategic oversight of the Transitional Care Hospital, Medical Center, School of Medicine, and Health Sciences Library.

“Fellow” means a Physician, Dentist or Ph.D. Clinical Psychologist in a program of graduate medical education that is beyond the requirements for eligibility for first board certification in the discipline.

“Focused Professional Practice Evaluation (“FPPE”) means a structured and time-limited evaluation of the competence of a practitioner to safely exercise a clinical privilege or set of privileges. FPPE is performed at the time of initial appointment to the clinical staff; upon the request of a new privilege, if the practitioner cannot provide prior documentation of competence to perform the requested procedure; or when a question arises regarding the ability of a currently privileged practitioner to competently and safely exercise the privileges he or she is currently granted. See Transitional Care Hospital Policy No. 0279 (“Professional Practice Evaluations for Members of the Clinical Staff”), Transitional Care Hospital Policy No. 0280 (“Allied Health Professionals Practice Evaluations”) and the Medical Center’s Credentials Manual.

“GME Manual” means the University of Virginia Medical Center Graduate Medical Education Manual, as such may be in effect from time to time and that is found online at http://www.healthsystem.virginia.edu/alive/gme/doc/Manual_GradMedTrainee_Nov2007.pdf.

“Graduate Medical Trainee Staff” or “GME Trainee” means Residents and Fellows.

“HCQIA” means the Health Care Quality Improvement Act of 1986, 42 U.S.C. Sections 11101 - 11152; as such law may be amended from time to time.

“Hearing Entity” means the entity appointed by the Clinical Staff Executive Committee to conduct an evidentiary hearing upon the request of a Member who has been the subject of an Adverse Action that is grounds for a hearing, in accordance with Article IX herein.
“Honorary Clinical Staff” means those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.4 of these Bylaws.

“In Good Standing” means a Member is currently serving without any limitation of prerogatives imposed by operation of the Bylaws or policies of the Transitional Care Hospital.

“Investigation” means the process specifically authorized by these Bylaws in order to perform a final assessment of whether a recommended corrective action is warranted.

“Joint Commission” means the accrediting body whose standards are referred to in these Bylaws.

“Licensed Independent Practitioners or LIPs” mean licensed independent practitioners who provide medical and clinical care to patients, in accordance with state licensing laws.

“Medical Center” or “UVAMC” means the University of Virginia academic medical center comprised of the acute care hospital, inpatient and outpatient clinics, clinical outreach programs, and related health care facilities as designated by the Medical Center Operating Board from time to time.

“Medical Center Operating Board” or “Operating Board” or “MCOB” means the governing body of the Transitional Care Hospital as designated by the Board of Visitors.

“Medical Center Operating Board Quality Subcommittee” or “MCOB Quality Subcommittee” is a Committee of the MCOB. From time to time, the MCOB may direct this Committee to oversee the quality and safety of care in the Transitional Care Hospital.

“Medical Director” means a clinical staff member in good standing who provides medical direction and leadership for a specific function at the Transitional Care Hospital. Responsibilities include clinical and administrative duties. Medical Directors are appointed by, and report to, the Chief Medical Officer.

“Member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist who is a member of the Clinical Staff of the University of Virginia Transitional Care Hospital.

“National Practitioner Data Bank” or “NPDB” means the national clearinghouse established pursuant to HCQIA, as amended from time to time, for obtaining and reporting information with respect to adverse actions or malpractice claims against physicians or other Practitioners.

“Non-Member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist, Ph.D. Clinical Pathologist or AHP who does not qualify as a Member of the Clinical Staff but who is required to have Clinical Privileges in order to provide patient care in the Transitional Care Hospital.

“Officer” means an elected official of the Clinical Staff as more particularly described in Article X of these Bylaws.
“Ongoing Professional Practice Evaluation (“OPPE”)” means a process that allows identification of professional practice trends that impact on the quality of care and patient safety on an ongoing basis and focuses on the practitioner’s performance and competence related to his or her clinical staff privileges. See Transitional Care Hospital Policy No. 0279 (“Professional Practice Evaluations for Members of the Clinical Staff”), Transitional Care Hospital Policy No. 0280 (“Allied Health Professionals Practice Evaluations”) and the Credentials Manual.

“Peer” means a Practitioner or clinician whose interest and expertise, as documented by clinical practice, is reasonably determined to be comparable in scope and emphasis to that of another Practitioner or clinician.

“Peer Review” means a systematic review of a Practitioner’s or clinician’s clinical practice or professionalism, or a review of a portion of the clinical practice or professionalism, by a Peer or Peers of the individual Practitioner or clinician.

“Ph.D. Clinical Pathologist” means an individual who has been awarded a doctoral degree (e.g., Ph.D., or D.Sc.) in a scientific discipline and completed additional clinical training in an area of clinical pathology.

“Ph.D. Clinical Psychologist” means an individual who has been awarded a Ph.D. degree or equivalent terminal degree in Clinical Psychology and who holds a current license to practice clinical psychology issued by the Virginia Board of Psychology.

“Physician” means any individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and holds a current license to practice medicine in the Commonwealth of Virginia.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and who holds a current license to practice podiatry issued by the Virginia Board of Medicine.

“Practitioner” means a care provider privileged through the processes in these Bylaws.

“Prerogative” means the participatory rights granted, by virtue of staff category or otherwise, to a Clinical Staff Member, which is exercisable subject to, in accordance with, the conditions imposed by these Bylaws.

“President” means the most senior elected Officer of the Clinical Staff as described in Article X of these Bylaws.

“Privileging” means the process of granting the right to examine and treat patients after verification of the authenticity and adequacy of a Practitioner’s educational, training, and work history.

“Proctor” means an LIP in good standing at the University of Virginia Transitional Care Hospital, who holds the privilege being monitored.
“Resident” means an individual who has been awarded an M.D., a D.D.S., or a Ph.D. in clinical psychology who is participating in a program of post-doctoral education in anticipation of fulfilling the requirements for first board certification.

“School of Medicine” means the medical school at the University of Virginia.

“Standing Committee of the Clinical Staff Executive Committee” means a duly-authorized Committee of the Clinical Staff reporting to the Clinical Staff Executive Committee.

“Temporary Privileges” means those Clinical Privileges granted for a period not to exceed 120 days as more specifically described in Section 6.7 of these Bylaws.

“Transitional Care Hospital” means the University of Virginia Transitional Care Hospital which is a long term acute care facility providing such services to in-patients; also referred to herein as “UVATCH”.

“Transitional Care Hospital Policy Manual” means the manual containing the administrative and various patient care policies of the Transitional Care Hospital.

“University” or “University of Virginia” means the corporation known as The Rector and Visitors of the University of Virginia, which is an agency of the Commonwealth of Virginia.

“University Physicians Group (‘UPG’)” means the physician group practice of the University of Virginia, representing doctors and other allied health professionals who provide care within the Medical Center and the Transitional Care Hospital.

“Vice President” means the Vice President of the Clinical Staff as described in Article X of these Bylaws.
ARTICLE II
GOVERNANCE OF THE TRANSITIONAL CARE HOSPITAL

2.1 MEDICAL CENTER OPERATING BOARD

The Medical Center Operating Board is the governing body of the Transitional Care Hospital. Each Member of the Clinical Staff assumes his or her responsibilities subject to the authority of the MCOB. The MCOB shall be constituted as directed by the Board of Visitors of the University from time to time.

2.2 CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff Executive Committee serves as the executive committee of the Clinical Staff and reports to the MCOB. In this role, the Clinical Staff Executive Committee oversees the quality of the clinical care delivered within the Transitional Care Hospital and delineates and adopts clinical policy within the Transitional Care Hospital. It is responsible for communications to Members of the Clinical Staff and other Non-Members regarding clinical practice issues and it represents the interests of the Clinical Staff to the MCOB. The Clinical Staff Executive Committee is empowered to act for the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which it is given authority in these Bylaws. The Clinical Staff Executive Committee shall be constituted and have the other duties as described in Article XI hereof.

ARTICLE III
NAME AND PURPOSES

3.1 NAME

The name of the clinical staff organization shall be the “Clinical Staff” of the University of Virginia Transitional Care Hospital (UVATCH). The organized Clinical Staff is accountable to the Medical Center Operating Board. For the purposes of these Bylaws, the words “Clinical Staff” shall be interpreted to include all Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who are authorized to provide care to patients of the UVATCH.
3.2 STATEMENT OF PURPOSE

The purposes of the Clinical Staff Bylaws are to:

1. Facilitate the provision of quality care to patients of the University of Virginia Transitional Care Hospital without any form of discrimination.

2. Clarify roles and responsibilities of Clinical Staff Members and Officers of the UVATCH.

3. Promote professional standards among members of the Clinical Staff.

4. Provide a means whereby problems may be resolved by the Clinical Staff with the collaboration of the MCOB.

5. Create a system of self-governance, and to initiate and maintain policies and procedures governing the conduct of Clinical Staff, subject to the ultimate authority of the MCOB.

3.3 THE PURPOSES OF THE ORGANIZED CLINICAL STAFF

The purposes of the organized Clinical Staff of the UVATCH are to:

1. To provide quality medical care to all patients admitted or treated in the UVATCH.

2. To establish and maintain high professional and ethical standards.

3. To establish and maintain collaborative, collegial relationships within the Clinical Staff and between all team members.

4. To oversee the quality of professional services by all practitioners with clinical privileges.

5. To provide a formalized organizational structure to facilitate the credentialing and review of the professional activities of practitioners and to make recommendations to the MCOB on appointment and/or clinical privileges granted to such individuals.

6. To appropriately delineate, in conjunction with the MCOB, the clinical privileges each practitioner may exercise through the continued review and evaluation.

7. To stimulate, promote and conduct research in human health, disease and delivery of medical care.

8. To cooperate with the various academic units of the University, affiliated hospitals and other health facilities and maintain standards at predoctoral and postdoctoral levels.
9. To initiate and maintain rules for governance of the Clinical staff and provide a means hereby issues and problems concerning the Clinical staff can be discussed and resolved.

10. To initiate, develop, review, approve, implement and enforce these Bylaws and associated Clinical Staff polices.

11. To provide a means for effective communication among the Clinical Staff, administration and the MCOB on matters of mutual concern.

12. To collaborate with Health System leadership to continuously enhance the quality, safety and efficiency of patient care, treatment and services as delegated to CSEC by the MCOB.

ARTICLE IV
CLINICAL STAFF MEMBERSHIP AND CLASSIFICATION

4.1 MEMBERSHIP

Membership of the Clinical Staff shall be extended to Physicians, Dentists, Podiatrists, and Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws and who are appointed by the MCOB. Membership on the Clinical Staff or clinical privileges shall not be granted or denied on the basis of race, religion, color, age, gender, national origin, ancestry, economic status, marital status, veteran status, disability or sexual orientation, provided the individual is competent to render care of the generally-recognized professional level of quality established by the Clinical Staff Executive Committee and the MCOB, and provided the UVATCH services occur in the appropriate environment of care setting.

No Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist, or Ph.D. Clinical Pathologist shall admit or provide services to patients in the UVATCH unless he/she is a Member of the Clinical Staff or has been granted Visiting, Temporary, Disaster, or Emergency privileges in accordance with the procedures set forth in these Bylaws.

GME Trainees who are in a UVAMC approved residency program shall not be eligible for membership on the Clinical Staff and shall be under the supervision of the GME Program Director and/or an attending Physician. A Department Chair may request privileges for GME Trainees to perform clinical work in a medical discipline for which they have had previous training. Such Applicants must meet the requirements, qualifications and responsibilities for such privileges and are subject to such policies and procedures as may be established by the Credentials Committee and the Clinical Staff Executive Committee. Graduate Medical Trainee appointments and job descriptions including job qualifications and current competencies are maintained by the Graduate Medical Education Office and by the Clinical Competency Committees of their respective academic departments.
4.2 EFFECT OF OTHER AFFILIATIONS

No Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist shall be automatically entitled to Clinical Staff membership, a particular Clinical Staff category or to exercise any particular clinical privilege merely because he/she hold a certain degree; is licensed to practice in Virginia or any other state; is a member of any professional organization; is certified by any clinical board; previously had membership or privileges at UVATCH; or had, or presently has, staff membership or privileges at another health care facility. Clinical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual’s participation or non-participation in a particular medical group, IPA, PPO, PHO, or Transitional Care Hospital-sponsored foundation.

4.3 REQUIREMENTS FOR CLINICAL STAFF MEMBERSHIP

4.3.1 Nature of Clinical Staff Membership

Membership on the Clinical Staff is a an honor that shall be limited to professionally competent Practitioners who continuously meet the qualifications, requirements and responsibilities set forth in these Bylaws, in applicable Transitional Care Hospital policies, including but not limited to Transitional Care Hospital Policy No. 0291 (“Clinical Staff Code of Conduct”) and Transitional Care Hospital Policy No. 305 (“General Requirements for Clinicians Holding Clinical Privileges”), and the Medical Center’s Credentials Manual. Membership implies active participation in Clinical Staff activities to an extent commensurate with the exercise of the Clinical Staff Member’s privileges and as may be required by the Clinical Staff Member’s Department.

4.3.2 Basic Qualifications of Clinical Staff Membership

In order to obtain or maintain membership on the Clinical Staff and in order to be granted privileges as a Member of the Clinical Staff, Applicants must have and document:

A. A faculty appointment in the School of Medicine or an employment contract with UPG with the consent of the appropriate Department Chair.

B. A current, unrestricted license, if such license is required by Virginia law, to practice medicine and surgery, dentistry, clinical psychology Ph.D. or clinical pathology Ph.D. in the Commonwealth of Virginia;

C. Except for specific exemptions permitted under Transitional Care Hospital Policy No. 0221 (“Board Certification Requirements for Transitional Care Hospital Physicians”), a Practitioner who seeks to be or is a Member must be Board Certified for the specialty in which he or she expects to exercise clinical privileges within six (6) years of completion of training. A Member who seeks or holds clinical privileges must be Board Certified in accordance with the specific requirements of the specialty, and in compliance with specific Departmental criteria for Delineation of Privileges. If an Applicant does not meet the board certification requirements and the Applicant may qualify for an exemption specified in Transitional Care Hospital Policy 0221, the Department Chair must send a written request
to the Credentials Committee requesting an exemption. Reappointment is contingent upon Board Certification or recertification as outlined in Transitional Care Hospital Policy No. 0221 (“Board Certification Requirements for Transitional Care Hospital Physicians”), which is incorporated herein by reference;

D. Eligibility to participate in Medicare, Medicaid and other federally sponsored health programs; and

E. Members shall have in force professional liability insurance satisfactory to the Transitional Care Hospital which covers all privileges requested.

A Practitioner who does not meet these basic requirements is ineligible to apply for Clinical Staff membership, and the application shall not be accepted for review, except that Members of the Honorary Staff do not need to comply with these basic qualifications. If it is determined during the processing that the Applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article IX.

4.3.3 General Requirements of Clinical Staff Membership

In order to obtain or maintain membership on the Clinical Staff and in order to be granted clinical privileges as a member of the clinical staff, applicants must demonstrate:

A. Current competency. Applicants for staff privileges shall have the background, relevant training, experience and competency that are sufficient to demonstrate to the satisfaction of the Credentials Committee and the MCOB that he or she can capably and safely exercise clinical privileges within the Transitional Care Hospital. Current competency shall be demonstrated as described in Transitional Care Hospital Policy 0291 (“Clinical Staff Code of Conduct”) and Transitional Care Hospital Policy 0305 (“General Requirements for Clinicians Holding Clinical Privileges”).

B. Compliance with Bylaws and Policies. Compliance with the Bylaws and Clinical Staff policies, as well as all enunciated policies of UVATCH.

C. Appropriate Management of Medical Records. Preparing in legible and accurate form, completing within prescribed timelines and maintaining the confidentiality of medical records for all patients to whom the Member provides care in the UVATCH in accordance with applicable policies of UVATCH and the University Physicians Group. This shall include, but is not limited to, performing histories and physicals and completing all necessary documentation as required by Transitional Care Hospital Policy No. 0094 (“Documentation of Patient Care (Electronic Medical Record”) which is incorporated herein by reference.

A medical history and physical examination (H&P) shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Transitional Care Hospital policy. (see Transitional Care Hospital Policy 0094, “Documentation of Patient Care Electronic Medical Record”).

4.3.4 Supervision of Graduate Medical Trainees

The Clinical Staff shall supervise participants on the Graduate Medical Education (GME) program in the performance of clinical activities within the Transitional Care Hospital. The Clinical Staff member shall meet the requirements as contained in the GME Policy and Procedure 012, and applicable Transitional Care Hospital and Departmental policies and as required by the ACGME and noted on the ACGME website.

4.3.5 Other Member Responsibilities

Additional responsibilities of Members may include, as appropriate:

A. Abiding by the Standards of Professional Conduct of the Virginia Boards of Medicine, Psychology and Dentistry, as appropriate, and ethical requirements of the Medical Society of Virginia, the American Board of Medical Specialties (as applicable), or the other professional associations of dentists, podiatrists, and psychologists, as appropriate;

B. Engaging in conduct that is professional, cooperative, respectful and courteous of others and is consistent with and reinforcing of the mission of the Transitional Care Hospital; see Transitional Care Hospital Policy No. 291 (“Clinical Staff Code of Conduct”) and Transitional Care Hospital Policy No. 305 (“General Requirements for Clinicians Holding Clinical Privileges”);

C. Attending meetings of the Clinical Staff, Department, Division, as appropriate, and committees to which a Member has been appointed, as required; and

D. Participating in recognized functions of Clinical Staff appointment, including quality improvement activities, FPPE as necessary, OPPE, Case Review and Peer Review and discharging other Clinical Staff functions as may be required from time to time by the Department Chair, the Division Chief, the Clinical Staff, the Clinical Staff Executive Committee, or the MCOB.

4.4 CATEGORIES OF THE CLINICAL STAFF

The categories of Clinical Staff membership shall be divided into the Active Staff, Consultative Staff and Honorary Staff. Non-Members include Contract Physicians, Visiting Clinicians, Graduate Medical Trainees, and Allied Health Professionals. Each time Clinical Staff
membership is granted or renewed, or at other times deemed appropriate, the Clinical Staff Executive Committee, and subsequently the MCOB, will approve the member’s staff category.

Each Clinical Staff Member shall be assigned to a Clinical Staff category based upon qualifications defined in these Bylaws. For the purposes of the below qualifications, patient contact includes admissions, treatments, and consults.

The Members of each Clinical Staff category shall have the prerogatives and shall carry out the duties defined in these Bylaws. Action may be initiated to change the Clinical Staff category or to terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described in these Bylaws. Changes in Clinical Staff category shall not be grounds for a hearing unless they adversely affect the Member’s privileges.

4.4.1 Active Clinical Staff

A. Qualifications

The Active Clinical Staff are voting members and shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Pathologists, and Ph.D. Clinical Psychologists who hold a School of Medicine faculty appointment and/or a UPG contract, and:

1. Meet the criteria for Clinical Staff membership set forth in these Bylaws and specifically in Section 4.3;

2. Regularly admit patients to, or are regularly involved in, direct or concurrent care of patients at the Transitional Care Hospital, and regularly participate in Clinical Staff functions as determined by Clinical Staff governance. See also Transitional Care Hospital Center Policy No.304 (“Responsibilities of Attending Physicians on Inpatient Services”); and

3. Have satisfactorily completed their designated term in the Provisional status.

B. Prerogatives and Responsibilities

1. Exercise an option to vote on all matters presented at general and special meetings of the Clinical Staff;

2. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual; and

3. Exercise an option to be considered for office in the Clinical Staff organization.

C. Transfer of Active Staff Members

After two (2) consecutive years in which a Member of the Active Clinical Staff does not regularly care for patients at UVATCH and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the member is qualified.
4.4.2 Consultative Clinical Staff

A. Qualifications

The Consultative Staff are non-voting members, and shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists, and Ph.D. Clinical Pathologists, who hold School of Medicine faculty appointments and/or employment contracts with UPG. Consultative Staff Members:

1. Meet the criteria for Staff membership set forth in these Bylaws and specifically in Section 4.3; and
2. Are involved in consultative care of patients at UVATCH.

B. Prerogative and Responsibilities

1. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual pursuant to Article VI;
2. Actively participate in performance improvement and quality assurance activities and in discharging such other Staff functions as may from time to time be required.

C. Limitations

1. Shall not have the right to vote at general and special meetings of the Clinical Staff; and
2. Cannot hold office in the Clinical Staff organization.

D. Transfer of Consultative Clinical Staff Members

After two (2) consecutive years in which a Member of the Consultative Clinical Staff does not regularly care for patients at UVATCH and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the Member is qualified.

4.4.3 Honorary Clinical Staff

A. Qualifications

The Honorary Clinical Staff shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists, each of whom is a former Member of the Clinical Staff who has retired or withdrawn from practice and who: is honored by an emeritus title in the School of Medicine; and/or has been nominated by the current Department Chair in which the person practiced, or by the Dean, in recognition of his or her noteworthy contributions to the UVAMC; and was a Member in good standing of the Clinical Staff at the time of his or her retirement or withdrawal from clinical practice.
B. Responsibilities

1. Exercise an option to attend general and special meetings of the Clinical Staff; and

2. Exercise an option to vote on Clinical Staff Committees that he/she has been requested to serve on.

C. Limitations

1. Shall not be granted or exercise clinical privileges

2. Shall not vote at general or special meetings of the Clinical Staff

3. Shall not hold office in the Clinical Staff organization

4.5 NON-MEMBER WITH PRIVILEGES

Other healthcare professionals not described above may not be Members of the Clinical Staff. Non-Members are Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists or Ph.D. Clinical Pathologists who are not Members of Clinical Staff but who are granted privileges to provide care to patients of the Transitional Care Hospital from time to time as provided in these Bylaws and in the Credentials Manual. Non-Members shall have Clinical Privileges as provided in Article VI and the Credentials Manual. Allied Health Professionals are also Non-Members who are granted privileges. Non-Members shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Articles IX hereof, but shall be required to follow policies and procedures of the Transitional Care Hospital.

4.5.1 Visiting Clinicians

Visiting Clinicians do not hold faculty appointments, nor are they contracted with UVATCH or UPG, but are granted privileges to provide services that are not otherwise available at UVATCH or to assist in difficult cases.

A. Qualifications

The Visiting Clinicians shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and LIPs who:

1. Meet the criteria for Staff membership set forth in these Bylaws excluding the faculty appointment or UPG contract and meet the criteria for Staff membership set forth in Section 4.3;

2. Hold appropriate clinical privileges at another accredited health care facility; and

3. Have a maximum of ten (10) patient contacts per year at the Transitional Care Hospital.
B. Responsibilities

1. Exercise an option to provide clinical care at UVATCH within the privileges as are granted to him/her pursuant to Article VI;

2. Provide patient activity and quality review information from primary facility as requested at time of reappointment;

3. Satisfy the requirements of the Clinical Department of which he/she is a member; and

4. Actively participate in performance improvement and quality assurance activities, supervising provisional appointees, evaluating and monitoring Clinical Staff members as may from time to time be required.

C. Limitations

1. Shall not vote at general or special meetings of the Clinical Staff;

2. Shall not hold office in the Clinical Staff organization; and

3. Shall not attend meetings of the Clinical Staff.

D. Transfer of Visiting Clinicians

Visiting Clinical Clinicians who regularly care for more than ten (10) patients per year at the Transitional Care Hospital will be reviewed by the Credentials Committee to consider appointment to another staff category.

4.5.2 Contract Physician Staff

The Contract Physician Staff shall consist of advanced greater than PGY-3 Graduate Medical Education (GME) Trainees at UVAMC who are engaged by the Transitional Care Hospital to provide explicit medical services outside their training program at the Transitional Care Hospital. A Contract physician must obtain prior approval for the outside activities in accordance with the GME Internal and External Moonlighting Activity Policy and provide a copy of the contract under which he or she will be working at the time the credentialing process begins. Members of the Contract Physician Staff must be board certified or board qualified in the specialty related to the privilege request, and have attestations of qualifications from both the Program Director and the Department Chair. Contract Physician Staff are not eligible to vote on Clinical Staff matters or to hold Clinical Staff Office.

In addition, Contract Physician Staff:

A. May not serve as the attending physician of record or admit patients to the Transitional Care Hospital unless an exemption is granted. Exemptions are considered at the request of the Designated Institutional Officer with explicit conditions regarding concurrent proctoring and agreed to by the Credentials Committee;
B. Can treat patients if authorized to do so in accordance with the Practitioner’s delineated clinical privileges and Article VI of these Bylaws;

C. Will have the same appointment procedures for Contract Physician Staff as the procedures for the Clinical Staff in accordance with Article VII of these Bylaws;

D. Shall actively participate in performance improvement and quality assurance activities of the Clinical Staff;

E. Shall meet the basic responsibilities of Staff membership as set forth in these Bylaws; and

F. The Contract Physician Staff Practitioner’s privileges will automatically terminate upon the termination or expiration of his/her contract or agreement with the UVATCH or UPG, and the Practitioner shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Article IX.

4.5.3 Graduate Medical Trainees

Except as provided in Section 4.5.2 above, Graduate Medical Trainees do not have independent privileges to admit or treat patients at the UVATCH. They are employees of the University of Virginia Medical Center and their scope of practice is defined by the Graduate Medical Education Program. They are not governed by these Bylaws. Graduate Medical Trainees shall be required to follow GME policies and procedures and will act only under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff Transitional Care Hospital and GME policies.

GME Trainees who are working in an independent practice capacity as Contract Physicians in the organization must be granted privileges as set forth in Article VI of these Bylaws.

4.5.4 Allied Health Professionals

Allied Health Professionals (AHPs) are non-physicians who hold a license, certificate, or other legal credentials to practice as required by Virginia law that authorizes the provision of complex and clinical services to patients. AHPs treat and/or perform services on patients at the Transitional Care Hospital. AHPs adhere to Clinical Staff Bylaws which are applicable to the AHP, Department policies, Transitional Care Hospital policies and professional guidelines. (See, e.g. Transitional Care Hospital Policy No. 280 “Allied Health Professionals Practice Evaluations”). AHPs are not Members of the Clinical Staff but are granted clinical privileges.

4.6 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request from a Member, the Clinical Staff Executive Committee may recommend a change in the Clinical Staff category of a Member, consistent with the requirements of these Bylaws, to the MCOB.
4.7 MEMBER RIGHTS

Clinical Staff Member Rights

A. Each Member in the Active category has the right to initiate a recall election of a Clinical Staff Officer by following the procedure outlined in Article X of these Bylaws regarding removal and resignation from office.

B. Each Member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Clinical Staff by presenting a petition signed by twenty-five percent (25%) of the Members of the Active category. Upon presentation of such a petition, CSEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

C. Each Member in the Active category may challenge any rule, regulation or policy established by the CSEC. In the event that a rule, regulation or policy is thought to be inappropriate, any Clinical Staff Member may submit a petition signed by twenty-five percent (25%) of the Members of the Active category. Upon presentation of such a petition, the adoption procedure noted in section Article XVI will be followed.

D. The above sections 1 to 3 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. The Bylaws provide recourse in these matters.

E. Any Practitioner eligible for Clinical Staff membership has a right to a hearing/appeal pursuant to the conditions and procedures described in the Clinical Staff’s hearing and appeal plan.

F. These member rights serve as a conflict resolution mechanism between the Clinical Staff and the Clinical Staff Executive Committee.

ARTICLE V
PROCEDURES FOR MEMBERSHIP

The process for evaluation of credentials for membership and/or privileges is the same for all Members and Non-Members. The Credentials Committee shall follow the credentialing procedures set forth in the Credentials Manual including the procedure related to the information required in an application for initial appointment and the processing of the application. Upon receipt and review of all necessary credentialing documentation, the Credentials Committee, upon review by the Department Chair, shall recommend to the Clinical Staff Executive Committee that such Applicant should either be granted or denied initial privileges in the Transitional Care Hospital. The Clinical Staff Executive Committee shall then review the Credentials Committee’s recommendation and all applicable documentation. If the Credentials Committee and the Clinical Staff Executive Committee are both in favor of granting privileges to the Applicant, the favorable recommendation shall be forwarded to the MCOB for final action.
If there is a recommendation for the denial of membership and/or privileges by the CSEC or MCOB, the applicant is entitled to the fair hearing and appeal plan appropriate to his/her clinical status.

5.1 PROCEDURE FOR ACTIVE AND CONSULTATIVE STAFF MEMBERSHIP

In order to become an Active or Consultative Member of the Clinical Staff, the individual Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist shall follow the applicable procedure in effect from time to time for obtaining an appointment as a Clinical Faculty Member in the School of Medicine, an employment contract with UPG, satisfy the criteria set forth in Article IV of these Bylaws for an Active or Consultative Member, and, if applicable, follow the procedure for obtaining Clinical Privileges as provided in these Bylaws and the Credentials Manual, all as verified by the Clinical Staff Office. The Dean and the applicable Department Chair shall jointly make the request in writing to the Clinical Staff Office for an individual to be appointed or reappointed as a Member in accordance with Article VII of these Bylaws. In the case of individuals who do not hold School of Medicine faculty appointments, the Chief Executive Officer of UPG will fill the role of the Dean for the procedures described above.

The Credentials Manual establishes requirements for application for Clinical Staff Clinical Privileges. The Credentials Manual may be amended from time to time by the Chair of the Credentials Committee in consultation with the President of the Clinical Staff and the Chief Executive Officer of the Transitional Care Hospital.

5.2 PROCEDURE FOR HONORARY CLINICAL STAFF MEMBERSHIP

In order to become an Honorary Member of the Clinical Staff, the individual who satisfies the criteria set forth in Article IV of these Bylaws shall be nominated by his or her former Chair or the Dean and approved by the Clinical Staff Executive Committee.

5.3 LEAVE OF ABSENCE

A Member of the Clinical Staff who has obtained a leave of absence from the School of Medicine or UPG, consistent with applicable faculty or UPG policies, may also obtain a leave of absence from clinical practice. Contemporaneous with a request for leave of absence from the School of Medicine or UPG, the Member shall provide notice to the Credentials Committee of the leave, including the reasons for the leave and the approximate period of leave desired. In addition, the Chair and the Dean of the School of Medicine or Chief Executive Officer of UPG shall provide notice to the Credentials Committee of any leave of absence granted to a Member. Such leave of absence is further subject to conditions and limitations that the President of the Clinical Staff, the Chair of the Credentials Committee or the CEO of the Transitional Care Hospital (or designee) determines to be appropriate. During the leave of absence, the Member shall not exercise his/her Clinical Privileges and his/her Clinical Staff responsibilities and prerogatives shall be inactive. The President of the Clinical Staff, in collaboration with the Department Chair of the Member on leave shall be responsible for arranging for alternative care for the Member’s patients while the Member is on leave. Prior to returning from a leave of absence, a Member shall notify the Credentials Committee in writing in accordance with the
procedures and the timelines set forth in the Credentials Manual, and shall provide all necessary information needed for the Credentials Committee to evaluate whether the Member is qualified to resume Clinical Staff membership, including the exercise of Clinical Privileges. A Member who has been on leave of absence may not have his or her Clinical Privileges reactivated until a determination is made by the Credentials Committee that the Member may return to clinical practice and the conditions of the return. If the Clinical Privileges of a Member who has been on leave are not reactivated, the Member shall have access to the procedures outlined in Article IX of these Bylaws.

Failure, without good cause, to request reinstatement prior to the end of an approved leave of absence shall be deemed a voluntary resignation from the Clinical Staff and voluntary relinquishment of Clinical Privileges. A request for Clinical Staff membership or Clinical Privileges subsequently received from an Applicant deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

If membership and/or privileges expire during the leave of absence, then the Practitioner must reapply for membership and/or privileges.

5.4 CESSATION OF MEMBERSHIP

Membership in the Clinical Staff shall cease automatically when the individual no longer meets the criteria set forth in these Bylaws, including failure to be reappointed to the faculty of the School of Medicine or resignation, retirement or termination from the School of Medicine or UPG.

ARTICLE VI
CATEGORIES OF CLINICAL PRIVILEGES

6.1 EXERCISE OF CLINICAL PRIVILEGES

Every Member, in connection with such membership, shall be entitled to exercise only those delineated Clinical Privileges specifically recommended by the Credentials Committee and the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, 6.8 and 6.9 of this Article. Every Non-Member shall be entitled to exercise only those delineated Clinical Privileges specifically reviewed by the Department Chair, recommended by the Credentials Committee, recommended by the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, 6.8, and 6.9 of this Article. The Transitional Care Hospital has the prerogative to audit from time to time Members’ clinical practice to verify that Members are practicing within the scope of the specific Clinical Privileges that have been granted.

6.2 DELINEATION OF PRIVILEGES

Every application for Clinical Staff appointment or reappointment (excluding Honorary Members) and every request for Clinical Privileges must contain a request for the specific
Clinical Privileges desired by the Applicant. The evaluation of such request shall be based upon the Applicant's education, training, experience, demonstrated competence as documented by evaluations from Peers, supervision or monitoring during a first or provisional year, FPPE and OPPE, references and other relevant information, including an appraisal by the Clinical Service in which such privileges are sought. The specific procedures set forth in these Bylaws and the Credentials Manual shall be followed throughout the appointment and reappointment process.

6.3 PRIVILEGES FOR NON-MEMBERS (EXCEPT AHP)

Physicians, Dentists, Podiatrists, Ph.D. Clinical Pathologists and Ph.D. Clinical Psychologists who are Non-Members who desire to practice in the Transitional Care Hospital may be granted limited privileges only as specifically permitted by the Credentials Manual or required by the Credentials Committee. Non-Members may be issued Clinical Privileges in one of the following categories: Visiting Privileges, or Contract Physicians.

6.4 PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals, as defined in these Bylaws, are privileged under a separate process that is specified in the Allied Health Professionals Manual. They are subject to the applicable sections of these Bylaws. Allied Health Professionals shall be required to follow policies and procedures as set forth in the AHP Manual and Transitional Care Hospital policies and will act under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff and UVATCH policies. An official list of current AHPs will be kept in the Clinical Staff Office.

6.5 VISITING PRIVILEGES

6.5.1 Description

Non-Members who may be granted Visiting Privileges shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Pathologists and Ph.D. Clinical Psychologists who will participate in patient care activities for Transitional Care Hospital patients for a period of time at the request of an Active Member of the Clinical Staff, with the support of the Active Member’s Department Chair or the President of the Clinical Staff, each of whom shall provide information and documentation relevant to his or her privilege specific expertise as may be required by the Credentials Committee.

6.5.2 Prerogatives

The prerogatives of the Non-Member with Visiting Privileges shall be to:

A. Participate as applicable in the care of patients within the scope of his or her delineated Clinical Privileges;

B. Exercise Clinical Privileges as specifically delineated; and

C. Attend Clinical Staff, Department and as applicable, Division meetings as invited.
6.5.3 Limitations

The Non-Member with Visiting Privileges shall not admit patients to nor serve as the primary attending of record in Transitional Care Hospital.

6.6 TEMPORARY PRIVILEGES

6.6.1 Circumstances Under Which Temporary Privileges May Be Granted

Temporary Privileges shall be granted in only two circumstances:

A. When an important patient care need mandates an immediate authorization to practice, an application for Temporary Privileges will be considered on a case-by-case basis; or

B. When an Applicant with a complete verified application with no indication of adverse information about state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern, the Credentials Committee, after review by the Transitional Care Hospital Vice-President of the Clinical Staff or a Transitional Care Hospital Medical Director, may recommend that the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, grant temporary privileges pending review and approval by the Clinical Staff Executive Committee and approval of the MCOB.

6.6.2 Application and Review

A. Where an important patient care need mandates an immediate authorization to practice as contemplated by Section 6.6.1(A) the Chair of the Credentials Committee, with the written concurrence of the Department Chair and the President of the Clinical Staff or designee, may grant Temporary Privileges. Such temporary grant of privileges shall not be made unless the following verifications are present:

1. Letter from the appropriate Department Chair explaining the important nature of the situation and the benefit to a patient or patients as a result of immediate authorization of the specified task(s) and their recommendation for approval;

2. Primary source verification of current license;

3. Listing of delineated privileges requested with appropriate documentation of competence to perform each of the specified tasks;

4. Proof of current liability coverage, showing coverage limits and dates of coverage; and

5. There exist no state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern to the Credentials Committee.
If the above requirements are not satisfied, Temporary Privileges may not be granted. In addition the Credentials Manual may specify additional verifications required before such Temporary Privileges may be granted.

B. For all situations arising under Section 6.6.1(A), the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, may grant Temporary Privileges for not more than one hundred twenty (120) days or until such time as the request is officially approved, whichever time is shorter. No such Temporary Privileges may be granted unless there is:

1. Complete application is received and all verifications are received;

2. Evidence of a completed query to the National Practitioner Data Bank and an analysis of the evaluation of the results of such query; and

3. The Applicant satisfies the requirements of Section 6.6.1(B) and has not been subject to involuntary termination of Clinical Staff membership at another organization, has not been subject to involuntary limitation, reduction, denial or loss of Clinical Privileges and has not relinquished Clinical Privileges at another organization while under investigation by that organization.

The Credentials Manual may specify additional documentation required before such Temporary Privileges may be granted.

6.6.3 General Conditions

If granted Temporary Privileges, the Applicant shall act under the supervision of the Chair (or his/her designee) of the Department to which the Applicant has been assigned, and shall ensure that the Department Chair or the Chair’s designee is kept closely informed as to his or her activities within the Transitional Care Hospital. The Credentials Manual specifies supervisory requirements for the Department Chair or the Chair’s designee when Temporary Privileges have been granted to an Applicant in the Clinical Department.

A. Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Credentials Committee upon recommendation of the Department Chair, the President of the Clinical Staff or the CEO, or unless affirmatively renewed, up to a maximum of 120 days, following the procedure set forth in Section 6.7.2.

B. Requirements for proctoring and monitoring, including FPPE, shall be imposed on such terms as may be appropriate under the circumstances upon any Member granted Temporary Privileges by the Chair of the Credentials Committee after consultation with the Department Chair or his or her designee.

C. At any time, Temporary Privileges may be terminated by the Clinical Staff Executive Committee. In such cases, the appropriate Department Chair shall assign a Member to assume responsibility for the care of such Practitioner’s patient(s). The preferences of the patient shall be considered in the choice of a replacement Member.
D. A person shall not be entitled to the procedural rights afforded by Article IX because a request for Temporary Privileges is refused or because all or any portion of Temporary Privileges are terminated or suspended for reasons not related to competence or conduct. Termination or suspension of Temporary Privileges which lasts longer than fourteen (14) days and for reasons or competence or conduct shall afford fair hearing and appeal rights.

E. All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws, the Credentials Manual, and the policies and procedures of the Transitional Care Hospital.

6.7 EMERGENCY PRIVILEGES

In the case of a medical emergency, any currently privileged Practitioner is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the Practitioner’s license, regardless of Clinical Service affiliation, staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.8 DISASTER PRIVILEGES

In the case of unpredictable disasters, including but not limited to those caused by natural disasters and bioterrorism, which result in the activation of the Transitional Care Hospital Emergency Management Plan, any clinician, to the degree permitted by his or her license and regardless of service or staff status or the lack thereof, shall perform services to save the life of a patient, using every medical facility within the University of Virginia necessary, including the calling of any consultation appropriate or desirable.

The Vice President and CEO, the President of the Clinical Staff, or the Chair of the Credentials Committee may grant Disaster Privileges for the period required to supplement normal patient care services during the emergency as more specifically provided in the Credentials Manual.

Before a volunteer clinician is considered eligible to function as a Licensed Independent Practitioner, the Transitional Care Hospital, or the Clinical Staff Office on behalf of the Transitional Care Hospital, will obtain his or her valid government issued photo identification (for example, a driver’s license or passport). When the emergency situation no longer exists, any such clinician must apply for the staff privileges necessary to continue to treat patients. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer Licensed Independent Practitioner presents himself or herself to the Transitional Care Hospital, whichever comes first. In the event such privileges are denied or are not requested, the patients shall be assigned to another Member.

A. If the Transitional Care Hospital Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs, the CEO or other individuals as identified in the Transitional Care Hospital Emergency Management Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These Practitioners must present 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:
1. A current picture Medical Center ID card that clearly identifies professional designation;

2. A current license to practice;

3. Primary source verification of the license;

4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;

5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

6. Identification by a current Transitional Care Hospital or Clinical Staff member(s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent Practitioner during a disaster.

B. The Clinical Staff has a mechanism (i.e., badging) to readily identify volunteer Practitioners who have been granted disaster privileges.

C. The Clinical Staff oversees the professional performance of volunteer Practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within seventy-two (72) hours whether disaster recovery privileges should be continued.

D. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the organization. If primary source verification cannot be completed in seventy-two (72) hours, there is documentation of the following: 1) why primary source verification could not be performed in seventy-two (72) hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

E. Once the immediate situation has passed and such determination has been made consistent with the Transitional Care Hospital Emergency Management Plan, the Practitioner’s disaster privileges will terminate immediately.

F. Any individual identified in the Transitional Care Hospital Emergency Management Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Transitional Care Hospital and will not give rise to a right to a fair hearing or an appeal.
6.10 EXPEDITED CREDENTIALING

6.10.1 Eligibility

An expedited review and approval process may be used for initial appointment and for reappointment. All initial applications for membership and/or privileges will be designated as eligible for expedited credentialing or not. A completed application that does not raise concerns, as identified by the lack of any of the criteria noted below, is eligible for expedited credentialing:

A. The application is deemed to be incomplete;

B. The final recommendation of the CSEC is adverse or with limitation;

C. The Applicant is found to have experienced an involuntary termination of clinical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

D. The Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

E. The Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of $250,000;

F. The Applicant has one or more reference responses that raise concerns or questions;

G. A discrepancy is found between information received from the Applicant and references or verified information;

H. The Applicant has an adverse National Practitioner Data Bank report;

I. The request for privileges is not reasonable based upon applicant’s experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

J. The Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

K. The Applicant has potentially relevant physical, mental and/or emotional health problems;

L. Other reasons as determined by a clinical staff leader or other representative of the Transitional Care Hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the Applicant for membership or privileges.
6.10.2 Approval Process

Applicants for expedited credentialing will be granted Clinical Staff membership and/or privileges after review and action by the following: the Department Chair or President of the Clinical Staff, the Credentials Committee and CSEC, with a quorum as defined for expedited credentialing and a committee of the MCOB consisting of at least two individuals.

ARTICLE VII
APPOINTMENT AND REAPPOINTMENT

7.1 PROCEDURE FOR INITIAL APPOINTMENT

When the Dean and a Department Chair have mutually agreed upon a candidate (hereinafter referred to as “Applicant”) for his or her Department, the Dean and the Chair jointly shall forward a copy of the offer letter and a request for appointment and privileges to the Credentials Committee for an initial period not to exceed one (1) year. All required information and documentation shall be submitted in accordance with the Credentials Manual, including the deadlines set forth therein using the application form or other forms required thereby. No application shall be considered until all required information and documentation is completed within the timeframes specified in the Credentials Manual.

The Credentials Committee shall then follow the credentialing procedures set forth in the Credentials Manual including the process related to the information required in an application for initial appointment and the processing of the application. Upon receipt and review of all necessary credentialing documentation, the Credentials Committee, upon recommendation of the Department Chair, shall recommend to the Clinical Staff Executive Committee that such Applicant should either be granted or denied initial privileges in the Transitional Care Hospital. The Clinical Staff Executive Committee shall then review the Credentials Committee’s recommendation and all applicable documentation. If the Credentials Committee and the Clinical Staff Executive Committee are both in favor of granting privileges to the Applicant, the favorable recommendation shall be forwarded to the MCOB for final action.

7.2 PROVISIONAL APPOINTMENT STATUS

Initial appointments and all initially granted Clinical Privileges for all Practitioners shall be provisional for a period of one year. During this provisional period, the individual’s performance and clinical competence at the Transitional Care Hospital shall be observed and evaluated through FPPE and OPPE by the Department Chair, Division Chair, or Peer designee of the applicable Clinical Department. If at the end of the year the Practitioner satisfies the requirements to become a Clinical Staff Member or have a privileging status as provided in the Credentials Manual, the provisional status ceases. If at the end of the year the Practitioner does not satisfy the requirements as specified in the Credentials Manual, then membership in the Clinical Staff and Clinical Privileges for that individual shall cease. Failure to achieve the appropriate status from provisional status, when due to a lack of clinical volume, shall not give rise to the procedural rights afforded by Article IX of these Bylaws. Failure to achieve the
appropriate status from provisional status, due to issues of competency or conduct, shall give rise to the procedural rights afforded by Article IX of these Bylaws.

All initial Clinical Staff appointees to the Active or Consultative Categories, all Non-Member appointees to the Visiting, Contract Physician or AHP categories, and all re-appointees to these categories after termination of a prior appointment, shall serve a provisional status period of no less than one (1) year. During this time proctoring must be satisfactorily completed unless a specific exception is applied for by the Department Chair and approved by the Credentials Committee as specified in Section 7.2.b below. Each Member in provisional status shall be assigned to a Department in which their performance at the Transitional Care Hospital shall be evaluated through proctoring to determine their eligibility for advancement to non-provisional status in the appropriate Clinical Staff category.

A. Responsibilities

A Practitioner in provisional status shall have all of the responsibilities of the membership category.

B. Proctoring

Each provisional appointee shall complete such proctoring (Focused Professional Practice Evaluation) as required by the Clinical Service and approved by the Credentials Committee in accordance with Transitional Care Hospital Policy No. 0279 (“Physician Professional Practice Evaluations” and Transitional Care Hospital Policy No. 280 “Allied Health Professionals Practice Evaluations”).

7.3 PROCEDURE FOR REAPPOINTMENT

Periodic redetermination of Clinical Privileges for Active and Consultative Clinical Staff Members, and the increase or curtailment of same, shall be based upon the reappointment procedures set forth in the Credentials Manual, including deadlines for submission of information and documentation and the forms required thereby. Criteria to be considered at the time of reappointment may include specific information derived from the Department’s direct observation of care provided at the Transitional Care Hospital, information gathered through FPPE and OPPE, review of records of patients treated in the Transitional Care Hospital, review of the records of the Departmental Clinical Staff as compared to the records of the particular Member and an appropriate comparison of the performance of the Member with his or her professional colleagues in the Department. If a Member chooses not to seek reappointment or renew privileges, the procedures set forth in Article IX shall not apply.

7.4 END OF PROVISIONAL STATUS

A Member in provisional status may become an Active or Consultative Member upon the satisfactory conclusion of provisional status as provided in these Bylaws and the Credentials Manual, which appointment shall be for no more than two (2) years at a time and as more specifically provided in the Credentials Manual.
7.5 CHANGES IN QUALIFICATION

If during the course of any period of appointment, the qualifications of the Member change, or the Department learns of Adverse Action taken by an official licensing or certification body or Medicare or Medicaid, then those changes in qualification or Adverse Action must be reported immediately to the Member's Department Chair and the Credentials Committee who will review the information and determine whether the Member's privileges should be revoked, revised, or suspended. The provisions of Section 8.6 or Article IX may apply.

7.6 NEW OR ADDITIONAL CLINICAL PRIVILEGES

Applications for new or additional Clinical Privileges must be in writing and submitted by the Applicant as well as by the appropriate Department Chair. All applications for new or additional Clinical Privileges shall be submitted on a form prescribed by the Credentials Committee upon which the type of Clinical Privileges desired and, among other things, the Member’s relevant recent training and/or experience are set out, together with any other information required by the Credentials Manual or the Credentials Committee. Such applications shall be processed as provided in the Credentials Manual, including the timeline for processing. Licensure and the National Practitioner Data Bank will be queried at any request for new privileges.

The Credentials Committee shall determine the conditions and requirements upon which any new or additional Clinical Privileges shall be granted, including but not limited to how current competence will be demonstrated and any proctoring or other monitoring requirements, and will recommend the requirements to the Clinical Staff Executive Committee for consideration. In turn, CSEC shall make appropriate recommendations regarding new or additional Clinical Privileges to the MCOB for final determination. A decision not to approve a new or additional Clinical Privilege to be performed within the Transitional Care Hospital and/or to be added to the Transitional Care Hospital privilege list shall not be deemed an Adverse Action or a denial of privileges nor entitle any individual to the hearing rights set forth in Article IX of these Bylaws. The Applicant’s performance and clinical competence shall be observed and evaluated through FPPE by the Department Chair, Division Chief or President of the Clinical Staff, and Peer designee of the applicable Clinical Department and documentation is completed within the timeframes specified in the Credentials Manual.

7.7 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment of membership and for Clinical Privileges, the Applicant shall have the burden of producing information for an adequate evaluation of the Applicant’s qualifications and suitability for the Clinical Privileges requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the Applicant’s expense, if deemed appropriate by the Department Chair, the President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Transitional Care Hospital or the Dean of the School of Medicine. The President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Transitional Care Hospital, or the Director of the Clinicians Wellness Program shall select the examining physician, program, and/or site of the examination.
The Applicant or Member has a duty to advise the Credentials Committee, within fifteen (15) days, of any change in information previously submitted by him or her related to his or her credentials. The Applicant’s failure to sustain these duties shall be grounds for denial of the application or termination of a Member’s Clinical Staff membership and a Member or Non-Member’s Clinical Privileges.

ARTICLE VIII
CORRECTIVE ACTION FOR MEMBERS AND NON-MEMBERS WITH CLINICAL PRIVILEGES

8.1 CRITERIA FOR INITIATION

A Member’s, Non-Member’s, or AHP’s Clinical Privileges may be reduced, suspended or revoked for activities or professional conduct considered to be lower than the standards of the Transitional Care Hospital and the Clinical Staff, or to be disruptive to operations of the Transitional Care Hospital, or for violation of these Bylaws, directives of the Clinical Staff Executive Committee or the MCOB, the Code of Conduct, or policies, procedures, rules or regulations of the Transitional Care Hospital or the applicable Clinical Service.

Any person may provide information to a Department Chair, the Clinical Staff Executive Committee, the Chief Executive Officer, the Dean, the Chief Medical Officer, the President, the Vice President, the MCOB or any member of the administration of the Transitional Care Hospital about the conduct, performance, or competence of any Member or Non-Member who has been granted Clinical Privileges.

A request for initiation of investigation or action against such Member or Non-Member shall be made by written request from any other Member, including the President, or from the Chief Executive Officer. Upon receipt of a written request for investigation or action, the individual or entity that received such request shall immediately forward the matter to the Credentials Committee for investigation when the information provided indicates that such Member or Non-Member may have exhibited acts, demeanor, or conduct reasonably likely to be: (a) detrimental to worker safety, patient safety or to the delivery of quality patient care; (b) unethical; (c) contrary to the Transitional Care Hospital’s policies and procedures, these Bylaws, or the Code of Conduct; (d) disruptive to the operation of the Transitional Care Hospital; (e) below applicable professional standards; or (f) the result of impairment of the Member or Non-Member by reason of illness, use of drugs, narcotics, alcohol, chemicals or other substances or as a result of any physical or mental condition that impairs the Member’s or Non-Member’s clinical practice; (g) loss of clinical privileges at another institution.

To the extent possible, the identity of the individual requesting initiation of investigation shall not be disclosed. In order to safeguard the privileged peer review status of a peer review investigation, the individual requesting an investigation is not be entitled to receive information about the course or findings of the investigation. The Chair of the Credentials Committee may inform the individual requesting an investigation about the status of the investigation (ongoing or concluded) and the expected date of completion.
8.2 ROUTINE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Clinical Staff leaders in addressing the conduct or performance of an individual shall not constitute formal corrective action, shall not afford the individual subject to such collegial efforts to the right to a fair hearing, and shall not require reporting to the National Practitioner Data Bank, except as otherwise provided in these Bylaws or required by law. Alternatives to formal corrective action may include:

A. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in these Bylaws or Transitional Care Hospital policies that may be taken to address disruptive conduct;

B. Written letters of guidance or warning regarding the concerns about conduct or performance;

C. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

D. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

E. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or

F. Requirements to seek assistance for impairment, as provided in these Bylaws.

8.3 INITIATING EVALUATION AND/OR INVESTIGATION OF POSSIBLE IMPAIRING CONDITIONS

At any time, a Department Chair, the President, the Chief Executive Officer, the Dean, the Chair of the Credentials Committee, or the Director of the Clinicians Wellness Program may require that a Member or Non-Member who has been granted Clinical Privileges undergo a physical and/or mental examination(s) by one or more qualified Practitioners or programs specified by the individual requiring the evaluation; see also Transitional Care Hospital Policy No. 242 (“Clinicians Wellness Program”). If the Member or Non-Member refuses to undergo the examination, his/her Clinical Privileges shall be automatically inactivated and there shall be no further consideration of continued privileges until the examination is performed. The Member or Non-Member shall authorize the qualified Practitioner(s) to submit reports of the evaluation(s), as appropriate, to the Chair of the Credentials Committee, the Department Chair, the President, the Chief Executive Officer, the Dean, and the Director of the Clinicians Wellness Program. Any time limit for action by the Credentials Committee, as specified in Section 8.4 below, shall be extended for the number of days from the request for the examination(s) to the receipt of the examination report(s).

The MCOB and the Clinical Staff Executive Committee recognize the need to assist Members or Non-Members who have been granted Clinical Privileges regarding their physical and mental health issues as well as to protect patients and staff members from harm. Any such Member or
Non-Member is encouraged to seek assistance from the Clinicians Wellness Program and/or the Faculty and Employee Assistance Program or any successor program thereto.

The Credentials Committee may also require periodic monitoring after completion of any evaluation treatment/or rehabilitation. If the Member or Non-Member does not complete the initial treatment/rehabilitation program or does not comply with the required monitoring, the provisions of Sections 8.4, or automatic inactivation under 8.5, shall be applicable. In addition, the Credentials Committee shall strictly adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

The purpose of the evaluation and investigation process concerning potential impairing conditions is to protect patients and others working with the affected practitioner and to aid the Member or Non-Member in retaining or regaining optimal professional functioning.

If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Member or Non-Member is unable to safely perform the Clinical Privileges he or she has been granted, the Credentials Committee shall proceed in accordance with Sections 8.4 or 8.5, as appropriate, below. Additionally, the Credentials Committee shall strictly adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

**8.4 INITIATING EVALUATION AND RECOMMENDATION FOR FORMAL CORRECTIVE ACTION**

**8.4.1 Investigation**

Upon receipt of the request for initiation of formal corrective action, the Credentials Committee shall conduct a thorough investigation of the Member or Non-Member who has been granted Clinical Privileges in question. The Member or Non-Member shall be notified in writing that an investigation is being conducted. In addition the applicable Department Chair, the Dean, and the Chief Executive Officer shall be notified of the investigation. The Member or Non-Member shall provide to the Credentials Committee all available information that it requests. Failure to provide such requested information will itself be considered grounds for corrective action.

The Credentials Committee may, but is not obligated to, review medical files or other documents and conduct interviews with witnesses; however, such investigation shall not constitute a “hearing” as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. The Credentials Committee may, in its sole discretion, request an interview with the Member or Non-Member under investigation and, during such interview, question the Member or Non-Member about matters under investigation. A record of such interview shall be made by the Credentials Committee.

Within forty (40) days of the receipt of the request for initiation of investigation, the Credentials Committee shall report to the Clinical Staff Executive Committee on the progress of the investigation and of the estimated time required to complete the investigation. In most instances, the investigation shall not last longer than ninety (90) days. However, for good cause, the Chair of the Credentials Committee may ask the Clinical Staff Executive Committee to extend the time for completion of the investigation. At the completion of the investigation, the Chair of the
Credentials Committee shall submit to the Clinical Staff Executive Committee the Credentials Committee’s findings and recommendations resulting from the investigation. The Clinical Staff Executive Committee may accept, reject or modify the findings and recommendations of the Credentials Committee and recommend to the MCOB approval of a final action. The Member and the Department Chair to which the Member is assigned shall be notified in writing of the recommendation of the Clinical Staff Executive Committee.

8.4.2 Recommendation

The Credentials Committee’s written recommendation to the Clinical Staff Executive Committee of action to be taken on the matter may include, without limitation:

A. Determining that no further action is necessary on the matter;
B. Issuing a warning, a letter of admonition, or a letter of reprimand;
C. Recommending terms of probation or requirements of consultation;
D. Recommending reduction, suspension or revocation of Clinical Privileges;
E. Recommending suspension or revocation of Clinical Staff category or AHP staff membership directly related to patient care;
F. Recommending concurrent monitoring or retrospective auditing;
G. Requiring additional training;
H. Requiring evaluation by a clinician assessment organization or individual; or
I. Requiring a Proctor for all procedures.

Any corrective action in accordance with subsections (c) through (f) of this Section shall entitle the Member to the procedural rights provided in Article IX of these Bylaws.

8.4.3 Cooperation with Investigation

All Members and Non-Members shall cooperate as necessary for the conduct of any investigation.

8.5 PRECAUTIONARY SUMMARY SUSPENSION

Whenever the conduct of a Member or a Non-Member who has been granted Clinical Privileges reasonably appears to pose a threat that requires that action be taken to protect the health, life or safety of patients or prospective patients, or any other person in or associated with the Transitional Care Hospital, or whenever the conduct of a Member or a Non-Member who has been granted Clinical Privileges reasonably appears to pose a substantial harm to the life, health and safety of any patient, prospective patient, or staff member then in any such event the President, the Chair of the Credentials Committee, the Department Chair, or the Chief Executive Officer may summarily restrict or suspend the Clinical Staff membership or Clinical Privileges of such Member or non-Member.

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Unless otherwise stated, such summary suspension shall become effective immediately upon imposition, and the person responsible shall promptly give written notice of the suspension or restriction to the Member or Non-Member in question and to the Department Chair and the Division Chief, if applicable, to which the Member is assigned, the Chief Executive Officer, and the Clinical Staff Executive Committee. The President of the Clinical Staff shall also be promptly notified. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not so limited, shall remain in effect until resolved by the procedures specified in Article IX with respect to Members and Non-Members who are Physicians and Dentists only.

An alternative fair hearing and appeal plan is available for Non-Members who are not Physicians or Dentists and for AHPs as noted in Section 9.5.1. Unless otherwise indicated by the terms of the summary restriction or suspension, the Clinical Department Chair or his/her designee shall assign the patients of the Member or Non-Member in question to another Member. Should the member or non-member who is subject to a precautionary summary suspension, upon being notified of the suspension, decide to voluntarily request inactivation of his/her privileges during the duration of the investigation required by 8.4.1, the precautionary summary suspension may be voided and withdrawn at the direction of the President of the Clinical Staff. A voluntary inactivation of privileges must be submitted in writing to the President within three business days of notification regarding precautionary summary restriction or suspension.

8.5.1 Procedure for Members

No later than 30 days after the date of the precautionary summary suspension and if the precautionary summary suspension still remains in effect, the Chair of the Clinical Staff Executive Committee shall designate a panel of its members to convene for review and consideration of the action; provided, however, that the Clinical Staff Executive Committee may extend the 30 day period for review for good cause if so requested by either the Member or the Chair of the Credentials Committee. Upon request and on such terms and conditions as the panel of the Clinical Staff Executive Committee may impose, the Member may attend and make a statement concerning the issues that led to the precautionary summary suspension, although in no event shall any meeting of the panel of the Clinical Staff Executive Committee, with or without the Member, constitute a “hearing” within the meaning of Article IX, nor shall any procedural rules apply except those adopted by the panel of the Clinical Staff Executive Committee. The panel of the Clinical Staff Executive Committee may recommend to the Clinical Staff Executive Committee that the summary restriction or suspension be modified, continued or terminated. The Clinical Staff Executive Committee shall consider this recommendation at its next scheduled meeting and shall furnish the Member with written notice of its decision.

Unless the Clinical Staff Executive Committee terminates the summary restriction or suspension within fourteen (14) working days of such restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article IX of these Bylaws.
8.5.2 Procedure for Non-Members

A Non-Member who’s Clinical Privileges are summarily suspended pursuant to Section 8.5 shall be notified in writing of the restriction or suspension and the grounds for the suspension. The Chair of the Credentials Committee shall refer the matter to the Credentials Committee at its next scheduled meeting. The Non-Member, who is not a Physician or a Dentist, shall not be entitled to the procedural rights afforded by Article IX of the Bylaws. An alternative fair hearing and appeal plan is available for Non-Members who are not Physicians or Dentists and for AHPs, as noted in Section 9.5.1.

8.6 AUTOMATIC ACTIONS

The Member’s or Non Member’s clinical privileges or Clinical Staff membership may be subject to automatic sanctions as follows:

8.6.1 Change in Licensure

8.6.1.1 Revocation, Suspension or Lapse

Whenever a Member’s or Non-Member’s license authorizing practice in the Commonwealth of Virginia is revoked, suspended by the applicable health regulatory board, or the Member’s or Non-Member’s license authorizing practice has lapsed, Clinical Privileges shall be automatically revoked or suspended as of the date such action becomes effective.

8.6.1.2 Probation and Other Restriction

If a Member’s or Non-Member’s license authorizing practice in the Commonwealth of Virginia is placed on probation by the applicable health regulatory board, his or her 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 duration.

Whenever a Member’s or Non-Member’s license authorizing practice in the Commonwealth of Virginia is limited or restricted by the applicable health regulatory board, any Clinical Privileges that the Member or Non-Member has been granted by the Transitional Care Hospital that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority’s action becomes effective and throughout its duration.

8.6.2 Change in DEA Certificate Status

8.6.2.1 Revocation, Suspension, or Lapse

If a Member’s or Non-Member’s DEA certificate is revoked, limited, suspended, or lapsed, the Member or Non-Member shall automatically be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.
8.6.2.2 Probation

If a Member’s or a Non-Member’s DEA certificate is subject to probation, the Member’s or Non-Member’s right to prescribe such medications automatically shall become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.6.3 Lack of Required Professional Liability Insurance

Failure to maintain professional liability insurance in amounts and of a type required by the MCOB, as such amounts shall be defined from time to time, shall be a basis for automatic suspension of a Member’s or a Non-Member’s Clinical Privileges. If within 30 days after written warnings of such delinquency, the Member or Non-Member does not provide evidence of the required professional liability insurance, and prior acts coverage for the uninsured period, such individual’s Clinical Privileges shall be automatically terminated.

8.6.4 Federal Program Exclusion

If a Member or a Non-Member is convicted of a crime pursuant to the Medicare and Medicaid Protection Act of 1987, Pub. L. 100-93, or a crime related to the provision of health care items or services for which one may be excluded under 42 U.S.C. Section 1320a7(a), or is suspended, excluded, debarred or otherwise declared ineligible to participate in Medicare or Medicaid or other federal or state health care or other programs, such Member’s or Non-Member’s Clinical Privileges shall be automatically suspended as of the date such conviction or action with respect to the Medicare or Medicaid federal program becomes effective.

8.6.5 Loss of Faculty Appointment or Termination of Employment

If a Member’s or non-Member’s faculty appointment in the School of Medicine, or his/her employment contract with UPG is terminated for any reason or for any length of time, his/her Clinical Privileges shall be automatically revoked or suspended as of the date such loss of faculty appointment or termination of UPG contract becomes effective. Loss of faculty appointment or termination of UPG contract shall not give rise to a hearing under Article IX, as such appointment is a prerequisite to being granted clinical privileges. Due process procedures applicable only to contesting the loss of a faculty appointment are set forth in the University of Virginia Faculty Handbook. In the case of AHP’s, if Transitional Care Hospital employment or UPG employment is terminated for any reason or any length of time, his/her Clinical Privileges within the Transitional Care Hospital shall automatically be revoked or suspended as of the date of such termination. Loss of privileges due to such termination shall not give rise to a hearing appeal under Section 9.5. Due process procedures applicable under these circumstances are specified by applicable Medical Center HR Policy or UPG contract.

8.6.6 Failure to Undergo Physical and/or Mental Examination

If a Member or Non-Member fails or refuses to undergo a physical and/or mental examination or fails to complete the evaluation, treatment, or rehabilitation program or does not comply with the required monitoring as required by Section 8.3 of these Bylaws, such failure or refusal shall
result in automatic suspension of the Clinical Privileges of the Member or Non-Member. Refusal to comply with health screening and/or infection control policies shall also result in automatic inactivation of Clinical Privileges.

8.6.7 Material Misrepresentation on Application/Re-Application

Whenever a Member or Non-Member has made a material misrepresentation on the application/re-application for Clinical Privileges, the application/re-application processing will stop (if still in progress) or membership and/or privileges will be automatically inactivated if they have already been granted prior to discovery of the material misrepresentation.

8.6.8 Failure to Comply with Medical Records Completion Requirements

Whenever a Practitioner has failed to comply with the medical records completion requirements per Transitional Care Policy No. 0094 (“Documentation of Patient Care {Electronic Medical Record}”), the Practitioner may have his/her membership and/or Clinical Privileges inactivated until he/she is compliant with those requirements.

8.6.9 Failure to Become Board Certified or Failure to Maintain Board Certification

The Clinical Privileges of a practitioner who fails to become board certified or to maintain board certification shall be inactivated, unless the practitioner has been granted an exception to these requirements by the Credentials Committee under the process outlined in Transitional Care Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”).

8.6.10 Conviction of a Serious Crime

Conviction of a serious crime as set out in Va. Code Section 37.2-314 shall result in automatic suspension of Clinical Privileges and inactivation of Clinical Staff membership.

8.6.11 Article IX Inapplicable

When a Member’s or Non-Member’s privileges are restricted pursuant to any of the circumstances set out in this Section 8.6, the hearing and appeal rights of Article IX shall not apply and the action shall be effective for the time specified. If the Member believes that any such automatic restriction of privileges is the result of an error, the Member may request a meeting with the Clinical Staff Executive Committee. A Non-Member shall have no right to a meeting with the Clinical Staff Executive Committee.

8.6.12 Clinical Privileges And Clinical Staff Membership Linkage

Except when explicitly stated otherwise in these Bylaws, the automatic inactivation of clinical privileges also results in automatic inactivation of Clinical Staff Membership.

Loss of clinical privileges at the UVA Medical Center shall automatically result in loss of clinical privileges at the UVA Transitional Care Hospital.
ARTICLE IX
HEARING AND APPELLATE REVIEW FOR MEMBERS

9.1 GENERAL PROVISIONS

The provisions of Article IX do not apply to those actions specified in Section 8.6 or to the informal actions specified in Section 8.2 of Article VIII.

Non-members who are not Physicians, Clinical Psychologists or Dentists shall be governed by the procedures set out in Section 9.5 below.

9.1.1 Right to Hearing and Appellate Review

A. When any Member, or a Non-member who is a Physician or Dentist, receives notice of a recommendation of the Clinical Staff Executive Committee that, if approved by the MCOB, will adversely affect his or her appointment to or status as a Member or his or her exercise of Clinical Privileges, he or she shall be entitled to a hearing before a hearing committee appointed by the Chair or Vice Chair of the Clinical Staff Executive Committee. If the recommendation of the Clinical Staff Executive Committee following such hearing is still adverse to the affected Member, he or she shall then be entitled to an appellate review by the MCOB or a committee appointed by the Chair of the MCOB, before the MCOB makes a final decision on the matter. Such review shall be made based on the evidentiary record, unless the MCOB or the committee appointed by the MCOB to hear the appeal requests additional information.

B. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in Article IX to assure that the affected Member is accorded all rights to which he or she is entitled.

9.1.2 Exhaustion of Remedies

If Adverse Action described in Section 9.2 is taken or recommended, the Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action. For purposes of Article IX, the term “Member” may include “Applicant”, as appropriate under the circumstances.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, the following recommended actions or actions shall be deemed Adverse Actions and constitute grounds for a hearing, if such action is based on professional conduct, professional competence, or character:

A. Denial of Clinical Staff Membership;

B. Denial of Clinical Staff reappointment (excluding failure to obtain active status following provisional status);
C. Suspension or Revocation of Clinical Staff Membership;

D. Denial of requested Clinical Privileges (excluding Temporary Privileges) for a Member;

E. Involuntary reduction of current Clinical Privileges for a Member;

F. Suspension of Clinical Staff Membership or Clinical Privileges for a Member if the duration of the suspension is for greater than 14 days and the reason for the suspension is one of competence or conduct; or

G. Suspension or Revocation of Clinical Privileges (excluding loss of faculty appointment) for a Member.

Actions described above in this Section that are the result of automatic relinquishment imposed pursuant to Section 8.6 of these Bylaws, shall not be considered an Adverse Action for purposes of Article IX.

9.3 REQUESTS FOR HEARING; WAIVER

9.3.1 Notice of Proposed Action

In all cases in which a recommendation has been made as set forth in Section 9.2, the Chair or Vice Chair of the Clinical Staff Executive Committee shall send a Member affected by an Adverse Action written notice of (a) his or her right to a hearing if requested by him or her within thirty (30) days of the member’s notice, (b) reasons for the Adverse Action recommended, including the acts or omissions that form the basis of recommendation and a list of the patients in question, if applicable, and (c) his or her rights at such a hearing, including the hearing procedures described in Section 9.4. Such notice shall be sent by hand delivery or certified mail, return receipt requested.

9.3.2 Request for Hearing

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chair of the Clinical Staff Executive Committee. The request shall contain a statement signed by the Member that the Member shall maintain confidentiality of all documents provided to the Member during the hearing process and shall not disclose or use the documents for any purpose outside the hearing process.

Unless the Member is under summary suspension, he or she shall retain existing rights and privileges until all steps provided for in Sections 9.4.1 through 9.4.8 of Article IX of these Bylaws below have concluded. If, however, the Member’s reappointment term is scheduled to expire during the hearing process, the Member’s membership and privileges shall expire unless (i) the Clinical Staff Executive Committee reappoints the practitioner until the hearing is concluded, or (ii) the Member is reappointed according to final action by the MCOB.

The Credentials Committee and the affected practitioner shall be parties to the hearing.
9.3.3 Waiver of Hearing

In the event the Member does not request a hearing within the time and manner described, the Member shall be deemed to have waived any right to a hearing and to have accepted the recommendation involved. The recommendation of the Clinical Staff Executive Committee shall then become final and effective as to the Member when it is approved by the MCOB.

9.3.4 Notice of Time, Place and Procedures for Hearing

Upon receipt of a request for hearing, the Chair or Vice Chair of the Clinical Staff Executive Committee shall schedule a hearing and give notice to the Member of the time, place and date of the hearing, which shall not be less than thirty (30) days after the date of the notice. Each party shall provide the other with a list of witnesses within fifteen (15) days of the hearing date, unless both parties agree otherwise. Witness lists shall be finalized no later than five (5) working days before the hearing. Notwithstanding the foregoing, the Hearing Entity shall have the right to call such witnesses as it deems appropriate and necessary.

Unless extended by the Chair of the Hearing Entity, described in Section 9.3.5 below, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made and provided further that the parties may agree to a mutually convenient date beyond the ninety (90) day period.

9.3.5 Hearing Entity

The Chair of the Clinical Staff Executive Committee may, in his or her discretion and in consultation with the Chair of the Credentials Committee, the Chief Executive Officer and other members of CSEC as he or she deems appropriate, direct that the hearing be held: (1) before a panel of no fewer than three (3) Members who are appointed by the Chair of the Clinical Staff Executive Committee and the Chief Executive Officer and if possible are Peers of the Member in clinical practice or academic rank and are not in direct economic competition with the Member involved, nor have been involved in the request for corrective action, any subsequent investigative process, or the decision to proceed with corrective action, or (2) by an independent Peer Review panel from outside the Transitional Care Hospital whose members are not in direct economic competition with the Member involved, or (3) a panel consisting of a combination of (1) and (2). Each type of panel described in the preceding sentence shall be referred to hereinafter as the “Hearing Entity.”

Knowledge of the matter involved shall not preclude a Clinical Staff Member from serving as a member of the Hearing Entity; however each member must certify at the time of appointment and also on the record at the hearing that any prior knowledge he or she may have does not preclude rendering a fair and impartial decision. The Chair of the Clinical Staff Executive Committee shall designate the chair of the Hearing Entity. At least three-quarters of the members of the Hearing Entity shall be present when the hearing takes place and no member may vote by proxy.
In the event of any conflict involving the Chair of the Clinical Staff Executive Committee, the Chief Executive Officer or designee shall be responsible for performing the duties described in this paragraph.

9.3.6 Failure to Attend and Proceed

Failure without good cause of the affected Member to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations involved and his or her request for a hearing shall be deemed to have been withdrawn.

9.3.7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Entity, or its chairperson, acting upon its behalf. Such decisions are solely within the discretion of the Hearing Entity or its presiding officer and may be granted only for good cause.

9.4 HEARING PROCEDURE

9.4.1 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency or character. If requested by either the affected Member or the Credentials Committee in accordance with Section 9.4.2, however, both sides may be represented by legal counsel. In lieu of legal counsel, the Member may be represented by another person of the Member’s choice.

9.4.2 The Hearing Officer

The President of the Clinical Staff may appoint a hearing officer to preside at the hearing. In the sole discretion of the President, the hearing officer may be an attorney qualified to preside over a quasi-judicial hearing. If requested by the Hearing Entity, the hearing officer may participate in the deliberations of the Hearing Entity and be an advisor to it, but the hearing officer shall not be entitled to vote.

9.4.3 The Presiding Officer

The Hearing Entity shall have a presiding officer. If the President of the Clinical Staff appoints a hearing officer pursuant to Section 9.4.2, then the hearing officer shall serve as the presiding officer. If no hearing officer is appointed, then the Chair of the Hearing Entity shall serve as the presiding officer. The presiding officer shall strive to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The presiding officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence. If the presiding officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances.
9.4.4 Record of the Hearing

An official reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the reporter shall be borne by the Transitional Care Hospital; the cost of the transcript, if any, shall be borne by the party requesting it.

9.4.5 Rights of the Parties

Within reasonable limitations imposed by the presiding officer, the Credentials Committee, the Hearing Entity and the affected Member may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues and otherwise rebut evidence. The Member may be called by the Credentials Committee or the Hearing Entity, as appropriate, and be examined as if under cross-examination.

A. Burden of Proof. The Credentials Committee shall appoint one of its members to represent it at the hearing, to present facts in support of its adverse recommendation and to examine witnesses. Where the issue concerns the denial of initial Clinical Staff membership, it shall be the obligation of the affected Practitioner to present appropriate evidence in support of his or her application, but the Credentials Committee representative shall then be responsible for showing that evidence exists to support the decision and that the Credentials Committee appropriately exercised its authority under these Bylaws and other applicable rules or regulations of the Transitional Care Hospital. In all other situations outlined in Section 9.2 above, it shall be the obligation of the Credentials Committee representative to present appropriate evidence in support of the adverse recommendation, but the affected Member shall then be responsible for supporting his or her challenge to the adverse recommendation by providing appropriate evidence showing that the grounds for the decision lacked support in fact or that such grounds or action based upon such grounds is either arbitrary or capricious.

B. Written Statement. Each party shall have the right to submit a written statement at the close of the hearing.

C. Written Decision. The affected Member shall be informed in writing by the Clinical Staff Executive Committee of the recommendation of the Hearing Entity, including a statement of the basis for the recommendation, and shall be informed in writing of the decisions of the Clinical Staff Executive Committee and the MCOB, including a statement of the basis for the decision.

9.4.6 Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under Article IX of these Bylaws. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Entity may question the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Entity may request both parties to file written arguments.
9.4.7 Recess and Conclusion

After consultation with the Hearing Entity, the presiding officer may recess the hearing and reconvene the same at such times and intervals as may be reasonable, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and documentary evidence and the receipt of any closing written arguments, the hearing shall be closed. The Hearing Entity shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Hearing Entity may seek legal counsel during its deliberations and the preparation of its report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

9.4.8 Decision of the Hearing Entity

Within fifteen (15) days after final adjournment of the hearing, the Hearing Entity shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Clinical Staff Executive Committee. If the affected Member is currently under summary suspension, the Hearing Entity shall render a decision and report to the Clinical Staff Executive Committee within five (5) working days after final adjournment. A copy of the decision shall also be forwarded to the MCOB and the affected Member. The report shall contain a concise statement of the reasons supporting the decision.

9.4.9 Decision of Clinical Staff Executive Committee and MCOB

At its next scheduled meeting, the Clinical Staff Executive Committee shall review the report and decision of the Hearing Entity and shall, within thirty (30) days of such meeting, give written notice of its recommendation to the MCOB and the Member. The Clinical Staff Executive Committee may affirm, modify or reverse the decision of the Hearing Entity.

9.4.10 Appeal

The Member may submit to the Chief Executive Officer a written appeal statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written appeal statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be delivered by hand or by certified or registered mail to the Chief Executive Officer and received no later than fourteen (14) days after the Member’s receipt of the recommendation of the Clinical Staff Executive Committee. The Chief Executive Officer shall provide a copy of the Member’s statement to the MCOB and the Chair of the Clinical Staff Executive Committee. In response to the statement submitted by the affected Member, the Clinical Staff Executive Committee may also submit a written statement to the MCOB and shall provide a copy of any such written statement to the Member.

9.4.11 Decision by the Operating Board

A. At a meeting following receipt of the Member’s written appeal statement (or after the expiration of the time in which the Member had the opportunity to submit a written statement) and the Clinical Staff Executive Committee’s written statement, the MCOB shall
reach a final decision, shall render a decision in writing, and shall forward copies thereof to each party involved in the hearing. The decision of the MCOB shall include a statement of the basis for its decision.

B. The MCOB may affirm, modify, or reverse the decision of the Clinical Staff Executive Committee. The MCOB may also refer the decision back to the Clinical Staff Executive Committee for reconsideration, or remand the matter to the hearing entity for further review. If the matter is remanded to the Hearing Entity for further review and recommendation, such Hearing Entity shall conduct its review within sixty days and make its recommendations to the MCOB. This further review and the time required to report back shall not exceed sixty (60) days, except as the parties may otherwise agree, for good cause, as jointly determined by the Chair of the MCOB and the Hearing Entity or the Chair of the Clinical Staff Executive Committee.

C. The decision of the MCOB as reflected in paragraphs a. or b. above shall constitute final action. This decision shall be immediately effective and shall not be subject to further hearing, or appellate review.

9.4.12 Right to One Hearing and One Appeal

No Member shall be entitled to more than one evidentiary hearing and one appeal on any matter that shall have been the subject of Adverse Action or recommendation.

9.5 HEARING AND APPEAL PLAN FOR NON-MEMBERS

9.5.1 Hearing Procedure

Allied Health Professionals and other Non-Members who are not Physicians or Dentists are not entitled to the hearing and appeals procedures set forth in the Clinical Staff Bylaws. In the event one of these Practitioners receives notice of a recommendation by the Clinical Staff Executive Committee that will adversely affect his/her exercise of Clinical Privileges, the Practitioner and his/her supervising physician, as applicable, shall have the right to meet personally with two Physicians and a Peer assigned by the President of the Clinical Staff to discuss the recommendation. The Practitioner and the supervising physician, as applicable, must request such a meeting in writing to the Clinical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the Practitioner and the supervising physician, as applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Clinical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected Practitioner, CSEC, and the MCOB.

9.5.2 Appeal

The Practitioner and the supervising physician, as applicable, may request an appeal in writing to the CEO within 10 days of receipt of the findings of the review body. Two members of the Clinical Staff assigned by the chair of the Clinical Staff shall hear the appeal from the Practitioner and the supervising physician as applicable. A representative from the Clinical Staff
leadership and from Transitional Care Hospital leadership may be present. The decision of the appeal body will be forwarded to the MCOB for final decision. The Practitioner and the supervising physician will be notified within 10 days of the final decision of the MCOB.

ARTICLE X
OFFICERS OF THE CLINICAL STAFF

10.1 IDENTIFICATION OF OFFICERS

The Officers of the Clinical staff shall be:

A. President
B. Vice President

10.2 QUALIFICATIONS OF OFFICERS

Officers must be Members of the Active Clinical Staff in good standing at the time of their election and must remain Members of the Active Clinical Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.3 NOMINATIONS

All nominations for Officers shall be made by the Nominating Committee (which is described in Article XIII of these Bylaws) with the concurrence of the Chief Executive Officer and the Dean. Any Active Clinical Staff Member may submit the name or names of any Member(s) of the Active Clinical Staff to the Nominating Committee for consideration as an Officer candidate. The Nominating Committee shall nominate one or more candidates for each office at least thirty (30) days prior to the election.

The Nominating Committee shall report its nominations for Officers to the Clinical Staff Executive Committee, with the approval of the Chief Executive Officer and the Dean, prior to the election and shall mail or deliver the nominations to the Clinical Staff at least ten (10) days prior to the election. Nominations for Officers shall not be accepted from the floor at the time of the election if voting occurs at a meeting.

10.4 ELECTIONS

The Officers shall be elected by electronic ballot. Only members of the Active Clinical Staff shall be eligible to vote. The nominee receiving the most votes shall be elected. In the case of a tie, a majority vote of the Clinical Staff Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.
10.5 TERMS OF OFFICE

The Officers shall take office on the first day of July following election to office. The Officers shall serve for terms of three (3) years, unless any one of them shall resign sooner or be removed from office. The Officers each shall be eligible for re-election for one additional three (3) year term.

10.6 VACANCIES IN OFFICE

If there is a vacancy in the office of the President, the Vice President shall serve during the vacancy. If there is a vacancy in the office of the Vice President, the Clinical Staff Executive Committee shall appoint an Active Member of the Clinical Staff to serve as Vice President until a special election to fill the position shall occur at a special meeting of the Clinical Staff, called for such purpose, or at a regular Clinical Staff meeting. The replacement Officer shall serve out the term of the original Officer.

10.7 REMOVING ELECTED OFFICERS

Elected Officers may be removed by a two-thirds (2/3) vote of the Members of the Active Staff, or by a majority vote of the MCOB.

Permissible bases for removal of an elected Officer of the Clinical Staff include, but are not limited to:

A. Failure to perform the duties of the position in a timely and appropriate manner;
B. Failure to satisfy continuously the qualifications for the position;
C. Having an automatic or summary suspension, or corrective action imposed that adversely affects the Officer's membership or privileges;
D. Failure to follow the Clinical Staff Bylaws, Credentials Manual, the Code of Conduct, the Compliance Code of Conduct, or Transitional Care Hospital policies, procedures, rules, or regulations; or
E. Conduct or statements inimical or damaging to the best interests of the Clinical Staff or the Transitional Care Hospital, including but not limited to violations of state or federal law or Transitional Care Hospital policy related to conflict of interest or relationships with vendors (see, for example, Transitional Care Hospital Policy No. 0013 “Interactions with Vendors, Sales and Service Representatives”).

10.8 DUTIES OF OFFICERS

10.8.1 Duties of the President

The President shall be the spokesperson for the Clinical Staff and shall:
A. Act in coordination and cooperation with the Chief Executive Officer and Transitional Care Hospital senior leadership in all matters of mutual concern within the Transitional Care Hospital;

B. Call, preside at, and be responsible for the agenda of all general meetings of the Clinical Staff;

C. Subject to the desire by the MCOB, serve on the MCOB as a nonvoting advisory member;

D. Serve as the Chair of the Clinical Staff Executive Committee and as ex-officio member of all other Clinical Staff committees;

E. Represent the views, policies, needs and grievances of the Clinical Staff to the MCOB, the Clinical Staff Executive Committee, and senior administration of the Transitional Care Hospital, including the presentation to the MCOB of a report of the Clinical Staff at every meeting of the MCOB or as otherwise requested by the MCOB;

F. Provide oversight of Clinical Staff affairs, including the Clinical Staff application process, committee performance, compliance with The Joint Commission and licensure requirements as they pertain to clinical practice and physician and patient concerns regarding clinical services;

G. Jointly with the Chief Executive Officer, appoint individuals to committees of the Clinical Staff, unless otherwise provided in these Bylaws; and

H. Perform such other functions as may be assigned to him or her by these Bylaws, the Clinical Staff Executive Committee or the MCOB.

10.8.2 Duties of the Vice President

The Vice President shall serve as the Chair of the Credentials Committee and the Vice-Chair of the Clinical Staff Executive Committee. In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall perform such other duties as the President may assign or as may be delegated by these Bylaws, the Clinical Staff Executive Committee, or the MCOB.

ARTICLE XI
CLINICAL STAFF EXECUTIVE COMMITTEE

11.1 DUTIES OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

Subject to the overall authority of the MCOB, the Clinical Staff Executive Committee shall be the executive committee of the Clinical Staff with the following duties to:

A. Monitor, oversee and, where appropriate, manage the quality of clinical care delivered within the Transitional Care Hospital;
B. Communicate to Members and Non-Members of the Clinical Staff regarding clinical practice issues and present the interests of the Clinical Staff to the MCOB;

C. Act for and on behalf of the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which CSEC is given authority in these Bylaws;

D. Establish, review, and enforce the policies applicable to the Clinical Staff, including the Bylaws, the Code of Conduct, and all other Transitional Care Hospital clinical policies regarding patient care;

E. Control and monitor the membership of the Clinical Staff through oversight of the appointment, credentialing, and privileging process;

F. Coordinate the activities and general clinical policies of the Transitional Care Hospital to support an institutional and integrated approach to patient care within the Transitional Care Hospital;

G. Oversee the functions of performance improvement of the professional services provided by the Clinical Staff within the Transitional Care Hospital;

H. Advise the Transitional Care Hospital management regarding the allocation and distribution of clinical resources, including assignments of beds and other elements important to efficient and effective medical care within the Transitional Care Hospital;

I. Provide Clinical Staff representation and participation in any Transitional Care Hospital deliberation affecting the discharge of Clinical Staff responsibilities;

J. Report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff and makes specific recommendations to the MCOB relating to the clinical efforts of the Transitional Care Hospital;

K. Approve the creation of and oversee committees of the Clinical Staff as necessary for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff;

L. Receive and act on reports and recommendations from the Clinical Staff committees and Departments;

M. Develop a procedure for managing such conflict as may arise between the Clinical Staff and the Clinical Staff Executive Committee on issues related to the adoption of or amendment to Clinical Policies of the Transitional Care Hospital;

N. Notify Members of the Clinical Staff of its adoption of or amendment to Clinical Staff policies of the Transitional Care Hospital, and

O. Perform such other duties as may be assigned to it by the MCOB.
11.2 MEMBERSHIP OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The membership of the Clinical Staff Executive Committee shall consist of the following individuals, all of whom shall be voting members:

- President of the Clinical Staff
- Medical Director for Transitional Care Hospital
- Associate Chief for Long Term Acute Care Operations
- Medical Directors, Transitional Care Hospital Programs
- Chair(s), Ethics Committee
- Chair(s), Patient Care Committee
- Chair(s), Quality and Patient Safety Committee
- Chair(s), Credentials Committee
- Chair(s), Bylaws Committee
- Director of Clinical Operations at the Transitional Care Hospital

The Chief Medical Officer, the Chief, and the Administrator for Quality/Risk/Compliance for the UVA Health System Post-Acute Care Division shall serve on the Clinical Staff Executive Committee as ex officio members, with voting privileges.

In addition, the Chief Medical Officer of the UVA Medical Center shall serve on the Clinical Staff Executive Committee as an ex officio member, without voting privileges.

In the event that any of the positions listed above are renamed, then the newly named position shall be substituted automatically in lieu of the old position without the necessity for an amendment of these Bylaws.

11.3 MEETINGS OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff Executive Committee shall meet at least (10) times per year at a time and place as designated by the Chair of the Clinical Staff Executive Committee, and the expectation is the each member of the Clinical Staff Executive Committee will attend these meetings. Fifty-one percent (51%) of the membership of the Clinical Staff Executive Committee shall constitute a quorum. Attendance at the Clinical Staff Executive Committee meetings is not assignable for voting purposes. A substitute who is not a deputy may attend a meeting for purposes of information sharing but may not vote by proxy and will not count in the quorum.

11.4 DUTIES OF THE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The President shall serve as the Chair of the Clinical Staff Executive Committee. The duties of the Chair are to:

A. Set the agenda for meetings of the Clinical Staff Executive Committee;

B. Preside at the meetings of the Clinical Staff Executive Committee;
C. Jointly with the Chief Executive Officer, coordinate and appoint committee members to all standing, special and multi-disciplinary committees of the Clinical Staff Executive Committee;

D. Report as appropriate to the Clinical Staff on the activities of the Clinical Staff Executive Committee;

E. In conjunction with the Chief Executive Officer, appoint individuals to serve on the Clinical Staff Committees described in Article XIII or otherwise created by the Clinical Staff Executive Committee; and

F. Report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff.

11.5 DUTIES OF THE VICE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Vice President shall serve as the Vice Chair of the Clinical Staff Executive Committee. The duties of the Vice Chair are to:

A. Preside at the meetings of the Clinical Staff Executive Committee in the absence of the Chair;

B. Present each Credentials Committee report to the Clinical Staff Executive Committee;

C. Assume all the duties and have the authority of the Chair in the event of the Chair’s temporary inability to perform his/her duties due to illness, absence from the community or unavailability for any other reason;

D. Assume all the duties and have the authority of the Chair in the event of his/her resignation as until such time as a successor is designated; and

E. Perform such other duties as may be assigned by the Chair.

11.6 DUTIES OF THE SECRETARY OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Chair of the Clinical Staff Executive Committee shall appoint a Secretary of the Clinical Staff Executive Committee. The Secretary is not required to be a Member. The duties of the Secretary are to:

A. Keep accurate and complete minutes of the meetings of the Clinical Staff Executive Committee;

B. Maintain a roster of the members of the Clinical Staff Executive Committee;

C. Send notices of meetings to the members of the Clinical Staff Executive Committee;
D. Attend to all correspondence of the Clinical Staff Executive Committee; and

E. Perform such other duties as ordinarily pertain to the office of secretary.

11.7 DELEGATING AND REMOVING AUTHORITY OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff may from time to time propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible, whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose, to approve such proposals as provided in this Section.

A. Any Member of the Active Clinical Staff may propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI, for which the Clinical Staff Executive Committee is responsible, by notifying the President of the Clinical Staff, in writing, of the proposal.

B. Upon receipt of the proposal, the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposal.

C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposal to all members of the Active Clinical Staff for review.

D. In accordance with the provisions of Article XIV of these Bylaws, if not less than fifteen percent (15%) of the Active Clinical Staff request a special meeting to consider any proposal to delegate additional duties to the Clinical Staff Executive Committee and/or to remove any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible, the President shall call a special meeting of the Clinical Staff. If not, any such proposal shall not proceed.

E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, any decision to add or remove any duties of the Clinical Staff Executive Committee shall require a majority vote in favor of the proposal by those Active Clinical Staff present at the special meeting.

F. Any such proposal to add or remove any of the duties of the Clinical Staff Executive Committee shall also require the approval of the Medical Center Operating Board.
ARTICLE XII
CLINICAL DEPARTMENTS

12.1. ORGANIZATION OF CLINICAL DEPARTMENTS

The Members of the Clinical Staff of the Transitional Care Hospital may have faculty appointments in the School of Medicine, and all Clinical Staff are required to have faculty appointments in the School of Medicine or an employment contract with UPG as a condition of appointment to the Clinical Staff. Exceptions to this requirement will be considered only when practitioners are requesting Temporary Privileges under emergency circumstances to meet patient care needs as provided in the Bylaws, or such other exceptional circumstances as may be approved by the Chief Executive Officer, the President of the Clinical Staff or the Chair of the Credentials Committee.

12.2 Transitional Care Hospital Medical Director

The Medical Director coordinates, directs and evaluates all aspects of patient care rendered by all practitioners who have been granted clinical privileges in the Transitional Care Hospital. In collaboration with other clinical departments and operational manager, the Medical Director oversees the care of patients being treated in assigned service area.

The Medical Director partners with the Transitional Care Hospital manager(s) to serve as co-leader of the Unit Based Clinical Leadership (UBL) team for their service area.

12.3 Duties of the Transitional Care Hospital and its Program Medical Directors
(e.g. Pulmonary, Nephrology, Plastics/Wound, Infectious Disease)

Medical director responsibilities include: regularly attending and leading UBL team and leadership meetings, participating in patient reviews to identify opportunities for improvement, and have peer to peer dialogues with colleagues as required by Transitional Care Hospital Policy No. 0262 (“Standards for Professional Behavior”), including the investigation and analysis of adverse events, clinical errors, and incidents, utilizing the institution’s Be Safe program and methods.

Departments and medical directors are expected to work together to accomplish the goals of the UVA TCH and the Health System.

ARTICLE XIII
CLINICAL STAFF STANDING COMMITTEES

13.1 STRUCTURE

The standing Committees of the Clinical Staff are as set forth in these Bylaws.
13.1.1 Reporting and Accountability to Clinical Staff Executive Committee

All Clinical Staff Committees report, and are accountable, to the Clinical Staff Executive Committee. The Chair of each Clinical Staff Committee shall maintain minutes of each meeting and shall report its activities to the Clinical Staff Executive Committee by submitting a written report on an annual basis, or as it is otherwise requested by the Chair or Vice Chair of the Clinical Staff Executive Committee, or as otherwise provided by these Bylaws.

13.1.2 Membership

The membership of the Clinical Staff Committees may consist of Members, Allied Health Professionals, Transitional Care Hospital administrative staff members, and other professional staff or employees of the Transitional Care Hospital appointed as provided in these Bylaws. The President and the Chief Executive Officer shall be ex-officio members of all Clinical Staff Committees unless otherwise provided in these Bylaws.

13.1.3 Appointments

Except as otherwise provided in these Bylaws, all chairpersons and members of the Clinical Staff Committees shall be appointed jointly by the President and the Chief Executive Officer. Appointments to Clinical Staff Committees shall be for an indefinite period, subject to the discretion of the President and the Chief Executive Officer or the resignation of the Clinical Staff Committee member. Each appointment shall be annually reviewed by the President of the Clinical Staff and the Chief Executive Officer.

13.1.4 Quorum, Voting and Meetings

A quorum for each Clinical Staff Executive Committee shall be thirty percent (30%) of the members currently serving, unless the decision involves privileging and/or corrective action of an individual Practitioner or governance, in which event the quorum shall be fifty-one percent (51%). All voting and decisions ordinarily shall occur in meetings of the Clinical Staff Committees, but decisions may be made by electronic means as may be reasonably necessary from time to time.

Except as otherwise provided in these Bylaws, all Clinical Staff Committees shall meet at least four (4) times per year, or as otherwise defined in these Bylaws, and as otherwise called by the chair of the Clinical Staff Committee.

13.1.5 Subcommittees

Each Standing Committee may, with the approval of the Clinical Staff Executive Committee, form Subcommittees or Task Forces as appropriate to carry out the charge of the Standing Committee. All such groups shall be considered Committees of the Clinical Staff.

The chair of each Subcommittee shall report its activities to the appropriate Clinical Staff Committee by submitting a written report on an annual basis and maintaining minutes with
attendance for each meeting. Subcommittees shall meet at least four (4) times per year and as otherwise called by the chair of the Subcommittee.

13.2 BYLAWS COMMITTEE

The Bylaws Committee shall ensure that the Bylaws of the Clinical Staff are consistent with the Transitional Care Hospital’s operational needs, current Joint Commission Standards, applicable CMS Conditions of Participation and other CMS requirements, and the policies, and procedures of the Transitional Care Hospital. In performing this function, the Bylaws Committee shall:

(a) review the Bylaws on at least on a biannual basis; (b) review proposed Bylaws amendments that may be proposed by Members of the Clinical Staff; (c) develop draft revisions and recommendations regarding proposed amendments to the Bylaws; (d) present proposed revisions to the Clinical Staff Executive Committee and the MCOB for review and approval; and (e) provide each Member a current copy of the Bylaws.

The Bylaws Committee shall meet as necessary, but not less than biannually. The President of the Clinical Staff shall serve as Chair of the Bylaws Committee. Only Members of the Clinical Staff serving on the Bylaws Committee shall be eligible to vote on Bylaws Committee matters.

The Bylaws Committee has the power to adopt revisions that are, in its judgment, non-substantial modifications for the purpose of clarifying, reorganizing or updating references, or to correct titles, punctuation, spelling or errors of grammar or expression.

13.3 CREDENTIALS COMMITTEE

The Credentials Committee shall review and evaluate the qualifications of each Applicant for initial appointment, reappointment, or modification of appointment, to the Clinical Staff, in accordance with the procedures outlined in the Credentials Manual and these Bylaws. The Credentials Committee shall recommend to the Clinical Staff Executive Committee and the MCOB appointment or denial of all Applicants to the Clinical Staff and the granting of Clinical Privileges.

When appropriate, the Credentials Committee shall interview a Member or Applicant and/or the Chair of the involved Department in order to resolve questions about appointment, reappointment, or change in privileges. The Credentials Committee shall review and make recommendations for revisions to the Credentials Manual from time to time; provided however, the Chair of the Credentials Committee, in consultation with the President and the Chief Executive Officer, shall have authority to amend the Credentials Manual.

The Credentials Committee shall also serve as the investigatory body for all matters set forth in Article VIII of these Bylaws. The Credentials Committee shall also independently assess the Departmental Peer Review process for Members of the Clinical Staff and for Allied Health Professionals in order to ensure that data related to qualifications and performance of individual Practitioners is collected, regularly assessed, compared to Peers, and acted upon by the Department in a timely manner. When appropriate, the Credentials Committee shall also refer Practitioners to the Physician Wellness Program or Employee Assistance Program, and shall work with these programs to determine appropriate privileges for each Practitioner’s individual
circumstances. The Vice President shall serve as chair of the Credentials Committee. Only Members of the Clinical Staff serving on the Credentials Committee shall be eligible to vote on Credentials Committee matters.

13.4 NOMINATING COMMITTEE

The Nominating Committee shall nominate Members to serve as Officers of the Clinical Staff. The Nominating Committee shall consist of (a) the immediate past president of the Clinical Staff, who shall serve as Chair of the Nominating Committee, and (b) two (2) Members of the Active Clinical Staff chosen by the President, subject to confirmation by the Chief Executive Officer.

13.5 ETHICS COMMITTEE

The Ethics Committee is an interdisciplinary committee charged with assisting leadership in ensuring consistency between mission and values, organizational behaviors and clinical practice. It has three primary functions which include conducting education on ethical issues, recommending policies that are ethically important and conducting case reviews with respect to ethical issues and shall meet as needed.

13.6 PATIENT CARE COMMITTEE

The Patient Care Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for the Transitional Care Hospital. This Committee addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (e.g., medicine, nutrition, nursing, pharmacy, therapies, social work, etc.) in all settings across the continuum of care. The Patient Care Committee shall meet quarterly, and as needed as determined by the Chair.

13.7 QUALITY AND PATIENT SAFETY COMMITTEE

The Quality and Patient Safety Committee is responsible for defining, prioritizing, overseeing and monitoring the performance improvement activities, including patient, team and environmental safety, within the Transitional Care Hospital. The primary duties of the Quality and Patient Safety Committee include analyzing and aggregating institutional performance data, monitoring performance improvement efforts for effectiveness, and making recommendations to the Patient Care Committee and the Clinical Staff Executive Committee for changes in clinical practice and to Transitional Care Hospital Executives for changes in operations.

The Quality and Patient Safety Committee coordinates the acquisition of performance improvement information to improve organizational performance. The Quality and Patient Safety Committee shall meet quarterly, and as needed as determined by the Chair.

13.8 OTHER COMMITTEES

The Chief Executive Officer and the President of the Clinical Staff may designate such other standing committees of the Clinical Staff Executive Committee as may be necessary from time to
time for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff. In such event, each such committee shall be subject to the provisions of Section 13.1. In addition, the Transitional Care Hospital may create, from time to time, any committees deemed necessary.

ARTICLE XIV
MEETINGS OF THE CLINICAL STAFF

14.1 REGULAR MEETINGS

Regular meetings of the Clinical Staff shall be held at a time mutually determined by the President of the Transitional Care Hospital Clinical Staff and the Chief Executive Officer. One week prior to the time of the meeting a written or printed notice shall be delivered either personally, by mail or by electronic mail to each Member stating the date, time and place of the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.

14.2 SPECIAL MEETINGS

The President or Vice President of the Clinical Staff, the Chief Executive Officer, the Clinical Staff Executive Committee, or the MCOB may call a special meeting of the Clinical Staff at any time. The President of the Clinical Staff shall call a special meeting within fourteen (14) days after receipt by him or her of a written request for same signed by not less than fifteen percent (15%) of the Active Clinical Staff and stating the purpose for such meeting.

At least twenty-four (24) hours prior to the meeting a written or printed notice stating the date, time and place of the special meeting of the Clinical Staff shall be delivered, either personally, by mail, or by electronic mail to each Member. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

14.3 QUORUM

Except as otherwise provided herein where a higher quorum is required, the presence of 25% of Members entitled to vote at any regular or special meeting shall constitute a quorum. No official business may be taken without a quorum except as otherwise provided herein.

14.4 ATTENDANCE REQUIREMENTS

Each Member of the Active Clinical Staff is encouraged to attend all regular Clinical Staff meetings in each year unless unusual circumstances prevent their attendance, as well as meetings of all committees to which they have been appointed as members. The Honorary Clinical Staff are encouraged to, but are not required to, attend.
14.5 ACTION BY ELECTRONIC MEANS

Unless otherwise required by these Bylaws, whenever these Bylaws require the vote of or action by the Clinical Staff or by the Clinical Staff Executive Committee, such vote or action may be taken by electronic means.

ARTICLE XV
CONFIDENTIALITY, IMMUNITY, AND RELEASES

15.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Transitional Care Hospital, an Applicant:

A. authorizes the Medical Center, the Transitional Care Hospital, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives, to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant’s professional ability and qualifications and any other matter within the scope of this Article;

B. authorizes all persons and organizations to provide information concerning such Applicant to the Medical Center, the Transitional Care Hospital, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives;

C. agrees to be bound by the provisions of this Article and to waive all legal claims against any third party, the Clinical Staff, the Medical Center, the Transitional Care Hospital, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives, for any matter within the scope of this Article; and

D. acknowledges that the provisions of this Article are express conditions to an application for Clinical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at the Transitional Care Hospital.

15.2 CONFIDENTIALITY OF INFORMATION; BREACH OF CONFIDENTIALITY

A. Clinical Staff, Department, Division, Committee, Clinical Staff Executive Committee, MCOB, MCOB Quality Subcommittee, Board of Visitors, or any other applicable minutes, files, and records within the scope of this Article shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where permitted by law, or pursuant to officially adopted policies of the Medical Center, the Transitional Care Hospital or Clinical Staff, or, where no officially adopted policy exists, only with the express approval of the Clinical Staff Executive Committee or its designee, or
to the appropriate University personnel and officers in connection with the discharge of their official duties.

B. Because effective Peer Review and consideration of the qualifications of Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Clinical Staff Departments, Divisions, or committees, is outside appropriate standards of conduct for this Clinical Staff and will be deemed disruptive to the operations of the Transitional Care Hospital. If it is determined that such a breach has occurred, the Clinical Staff Executive Committee may undertake such corrective action as it deems appropriate.

15.3 IMMUNITY

The Clinical Staff, the Medical Center, Transitional Care Hospital, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives and all third parties, shall be immune, to the fullest extent permitted by law, from liability to an Applicant or Member for damages or other relief for any matter within the scope of this Article.

For the purpose of this Article, “third parties” means both individuals and organizations from which information has been requested by the Medical Center, the Transitional Care Hospital, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, or the Board of Visitors, or any of their members or authorized representatives.

15.4 SCOPE OF ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization’s activities concerning, but not limited to:

A. the application for appointment to the Clinical Staff for the granting of Clinical privileges;

B. periodic reappraisals for reappointment to the Clinical Staff or renewals of Clinical Privileges;

C. corrective action, including summary or automatic revocation or suspension;

D. hearings and appeals;

E. medical care evaluations;

F. utilization reviews;

G. other Transitional Care Hospital, Department, or Division, committee, or Clinical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
H. FPPE, OPPE and other Peer Review activities and organizations Virginia Board of Medicine, the National Practitioner Data Bank pursuant to HCQIA, and similar reports; and

I. to the greatest extent permitted by law, all other actions taken in pursuit of activities provided for under these Bylaws.

The acts, communications, reports, recommendations, and disclosure referred to in this Section may relate to a Practitioner’s professional qualifications, clinical competency, character, mental and emotional stability, physical condition, ethics, malpractice claims and suits, and any other matter that might directly or indirectly have an effect on patient care.

15.5 RELEASES

Each Applicant or Member shall, upon request of the Clinical Staff, or the Medical Center, or the Transitional Care Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE XVI
AMENDMENT OF BYLAWS AND CLINICAL POLICIES

16.1 AMENDMENT OF BYLAWS

The Allied Health Professional Credentialing Manual is part of the Clinical Staff Bylaws and shall have the same option and amendment process as these Bylaws.

16.1.1 Annual Update

The Clinical Staff Bylaws shall be reviewed at least annually by the Bylaws Committee and updated as necessary.

16.1.2 Proposals to the MCOB

The Clinical Staff shall have the ability to adopt Bylaws, and amendments thereto, and to propose them directly to the MCOB as provided in these Bylaws.

16.1.3 Process for Amendment

A. Consideration shall be given to amendment of these Bylaws upon the request of the President, the Vice President, the Chief Executive Officer, the Clinical Staff Executive Committee, the MCOB, upon a written petition signed by at least twenty five percent (25) of the Active Clinical Staff entitled to vote, or upon recommendation by the Bylaws Committee.
B. All proposed amendments to the Bylaws shall be delivered to the Clinical Staff Executive Committee, which shall review and approve, disapprove, or offer modification, as appropriate.

C. In the event the Clinical Staff Executive Committee does not approve a request for amendment of the Bylaws that is requested by at least twenty-five percent (25%) of the Active Clinical Staff members, the Active Clinical Staff members seeking the amendment may ask the President of the Clinical Staff to present the request for amendment to the MCOB. The President of the Clinical Staff shall present the petition seeking amendment of the Bylaws to the MCOB at the next scheduled meeting of the MCOB. The MCOB shall review the petition and approve, disapprove, or modify the request for amendment of the Bylaws.

D. Any amendment(s) to the Bylaws adopted by the Clinical Staff Executive Committee shall be submitted to the Active Clinical Staff and the MCOB for review and approval, disapproval or modification, as appropriate.

E. A minimum of 25% of the Active Clinical Staff shall vote in favor or against any proposed amendments to the Bylaws. In order to approve amendments to the Bylaws, a majority of those members of the Active Clinical Staff who vote must vote in favor. Any vote regarding amendments to the Bylaws may be by electronic means.

16.1.4 Review and Action by the MCOB

Proposed Bylaws or amendments shall become effective when approved by the MCOB or on another date as mutually agreed to by the MCOB and Clinical Staff Executive Committee. In the event proposed Bylaws or amendments are not approved or are substantially changed upon MCOB review, such Bylaws or amendments shall be referred to the Bylaws Committee, which shall attempt to resolve the differences among the Clinical Staff or the Clinical Staff Executive Committee and the MCOB. The Clinical Staff, Clinical Staff Executive Committee, or the MCOB may not unilaterally amend these Bylaws.

16.2 PROPOSING, ADOPTING AND AMENDING CLINICAL POLICIES OF THE TRANSITIONAL CARE HOSPITAL

In addition to the policy and procedures set forth in Transitional Care Hospital Policy No. 0001 (“Transitional Care Hospital Policy on Policy, Development, Review and Approval”) regarding the adoption of or amendment to Transitional Care Hospital policies, the Clinical Staff may from time to time propose the adoption of or amendment to clinical policies of the Transitional Care Hospital whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose to approve such proposals as provided in this Section 16.2.

A. Any Member of the Clinical Staff may propose the adoption of a new Transitional Care Hospital clinical policy or the amendment of a current Transitional Care Hospital clinical policy by notifying the President of the Clinical Staff, in writing, of the proposed policy or policy amendment.
B. Upon receipt of the proposed policy or policy amendment, the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposed policy or policy amendment.

C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposed policy or policy amendment to all members of the Active Clinical Staff for review.

D. In accordance with the provisions of Article XIV of these Bylaws, if not less than twenty-five percent (25%) of the Active Clinical Staff request a special meeting to consider the policy or policy amendment, the President shall call a special meeting of the Clinical Staff. If not, the policy or policy amendment shall not proceed.

E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, and a majority of the Active Clinical Staff present at the special meeting approves the proposed policy or policy amendment, then the proposal shall be submitted to the Committee of the Clinical Staff (e.g., Credentials Committee, Quality Committee, Patient Care Committee, etc.) that is responsible for the clinical area to which the proposal relates in accordance with Transitional Care Hospital Policy No. 0001.

F. If the appropriate Clinical Staff Committee approves the proposed policy or policy amendment, it shall be forwarded to the Clinical Staff Executive Committee for proposed adoption in accordance with the provisions of Transitional Care Hospital Policy No. 0001.

16.3 DISTRIBUTION OF BYLAWS

Each Member shall be provided with on-line access to these Amended and Restated Clinical Staff Bylaws. If at any time amendments are made to the Bylaws, each Member shall be notified and provided with on-line access to such amendments.
AMENDED AND RESTATED

BYLAWS

OF THE CLINICAL STAFF

OF THE

UNIVERSITY OF VIRGINIA MEDICAL CENTER

September 19, 2002
REVISED September 1, 2005
REVISED October 2, 2008
REVISED February 5, 2009
REVISED September 14, 2010
REVISED September 15, 2011
REVISED May 21, 2012
REVISED September 17, 2015
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AMENDED AND RESTATED 
BYLAWS 
OF THE CLINICAL STAFF 
OF THE UNIVERSITY OF VIRGINIA MEDICAL CENTER

PREAMBLE

WHEREAS, the University of Virginia Medical Center is an integral part of the University of Virginia, which is a public corporation organized under the laws of the Commonwealth of Virginia and an agency of the Commonwealth; and

WHEREAS, the Medical Center is an academic medical center comprised of an acute care teaching hospital, a Children’s Hospital within that hospital, outpatient clinics, clinical outreach programs, and related health care facilities, as designated by the Operating Board of the University of Virginia Medical Center from time to time, which provide inpatient and outpatient medical and dental services, and health sciences education and related clinical research in conjunction with the University of Virginia School of Medicine and the University of Virginia School of Nursing; and

WHEREAS, the Operating Board of the University of Virginia Medical Center is the governing body for the Medical Center and has delegated to the Clinical Staff the responsibility for the provision of quality clinical care it provides throughout the Medical Center; and

WHEREAS, these Bylaws set forth the requirements for membership on the Clinical Staff, including a mechanism for reviewing the qualifications of Applicants for Clinical Privileges and a process for their continuing review and evaluation, and provide for the internal governance of the Clinical Staff;

NOW, THEREFORE, these Bylaws are adopted by the Clinical Staff and approved by the Operating Board to accomplish the aims, goals, and purposes set forth in these Bylaws.

MISSION, VISION AND VALUES OF THE UNIVERSITY OF VIRGINIA MEDICAL CENTER

Mission

To provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge.

Vision

In all that we do, we work to benefit human health and improve the quality of life. We will be:
• Our local community’s provider of choice for its healthcare needs
• A national leader in quality, patient safety, service and compassionate care
• The leading provider of technologically-advanced, ground-breaking care throughout Virginia
• Recognized for translating research discoveries into improvements in clinical care and patient outcomes
• Fostering innovative care delivery and teaching/training models that respond to the evolving health environment

Values

This institution exists to serve others, and does so through the expression of our core values:

Respect: To recognize the dignity of every person

Integrity: To be honest, fair and trustworthy

Stewardship: To manage resources responsibly

Excellence: To work at the highest level of performance, with a commitment to continuous improvement

UVA Health System Goals

• Become the safest place to receive care.
• Be the healthiest work environment.
• Provide exceptional clinical care.
• Generate biomedical discovery that betters the human condition.
• Train healthcare providers of the future to work in multi-disciplinary teams.
• Ensure value-driven and efficient stewardship of resources.
“Active Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.1 of these Bylaws.

“Active Clinical Staff – Provisional” means those Members of the Clinical Staff who are in their first year of appointment as an Active Member of the Clinical Staff as described in Section 4.4.1 of the Bylaws.

“Administrative Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.3 of these Bylaws.

“Adverse Action” means the reduction, restriction (including the requirement of prospective or concurrent consultation), suspension, revocation, or denial of Clinical Privileges of a Member that constitute grounds for a hearing as provided in Section 9.2 of these Bylaws. Adverse Action shall not include warnings, letters of admonition, letters of reprimand or recommendations or actions taken as a result of an individual’s failure to satisfy specified objective credentialing criteria that are applicable to all similarly situated individuals.

“Allied Health Professionals” means but are not limited to, Optometrists, Audiologists, Certified Substance Abuse Counselors, Licensed Professional Counselors, Licensed Clinical Social Workers, Nurse Practitioners, Physician Assistants, and Certified Registered Nurse Anesthetists.

“Allied Health Professionals Manual” means the Medical Center Allied Health Professionals Staff Credentialing Manual, as such may be in effect from time to time. The Allied Health Professionals Manual is incorporated by reference into these Bylaws.

“Applicant” means a person who is applying for appointment or reappointment of Clinical Staff membership and may also mean a person who is applying for Clinical Privileges to practice within the University of Virginia Medical Center, as the context requires.

“Associate Chief Medical Officers (ACMO)” means Active Members in good standing who are appointed by the CMO, in consultation with the Chief Executive Officer and who are responsible for assisting the Clinical Staff in performing their assigned functions, in coordinating such functions with the responsibilities and programs of the Medical Center including compliance with all relevant policies concerning the operations of the Medical Center, and the performance of other duties as outlined in these Bylaws may be necessary from time to time. Each ACMO is accountable to the CMO.

“Be Safe” means to advance the University of Virginia Medical Center’s status as the safest place to work and to receive care. The core belief is that patient and team member safety are preconditions to excellence in health care, and that collective system-wide focus on these areas will jointly improve outcomes and develop broad capacity to engage in organizational problem solving and continuous improvement. Based in Lean management principles, the Be Safe program emphasizes real-time root cause problem solving, the use of standard work as a basis for
improvement, and rapid escalation of safety issues within a tiered chain of leadership support.

“Board Certified” means that a Practitioner, if a Physician, is certified as a specialist by a specialty board organization, recognized as such by the American Board of Medical Specialties, or the American Osteopathic Association’s Council for Graduate Medical Education; if an Oral Surgeon, is specialty certified as such by the Virginia Board of Dentistry and the American Board of Maxillo-Facial Surgery; if a Podiatrist, is certified by the American Board of Podiatric Surgery; and if a Dentist, is certified by the American Board of Dentistry; and if a clinical pathologist, is certified by a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“Board Qualified” means a Practitioner has met the educational, post-graduate training and skill qualifications, and is currently eligible to sit, within a specified amount of time for a board certification examination of a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Dental Association or the American Podiatric Medical Association or a CLIA-approved certifying agency such as the American Board of Clinical Chemistry.

“Board of Visitors” means the governing body of the University of Virginia as appointed by the Governor of Virginia.

“Bylaws” means these Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Medical Center, as amended from time to time.

“Case Review” means a full review and analysis of an event related to a single patient’s experience in the Medical Center and may also mean a review of multiple patient cases involving a single procedure, as the context requires.

“Chief Executive Officer” or “CEO” means the individual appointed by the Board of Visitors or the Medical Center Operating Board, as applicable, to serve as its representative in the overall administration of the Medical Center.

“Chief Medical Officer” means an Active Member in good standing, appointed by the CEO who is responsible for assisting the Clinical Staff in performing its assigned functions, in coordinating such functions with the responsibilities and programs of the Medical Center including compliance with all relevant policies concerning the operations of the Medical Center, and the performance of other duties as may be necessary from time to time.

“Children’s Hospital” means a hospital within the Medical Center that is comprised of all inpatient and outpatient services, diagnostic services, clinical outreach programs and related healthcare services and staff that are specifically dedicated to providing healthcare to children in a patient and family centered care environment.

“Clinical Privileges” means the permission granted to a Member or Non-member to render specific diagnostic, therapeutic, medical, dental, or surgical services for patients of the Medical Center.

“Clinical Staff” or “Staff” means the formal organizations of all licensed Physicians, Dentists,
PhD Clinical Psychologists, PhD Clinical Pathologists and Podiatrists who may practice independently and who are granted recognition as Members under the terms of these Bylaws.

“Clinical Staff Executive Committee” or “Executive Committee” or “CSEC” means the executive committee of the Clinical Staff as more particularly described in Article XI of these Bylaws.

“Clinical Staff Office” means the administrative office of the Medical Center responsible for the administration of the Clinical Staff, including the process for membership and the granting of Clinical Privileges.

“Clinical Staff Representatives” mean those representatives selected by the Clinical Staff to serve on the Clinical Staff Executive Committee as provided in Article XI.

“Clinical Staff Year” means the fiscal year of the Medical Center; currently July 1 to June 30, as such fiscal year may be changed from time to time.

“CMS” means the Center for Medicare and Medicaid Services.

“Code of Conduct” means the Code of Conduct for the Clinical Staff that is described in Medical Center Policy No. 0291 (“Clinical Staff Code of Conduct”).

“Committees” means those Standing Committees of the Clinical Staff as described in Article XIII of these Bylaws.

“Community Medicine” means Community Medicine University of Virginia, LLC, a Virginia limited liability company.

“Complete Application” means an application for either initial appointment or reappointment to the Clinical Staff, or an application for clinical privileges that has been determined by the applicable Chair (or the Chair’s Deputy), the Credentials Committee, the Clinical Staff Executive Committee (CSEC), and the MCOB to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete, the application must be submitted on a form approved by CSEC, MCOB and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.

“Compliance Code of Conduct” means the Medical Center Compliance Code of Conduct that is described in Medical Center Policy No. 0235 (“Compliance Code of Conduct”).

“Credentialing” means the process of verifying the authenticity and adequacy of a Practitioner’s educational, training, and work history in order to determine whether the individual meets predefined criteria for membership and/or privileges.

“Credentials Manual” means the Clinical Staff and Resource Manual as such may be in effect from time to time. The Credentials Manual is an associate manual to these Bylaws.
“DEA” means the Federal Drug Enforcement Agency, or any successor agency.

“Dean” means the Dean of the School of Medicine of the University of Virginia.

“Dentist” means any individual who has received a degree in and is currently licensed to practice dentistry in the Commonwealth of Virginia.

“Department” means a clinical department within the Medical Center.

“Department Chair” or “Chair” means the Active Member appointed by the Dean of the School of Medicine who has the responsibility for overseeing his or her Department and who is the liaison between the Members in his or her Department and the Clinical Staff Executive Committee. “Department Chair” also shall mean the Medical Director of Regional Primary Care with respect to Regional Primary Care, the Chief Medical Officer with respect to Community Medicine, and the UPG Medical Director of Outreach programs for Outreach Physicians.

“Deputy” means the one active member of the Clinical Staff appointed by the Department Chair for one year for the sole purpose of attending meetings of CSEC when the Department Chair is unable to attend those meetings. Only one Deputy shall be appointed each year. The Deputy may attend CSEC meetings and vote in place of the Chair and will count in establishing the quorum.

“Disaster Privileges” means those Clinical Privileges granted during a declared disaster as more specifically provided in Section 6.10 of these Bylaws.

“Division” means a subdivision of a Department.

“Emergency Privileges” means those Clinical Privileges granted already existing Practitioners to provide emergency treatment outside the scope of their existing privileges in order to save the life, limb, or organ of a patient as provided in Section 6.9 of these Bylaws.

“Executive Vice President for Health Affairs (“EVPHA”) means an individual appointed by the Board of Visitors with operational, financial and strategic oversight of the Medical Center, School of Medicine, and Health Sciences Library.

“Fellow” means a Physician, Dentist or Ph.D. Clinical Psychologist in a program of graduate medical education that is beyond the requirements for eligibility for first board certification in the discipline.

“Focused Professional Practice Evaluation (“FPPE”) means a structured and time-limited evaluation of the competence of a practitioner to safely exercise a clinical privilege or set of privileges. FPPE is performed at the time of initial appointment to the clinical staff; upon the request of a new privilege, if the practitioner cannot provide prior documentation of competence to perform the requested procedure; or when a question arises regarding the ability of a currently privileged practitioner to competently and safely exercise the privileges he or she is currently granted. See Medical Center Policy No. 0279 (“Professional Practice Evaluations for Members of the Clinical Staff”), Medical Center Policy No. 0280 (“Allied Health Professionals Practice Evaluations”) and the Credentials Manual.
“GME Manual” means the University of Virginia Medical Center Graduate Medical Education Manual, as such may be in effect from time to time and that is found online at http://www.healthsystem.virginia.edu/alive/gme/doc/Manual_GradMedTrainee_Nov2007.pdf.

“Graduate Medical Trainee Staff” or “GME Trainee” means Residents and Fellows.

“HCQIA” means the Health Care Quality Improvement Act of 1986, 42 U.S.C. Sections 11101 - 11152, as such law may be amended from time to time.

“Hearing Entity” means the entity appointed by the Clinical Staff Executive Committee to conduct an evidentiary hearing upon the request of a Member who has been the subject of an Adverse Action that is grounds for a hearing in accordance with Article IX herein.

“Honorary Clinical Staff” mean those Members of the Clinical Staff who meet the criteria set forth in Section 4.4.4 of these Bylaws.

“Hospital-Based Specialty” means the clinical services of anesthesia, emergency medicine, pathology, radiology, and radiation oncology.

“In Good Standing” means a Member is currently serving without any limitation of prerogatives imposed by operation of the Bylaws or policies of the Medical Center.

“Investigation” means the process specifically authorized by these Bylaws in order to perform a final assessment of whether a recommended corrective action is warranted.

“Joint Commission” means the accrediting body whose standards are referred to in these Bylaws.

“Licensed Independent Practitioners or LIPs” means licensed independent practitioners who provide medical care to patients, in accordance with state licensing laws.

“Medical Center” or “UVAMC” means the University of Virginia academic medical center comprised of the acute care hospital, inpatient and outpatient clinics, clinical outreach programs, and related health care facilities as designated by the Medical Center Operating Board from time to time.

“Medical Center Operating Board” or “Operating Board” or “MCOB” means the governing body of the Medical Center as designated by the Board of Visitors.

“Medical Center Operating Board Quality Subcommittee” or “MCOB Quality Subcommittee” means a Committee of the MCOB with oversight of the quality and safety of care in the Medical Center and as designated by the MCOB from time to time.

“Medical Center Policy Manual” means the manual containing the administrative and various patient care policies of the Medical Center.

“Medical Director” means a clinical staff member in good standing who provides medical direction and leadership for a specific function at UVAMC. Responsibilities include
administrative and clinical duties. Medical Directors are appointed by the CMO, and report to the CMO through the appropriate ACMO.

“Member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist who is a member of the Clinical Staff of the University of Virginia Medical Center.

“National Practitioner Data Bank” or “NPDB” means the national clearinghouse established pursuant to HCQIA, as amended from time to time, for obtaining and reporting information with respect to adverse actions or malpractice claims against physicians or other Practitioners.

“Non-member” means any Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist, Ph.D. Clinical Pathologist or AHP who does not qualify as a Member of the Clinical Staff but who is required to have Clinical Privileges in order to provide patient care in the Medical Center.

“Officer” means an elected official of the Clinical Staff as more particularly described in Article X of these Bylaws.

“Ongoing Professional Practice Evaluation (“OPPE”)” means a process that allows identification of professional practice trends of practitioners who have been granted clinical privileges that impact on quality of care and patient safety on an ongoing basis and focuses on the individual member’s performance and competence related to his or her clinical staff privileges. See Medical Center Policy No. 0279 (“Professional Practice Evaluations for Members of the Clinical Staff”), Medical Center Policy No. 0280 (“Allied Health Professionals Practice Evaluations”) and the Credentials Manual.

“Peer” means a Practitioner or clinician whose interest and expertise as documented by clinical practice is reasonably determined to be comparable in scope and emphasis to that of another Practitioner or clinician.

“Peer Review” means a systematic review of a Practitioner’s or clinician’s clinical practice or professionalism, or a review of a portion of the clinical practice or professionalism, by a Peer or Peers of the individual Practitioner or clinician.

“Ph.D. Clinical Pathologist” means an individual who has been awarded a doctoral degree (e.g., Ph.D., or D.Sc.) in a scientific discipline and completed additional clinical training in an area of clinical pathology.

“Ph.D. Clinical Psychologist” means an individual who has been awarded a Ph.D. degree or equivalent terminal degree in Clinical Psychology and who holds a current license to practice clinical psychology issued by the Virginia Board of Psychology.

“Physician” means any individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and holds a current license to practice medicine in the Commonwealth of Virginia.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and who holds a current license to practice podiatry issued by the Virginia Board of Medicine.
“Practitioner” means a care provider privileged through the processes in these Bylaws.

“Prerogative” means the participatory rights granted, by virtue of staff category or otherwise, to a Clinical Staff Member, which is exercisable subject to, in accordance with, the conditions imposed by these Bylaws.

“President” means the most senior elected Officer of the Clinical Staff as described in Article X of these Bylaws.

“Privileging” means the process of granting the right to examine and treat patients after verification of the authenticity and adequacy of a Practitioner’s educational, training, and work history.

“Proctor” means an LIP in good standing at the University of Virginia Medical Center, who holds the privilege being monitored.

“Regional Primary Care” means the primary care satellite offices as designated by the Medical Center from time to time.

“Resident” means an individual who has been awarded an M.D., a D.D.S., or a Ph.D. in clinical psychology who is participating in a program of post-doctoral education in anticipation of fulfilling the requirements for first board certification.

“School of Medicine” means the medical school at the University of Virginia.

“Standing Committee of the Clinical Staff Executive Committee” means a duly-authorized Committee of the Clinical Staff reporting to the Clinical Staff Executive Committee.

“Temporary Privileges” means those Clinical Privileges granted for a period not to exceed 120 days as more specifically described in Section 6.8 of these Bylaws.

“University” or “University of Virginia” means the corporation known as The Rector and Visitors of the University of Virginia, which is an agency of the Commonwealth of Virginia.

“University Physicians Group (UPG)” means the physician group practice of the University of Virginia, representing doctors and other allied health professionals who provide care within the Medical Center.

“Vice President” means the Vice President of the Clinical Staff as described in Article X of these Bylaws.
ARTICLE II
GOVERNANCE OF THE MEDICAL CENTER

2.1 MEDICAL CENTER OPERATING BOARD

The Medical Center Operating Board is the governing body of the Medical Center. Each Member of the Clinical Staff assumes his or her responsibilities subject to the authority of the MCOB. The MCOB shall be constituted as directed by the Board of Visitors of the University from time to time.

2.2 CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff Executive Committee serves as the executive committee of the Clinical Staff and reports to the MCOB. In this role, the Clinical Staff Executive Committee oversees the quality of the clinical care delivered within the Medical Center and delineates and adopts clinical policy within the Medical Center. It is responsible for communications to Members of the Clinical Staff and other Non-members regarding clinical practice issues and it represents the interests of the Clinical Staff to the MCOB. The Clinical Staff Executive Committee is empowered to act for the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which it is given authority in these Bylaws. The Clinical Staff Executive Committee shall be constituted and have the other duties as described in Article XI hereof.

ARTICLE III
NAME AND PURPOSE

3.1 NAME

The name of the clinical staff organization shall be the “Clinical Staff” of the University of Virginia Medical Center (UVAMC). The organized Clinical Staff is accountable to the Medical Center Operating Board. For the purposes of these Bylaws, the words “Clinical Staff” shall be interpreted to include all Physicians, Dentists, Podiatrists, PhD Clinical Psychologists and PhD Clinical Pathologists who are authorized to provide care to patients of the UVAMC, including its outpatient facilities, and in any other medical care activity administered by UVAMC.

3.2 STATEMENT OF PURPOSE

The purposes of the Clinical Staff Bylaws are to:

1. Facilitate the provision of quality care to patients of the University of Virginia Medical Center and in any other medical care activity administered by the UVAMC without any form of discrimination.
2. Clarify roles and responsibilities of Clinical Staff Members and Officers of the UVAMC.
3. Promote professional standards among members of the Clinical Staff.
4. Provide a means whereby problems may be resolved by the Clinical Staff with the collaboration of the MCOB.
5. Create a system of self-governance, and to initiate and maintain, policies and procedures governing the conduct of Clinical Staff, subject to the ultimate authority of the MCOB.

3.3 THE PURPOSES OF THE ORGANIZED CLINICAL STAFF

The purposes of the organized Clinical Staff of the UVAMC are:

1. To provide quality medical care to all patients admitted or treated in any of the UVAMC facilities
2. To establish and maintain high professional and ethical standards
3. To establish and maintain collaborative, collegial relationships within the Clinical Staff and between all team members
4. To oversee the quality of professional services by all practitioners with clinical privileges
5. To provide a formalized organizational structure to facilitate the credentialing and review of the professional activities of practitioners and to make recommendations to the MCOB on appointment and/or clinical privileges granted to such individuals
6. To appropriately delineate, in conjunction with the MCOB, the clinical privileges each practitioner may exercise through the continued review and evaluation
7. To stimulate, promote and conduct research in human health, disease and delivery of medical care
8. To cooperate with the various academic units of the University, affiliated hospitals and other health facilities and maintain standards at predoctoral and postdoctoral levels
9. To initiate and maintain rules for governance of the Clinical staff and provide a means whereby issues and problems concerning the Clinical staff can be discussed and resolved
10. To initiate, develop, review, approve, implement and enforce these Bylaws and associated Clinical Staff polices
11. To provide a means for effective communication among the Clinical staff, administration and the MCOB on matters of mutual concern
12. To collaborate with Health System leadership to continuously enhance the quality, safety and efficiency of patient care, treatment and services as delegated to CSEC by the MCOB

ARTICLE IV

CLINICAL STAFF MEMBERSHIP AND CLASSIFICATION

4.1 MEMBERSHIP

Membership on the Clinical Staff shall be extended to Physicians, Dentists, Podiatrists, and PhD Clinical Psychologists and PhD Clinical Pathologists who continuously meet the requirements, qualifications, and responsibilities set forth in these Bylaws and who are appointed by the MCOB. Membership on the Clinical Staff or clinical privileges shall not be granted or denied on the basis of race, religion, color, age, gender, national origin, ancestry, economic status, marital status, veteran status, disability or sexual orientation, provided the individual is competent to render care of the generally-recognized professional level of quality established by the Clinical Staff Executive Committee and the MCOB, and provided the UVAMC services occur in the appropriate environment of care setting.
No Physician, Dentist, Podiatrist, PhD Clinical Psychologist, or PhD Clinical Pathologist shall admit or provide services to patients in UVAMC facilities unless he/she is a Member of the Clinical Staff or has been granted Temporary, Disaster, or Emergency privileges in accordance with the procedures set forth in these Bylaws.

GME Trainees who are in a UVAMC approved residency program shall not be eligible for membership on the Active Clinical Staff and shall be under the supervision of the GME Program Director and/or an attending Physician. A Department Chair may request privileges for GME Trainees to perform clinical work in a medical discipline for which they have had previous training. Such Applicants must meet the requirements, qualifications and responsibilities for such privileges and are subject to such policies and procedures as may be established by the Credentials Committee and the Clinical Staff Executive Committee. Graduate Medical Trainee appointments and job descriptions including job qualifications and current competencies are maintained by the Graduate Medical Education Office and by the Clinical Competency Committees of their respective academic departments.

4.2 EFFECT OF OTHER AFFILIATIONS

No Physician, Dentist, Podiatrist, PhD Clinical Psychologist or PhD Clinical Pathologist shall be automatically entitled to Clinical Staff membership, a particular Clinical Staff category or to exercise any particular clinical privilege merely because he/she hold a certain degree; is licensed to practice in Virginia or any other state; is a member of any professional organization; is certified by any clinical board; previously had membership or privileges at UVAMC; or had, or presently has, staff membership or privileges at another health care facility. Clinical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual’s participation or non-participation in a particular medical group, IPA, PPO, PHO, or Medical Center sponsored foundation.

4.3 REQUIREMENTS FOR CLINICAL STAFF MEMBERSHIP

4.3.1 NATURE OF CLINICAL STAFF MEMBERSHIP

Membership on the Clinical Staff is a an honor that shall be limited to professionally competent Practitioners who continuously meet the qualifications, requirements and responsibilities set forth in these Bylaws, in applicable Medical Center policies, including but not limited to Medical Center Policy No. 0291 (“Clinical Staff Code of Conduct”) and Medical Center Policy No. 0305 (“General Requirements for Clinicians Holding Clinical Privileges”), and the Credentials Manual. Membership implies active participation in Clinical Staff activities to an extent commensurate with the exercise of the Clinical Staff Member’s privileges and as may be required by the Clinical Staff Member’s Department.

4.3.2 BASIC QUALIFICATIONS OF CLINICAL STAFF MEMBERSHIP

In order to obtain or maintain membership on the Clinical Staff and in order to be granted privileges as a Member of the Clinical Staff, Applicants must have and document:
1. A faculty appointment in the School of Medicine or an employment contract with UPG;
2. A current, unrestricted license, if such license is required by Virginia law, to practice medicine and surgery, dentistry, clinical psychology PhD or clinical pathology PhD in the Commonwealth of Virginia;
3. Except for specific exemptions permitted under UVAMC Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”), a Practitioner who seeks to be or is a Member must be Board Certified for the specialty in which he or she expects to exercise clinical privileges within six (6) years of completion of training. A Member who seeks or holds clinical privileges must be Board Certified in accordance with the specific requirements of the specialty, and in compliance with specific Departmental criteria for Delineation of Privileges. If an Applicant does not meet the board certification requirements and the Applicant may qualify for an exemption specified in Medical Center Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”), the Department Chair must send a written request to the Credentials Committee requesting an exemption. Reappointment is contingent upon Board Certification or recertification as outlined in Medical Center Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”), which is incorporated herein by reference;
4. Eligibility to participate in Medicare, Medicaid and other federally sponsored health programs; and
5. Members shall have in force professional liability insurance satisfactory to the Medical Center which covers all privileges requested.

A Practitioner who does not meet these basic requirements is ineligible to apply for Clinical Staff membership, and the application shall not be accepted for review, except that Members of the Administrative and Honorary Staff do not need to comply with these basic qualifications. If it is determined during the processing that the Applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article IX.

4.3.3 GENERAL REQUIREMENTS OF CLINICAL STAFF MEMBERSHIP

In order to obtain or maintain membership on the Clinical Staff and in order to be granted clinical privileges as a member of the clinical staff, applicants must demonstrate:

A. Current competency. Applicants for staff privileges shall have the background, relevant training, experience and competency that are sufficient to demonstrate to the satisfaction of the Credentials Committee and the MCOB that he or she can capably and safely exercise clinical privileges within the Medical Center. Current competency shall be demonstrated as described in Medical Center Policy No. 0291 (“Clinical Staff Code of Conduct”) and Medical Center Policy No. 0305 (“General Requirements for Clinicians Holding Clinical Privileges“).

B. Compliance with Bylaws and Policies. Compliance with the Bylaws, Clinical Staff policies, Departmental and Service rules and regulations, as well as all enunciated policies of UVAMC.
C. **Appropriate Management of Medical Records.** Preparing in legible and accurate form, completing within prescribed timelines and maintaining the confidentiality of medical records for all patients to whom the Member provides care in UVAMC facilities in accordance with applicable policies of UVAMC and the University Physicians Group. This shall include, but is not limited to, performing histories and physicals and completing all necessary documentation as required by Medical Center Policy 0094 ("Documentation of Patient Care (Electronic Medical Record)") which is incorporated herein by reference.

A medical history and physical examination (H&P) shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Medical Center policy. (see Medical Center Policy No. 0094, “Documentation of Patient Care (Electronic Medical Record)”).

### 4.3.4 SUPERVISION OF GRADUATE MEDICAL TRAINEES

The Clinical Staff shall supervise participants in the Graduate Medical Education program in the performance of clinical activities within the Medical Center. The Clinical Staff member shall meet the requirements as contained in the GME Policy and Procedure 012, and applicable Medical Center and Departmental policies and as required by the ACGME and noted on the ACGME website.

### 4.3.5 OTHER MEMBER RESPONSIBILITIES

Additional responsibilities of Members may include, as appropriate:

A. Abiding by the Standards of Professional Conduct of the Virginia Boards of Medicine, Psychology and Dentistry, as appropriate, and ethical requirements of the Medical Society of Virginia, the American Board of Medical Specialties (as applicable), or the other professional associations of dentists, podiatrists, and psychologists, as appropriate;

B. Engaging in conduct that is professional, cooperative, respectful and courteous of others and is consistent with and reinforcing of the mission of the Medical Center; see Medical Center Policy 0291 (“Clinical Staff Code of Conduct”) and Medical Center Policy Medical Center Policy No. 0305 (“General Requirements for Clinicians Holding Clinical Privileges”).

C. Attending meetings of the Clinical Staff, Department, Division, as appropriate, and committees to which a Member has been appointed, as required; and

D. Participating in recognized functions of Clinical Staff appointment, including quality improvement activities, FPPE as necessary, OPPE, Case Review and Peer Review and discharging other Clinical Staff functions as may be required from time to time by the
Department Chair, the Division Chief, the Clinical Staff, the Clinical Staff Executive Committee, or the MCOB.

4.4 CATEGORIES OF THE CLINICAL STAFF

The categories of Clinical Staff membership shall be divided into the Active Staff, Associate Staff, Administrative Staff, and Honorary Staff. Non-members include Contract Physicians, Consulting and Visiting Clinical Staff, Telemedicine providers, Graduate Medical Trainees, Allied Health Professionals, and Visiting/Re-Entry Physicians. Each time Clinical Staff membership is granted or renewed, or at other times deemed appropriate, the Clinical Staff Executive Committee, and subsequently the MCOB, will approve the member’s staff category.

Each Clinical Staff Member shall be assigned to a Clinical Staff category based upon qualifications defined in these Bylaws. For the purposes of the below qualifications, patient contact includes admissions, treatments, consults, outpatient clinic visits, and outpatient surgery and procedures.

The Members of each Clinical Staff category shall have the prerogatives and shall carry out the duties defined in these Bylaws. Action may be initiated to change the Clinical Staff category or to terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described in these Bylaws. Changes in Clinical Staff category shall not be grounds for a hearing unless they adversely affect the Member’s privileges.

4.4.1 ACTIVE CLINICAL STAFF

A. Qualifications

The Active Clinical Staff are voting members and shall consist of Physicians, Dentists, Podiatrists, PhD Clinical Pathologists, and PhD Clinical Psychologists who hold a School of Medicine faculty appointment and:

1. Meet the criteria for Clinical Staff membership set forth in these Bylaws and specifically in Section 4.3; and
2. Regularly admit patients to the Medical Center or regularly practice in a hospital-based or a Medical Center recognized practice, or are regularly involved in the direct care of patients at a facility under the provider number of UVAMC and regularly participate in Clinical Staff functions as determined by Clinical Staff governance. See also Medical Center Policy 0304 (“ Responsibilities of Attending Physicians on Inpatient Services”)
3. Have satisfactorily completed their designated term in the Provisional status.

B. Prerogatives and Responsibilities

1. Exercise an option to vote on all matters presented at general and special meetings of the Clinical Staff;
2. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual; and
3. Exercise an option to be considered for office in the Clinical Staff organization.
C. Transfer of Active Staff Members

After two (2) consecutive years in which a Member of the Active Clinical Staff does not regularly care for patients at UVAMC and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the member is qualified.

4.4.2 ASSOCIATE CLINICAL STAFF

A. Qualifications

The Associate Staff, a non-voting member, shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists, and Ph.D. Clinical Pathologists, who hold an employment contract with UPG but who do not hold a School of Medicine faculty appointment. Associate Staff Members:

1. Meet the criteria for Staff membership set forth in these Bylaws and specifically in Section 4.3
2. Are regularly involved in the care of patients at a facility that is under the provider number of UVAMC and who need to be privileged and re-privileged through UVAMC; and
3. Do not admit or treat patients at the Acute Care Hospital facilities of the Medical Center, including the outpatient surgery center; and
4. Have satisfactorily completed their designated term in the Provisional status.

B. Prerogative and Responsibilities

1. Exercise an option to practice the clinical privileges as granted in accordance with these Bylaws and the Credentials Manual pursuant to Article VI at a facility that is under the provider number of UVAMC; and
2. Actively participate in performance improvement and quality assurance activities, supervising provisional appointees, evaluating and monitoring Clinical Staff Members, and in discharging such other Staff functions as may from time to time be required.

C. Limitations

1. Shall not have the right to vote at general and special meetings of the Clinical Staff, except to the extent the right to vote is specified at the time of appointment; and
2. Cannot hold office in the Clinical Staff organization.

D. Transfer of Associate Clinical Staff Members

After two (2) consecutive years in which a Member of the Associate Clinical Staff does not regularly care for patients at UVAMC and/or be regularly involved in Clinical Staff functions as determined by the Clinical Staff, that Member may be transferred to the appropriate category, if any, for which the member is qualified.
**4.4.3 ADMINISTRATIVE STAFF**

A. Qualifications

The Administrative Staff category shall be held by any Physician, Dentist, Podiatrist, PhD Clinical Psychologist or PhD Clinical Pathologist who is not otherwise eligible for another staff category and who is to perform ongoing medical administrative activities.

1. Are charged with assisting the Clinical Staff in carrying out medical-administrative functions, including but not limited to quality assessments of clinical programs and utilization reviews;
2. Are able to document their good judgment, current physical and mental health status so as to demonstrate to the satisfaction of the Clinical Staff that they are professionally and ethically competent to exercise their duties, and is able to work cooperatively with the Clinical Staff office; and
3. Are willing to participate and properly discharge those responsibilities as determined by the VP and CEO and the Dean.

B. Responsibilities

1. Defined by the VP and CEO and the Dean; and
2. Exercise an option to attend and vote at general and special meetings of the Clinical Staff.

C. Limitations

1. Cannot hold office in the Clinical Staff organization; and
2. Cannot admit patients or exercise clinical privileges.

**4.4.4 HONORARY CLINICAL STAFF**

A. Qualifications

The Honorary Clinical Staff shall consist of Physicians, Dentists, Podiatrists, PhD Clinical Psychologists and PhD Clinical Pathologists, each of whom is a former Member of the Clinical Staff who has retired or withdrawn from practice and who are honored by an emeritus title in the School of Medicine, and/or have been nominated by the current Department Chair in which the person practiced or by Dean in recognition of his or her noteworthy contributions to the UVAMC.

B. Was a member in good standing of the Clinical Staff at the time of his or her retirement or withdrawal from clinical practice

C. Responsibilities

1. Exercise an option to attend general and special meetings of the Clinical Staff;
2. Exercise an option to vote on Clinical Staff Committees that he/she has been requested to serve on.
D. Limitations

1. Shall not be granted or exercise clinical privileges;
2. Shall not vote at general or special meetings of the Clinical staff;
3. Shall not hold office in the Clinical Staff organization.

4.5 NON-MEMBERS WITH PRIVILEGES

Other healthcare professionals not described above may not be Members of the Clinical Staff. Non-members are Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists or Ph.D. Clinical Pathologists who are not Members of Clinical Staff but who are granted privileges to provide care to patients of the Medical Center from time to time as provided in these Bylaws and in the Credentials Manual. Non-members shall have Clinical Privileges as provided in Article VI and the Credentials Manual. Allied Health Professionals are also Non-members who are granted privileges. Non-members, who are not Physicians or Dentists, shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Articles IX hereof, but shall be required to follow policies and procedures of the Medical Center and the Clinical Departments.

4.5.1 CONSULTING AND VISITING STAFF

Consulting and Visiting Staff do not hold faculty appointments, nor are contracted with UVAMC or UPG, but are granted privileges to provide services that are not otherwise available at UVAMC or to assist in difficult cases.

A. Qualifications

The Consulting and Visiting Staff shall consist of Physicians, Dentists, Podiatrists, and PhD Clinical Psychologists who:

1. Meet the criteria for Staff membership set forth in these Bylaws excluding the faculty appointment or UPG contract and Meet the criteria for Staff membership set forth in Section 4.3;
2. Hold appropriate clinical privileges at another accredited health care facility; and
3. Have a maximum of ten (10) patient contacts per year at the Medical Center.

B. Responsibilities

1. Exercise an option to provide clinical care at UVAMC within the privileges as are granted to him/her pursuant to Article VI;
2. Provide patient activity and quality review information from primary facility as requested at time of reappointment; and
3. Satisfy the requirements of the Clinical Department of which he/she is associated.
4. Actively participate in performance improvement and quality assurance activities, supervising provisional appointees, evaluating and monitoring as may from time to time be required.
C. Limitations

1. Shall not vote at general or special meetings of the Clinical staff; and
2. Shall not hold office in the Clinical Staff organization.
3. Shall not attend meetings of the Clinical Staff.

D. Transfer of Consulting and Visiting Staff

Consulting and Visiting Staff members who regularly care for more than ten (10) patients per year at the Medical Center will be reviewed by the Credentials Committee to consider appointment to another staff category.

4.5.2 CONTRACT PHYSICIAN STAFF

The Contract Physician Staff shall consist of GME Trainees at UVAMC who are engaged by the Medical Center to provide explicit medical services outside their training program at a UVAMC facility. A contract physician must obtain prior approval for the outside activities in accordance with the GME Internal and External Moonlighting Activity Policy and provide a copy of the contract under which he or she will be working at the time the credentialing process begins. Members of the Contract Physician Staff must be board certified or board qualified in the specialty related to the privilege request, and has attestations of qualifications from both the Program Director and the Department Chair. Contract Physician Staff are not eligible to vote on Clinical Staff matters or to hold Clinical Staff Office.

In addition, Contract Physician Staff:

1. May not serve as the attending physician of record or admit patients to the Medical Center unless an exemption is granted. Exemptions are considered at the request of the Designated Institutional Officer with explicit conditions regarding concurrent proctoring and agreed to by the Credentials Committee;
2. Can treat patients if authorized to do so in accordance with the Practitioner’s delineated clinical privileges and Article VI of these Bylaws;
3. Appointment procedures for Contract Physician Staff will be the same as the procedures for the Clinical Staff in accordance with Article VII of these Bylaws;
4. Shall actively participate in performance improvement and quality assurance activities of the Clinical Staff;
5. Shall meet the basic responsibilities of Staff membership as set forth in these Bylaws; and
6. The Contract Physician Staff Practitioner’s privileges will automatically terminate upon the termination or expiration of his/her contract or agreement with the UVAMC or UPG, and the Practitioner shall have none of the rights conferred on Members in these Bylaws, including but not limited to those provided in Article IX.

4.5.3 TELEMEDICINE

Telemedicine providers are privileged as set forth in Article VI. Telemedicine providers access patients remotely and do not practice within the UVAMC facilities. Telemedicine providers are not eligible to vote on Clinical Staff matters or hold Clinical Staff Office.
4.5.4 GRADUATE MEDICAL TRAINEES

Except as provided in Section 4.5.2 above, members of the Graduate Medical Trainee staff as defined in these Bylaws do not have independent privileges to admit or treat patients at the UVAMC. They are employees of the University of Virginia Medical Center and their scope of practice is defined by the Graduate Medical Education Program. They are not governed by these Bylaws. Graduate Medical Trainees shall be required to follow GME policies and procedures and will act only under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff, UVAMC, and GME policies.

GME Trainees, who are working in an independent practice capacity as Contract physicians in the organization, must be granted privileges as set forth in Article VI of these Bylaws.

4.5.5 ALLIED HEALTH PROFESSIONALS

AHPs are individuals that hold a license, certificate, or other legal credential to practice as required by Virginia law that authorizes the provision of complex and clinical services to patients. AHPs treat and/or perform services on patients at a facility that is under the provider number of UVAMC. AHPs adhere to Clinical Staff Bylaws which are applicable to the AHP, Department policies, Medical Center policies and professional guidelines. (See, e.g., Medical Center Policy No. 280 “Allied Health Professionals Practice Evaluations”) AHPs are not Members of the Clinical Staff but are granted clinical privileges. AHPs may vote for the AHP representative to CSEC, and serve as voting members on Clinical Staff Committees. Only AHP’s are eligible to serve as the AHP representative to CSEC.

4.5.6 VISITING/RE-ENTRY PHYSICIAN STATUS

A Non-member of the Clinical Staff may apply for re-entry status to learn a specific defined patient care technique under the direction of one of the Departments at UVAMC. Individuals applying for visiting postgraduate trainee status shall be licensed to practice medicine, dentistry or clinical psychology in any one of the United States and shall have been accepted by the course director to participate in a specific clinical training program at UVAMC. These Bylaws and other applicable UVAMC policies and procedures shall govern the activities and conduct of Visiting Postgraduate Trainees.

A. Limitations

1. Shall not perform any independent patient care or evaluation at UVAMC facilities;
2. Shall not take call; and
3. Shall not use the UVAMC Visiting/Re-Entry Trainee status as the basis for independent practice at any other site.

4.6 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request from a Member, the Clinical Staff Executive Committee may recommend a change in the Clinical Staff category of a Member, consistent with the requirements of these Bylaws, to the MCOB.
4.7 MEMBER RIGHTS

Clinical Staff Member Rights

1. Each Member in the Active category has the right to initiate a recall election of a Clinical Staff Officer by following the procedure outlined in Article X of these Bylaws, regarding removal and resignation from office.

2. Each Member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Clinical Staff by presenting a petition signed by ten percent (10%) of the Members of the Active category. Upon presentation of such a petition, CSEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

3. Each Member in the Active category may challenge any rule, regulation or policy established by the CSEC. In the event that a rule, regulation or policy is thought to be inappropriate, any Clinical Staff Member may submit a petition signed by ten percent (10%) of the Members of the Active category. Upon presentation of such a petition, the adoption procedure noted in section Article XVI will be followed.

4. The above sections 1 to 3 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. The Bylaws provide recourse in these matters.

5. Any Practitioner eligible for Clinical Staff membership has a right to a hearing/appeal pursuant to the conditions and procedures described in the Clinical Staff’s hearing and appeal plan.

6. These member rights serve as a conflict resolution mechanism between the Clinical Staff and the Clinical Staff Executive Committee.

ARTICLE V
PROCEDURES FOR MEMBERSHIP

The process for evaluation of credentials for membership and/or privileges is the same for all Members and Non-members. The Credentials Committee shall follow the credentialing procedures set forth in the Credentials Manual including the procedure related to the information required in an application for initial appointment and the processing of the application. Upon receipt and review of all necessary credentialing documentation, the Credentials Committee, upon review by the Department Chair, shall recommend to the Clinical Staff Executive Committee that such Applicant should either be granted or denied initial privileges in the Medical Center. The Clinical Staff Executive Committee shall then review the Credentials Committee’s recommendation and all applicable documentation. If the Credentials Committee and the Clinical Staff Executive Committee are both in favor of granting privileges to the Applicant, the favorable recommendation shall be forwarded to the MCOB for final action.

If there is a recommendation for the denial of membership and/or privileges by the CSEC or MCOB, the applicant is entitled to the fair hearing and appeal plan appropriate to their clinical status.
5.1 PROCEDURE FOR ACTIVE AND ASSOCIATE CLINICAL STAFF MEMBERSHIP

In order to become an Active or Associate Member of the Clinical Staff, the individual Physician, Dentist, Podiatrist, Ph.D. Clinical Psychologist or Ph.D. Clinical Pathologist shall follow the applicable procedure in effect from time to time for obtaining an appointment as a Clinical Faculty Member in the School of Medicine, an employment contract with UPG, satisfy the criteria set forth in Article IV of these Bylaws for an Active or Associate Member and if applicable, follow the procedure for obtaining Clinical Privileges as provided in these Bylaws and the Credentials Manual, all as verified by the Clinical Staff Office. The Dean and the applicable Department Chair shall jointly make the request in writing to the Clinical Staff Office for an individual to be appointed or reappointed as a Member in accordance with Article VII of these Bylaws. In the case of individuals who do not hold School of Medicine faculty appointments, the Chief Executive Officer of UPG will fill the role of the Dean for the procedures described above.

The Credentials Manual establishes requirements for application for Clinical Staff Clinical Privileges. The Credentials Manual may be amended from time to time by the Chair of the Credentials Committee in consultation with the President of the Clinical Staff and the Chief Executive Officer of the Medical Center.

5.2 PROCEDURE FOR ADMINISTRATIVE CLINICAL STAFF MEMBERSHIP

The Clinical Staff Executive Committee shall approve the appointment of any person selected by the Chief Executive Officer or the Dean to be an Administrative Member.

5.3 PROCEDURE FOR HONORARY CLINICAL STAFF MEMBERSHIP

In order to become an Honorary Member of the Clinical Staff, the individual who satisfies the criteria set forth in Article IV of these Bylaws shall be nominated by his or her former Chair or the Dean and approved by the Clinical Staff Executive Committee.

5.4 LEAVE OF ABSENCE

A Member of the Clinical Staff who has obtained a leave of absence from the School of Medicine, consistent with applicable faculty policies, may also obtain a leave of absence from clinical practice. Contemporaneously with a request for leave of absence from the School of Medicine or UPG, the Member shall provide notice to the Credentials Committee of the leave, including the reasons for the leave and the approximate period of leave desired. In addition the Chair and the Dean of the School of Medicine or Chief Executive Officer of UPG (for Associate Members) shall provide notice to the Credentials Committee of any leave of absence granted to a Member. Such leave of absence is further subject to conditions and limitations that the President of the Clinical Staff, the Chair of the Credentials Committee or the CEO of the Medical Center determines to be appropriate. During the leave of absence, the Member shall not exercise his/her Clinical Privileges and his/her Clinical Staff responsibilities and prerogatives shall be inactive. The Department Chair of the Member on leave shall be responsible for arranging for alternative care for the Member’s patients while the Member is on
Prior to returning from a leave of absence, a Member shall notify the Credentials Committee in writing in accordance with the procedures and the timelines set forth in the Credentials Manual and shall provide all necessary information needed for the Credentials Committee to evaluate whether the Member is qualified to resume Clinical Staff membership, including the exercise of Clinical Privileges. A Member who has been on leave of absence may not have his or her Clinical Privileges reactivated until a determination is made by the Credentials Committee that the Member may return to clinical practice and the conditions of the return. If the Clinical Privileges of a Member who has been on leave are not reactivated, the Member shall have access to the procedures outlined in Article IX of these Bylaws.

Failure, without good cause, to request reinstatement prior to the end of an approved leave of absence shall be deemed a voluntary resignation from the Clinical Staff and voluntary relinquishment of Clinical Privileges. A request for Clinical Staff membership or Clinical Privileges subsequently received from an Applicant deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

If membership and/or privileges expire during the leave of absence, then the Practitioner must reapply for membership and/or privileges.

5.5 CESSATION OF MEMBERSHIP

Membership in the Clinical Staff shall cease automatically when the individual no longer meets the criteria set forth in these Bylaws, including failure to be reappointed to the faculty of the School of Medicine or resignation, retirement or termination from the School of Medicine or UPG.

ARTICLE VI
CATEGORIES OF CLINICAL PRIVILEGES

6.1 EXERCISE OF CLINICAL PRIVILEGES

Every Member, in connection with such membership, shall be entitled to exercise only those delineated Clinical Privileges specifically recommended by the Credentials Committee and the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, and 6.8 of this Article. Every Non-member shall be entitled to exercise only those delineated Clinical Privileges specifically reviewed by the Department Chair, recommended by the Credentials Committee, recommended by the Clinical Staff Executive Committee and approved by the MCOB, except as provided in Sections 6.6, 6.7, and 6.8 of this Article. The Medical Center has the prerogative to audit from time to time Members’ clinical practice to verify that Members are practicing within the scope of the specific Clinical Privileges that have been granted.
6.2  DELINEATION OF PRIVILEGES

Every application for Clinical Staff appointment or reappointment (excluding Administrative and Honorary Members) and every request for Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Applicant. The evaluation of such request shall be based upon the Applicant's education, training, experience, demonstrated competence as documented by evaluations from Peers, supervision or monitoring during a first or provisional year, FPPE and OPPE, references and other relevant information, including an appraisal by the Clinical Service in which such privileges are sought. The specific procedures set forth in these Bylaws and the Credentials Manual shall be followed throughout the appointment and reappointment process.

6.3  PRIVILEGES FOR NON-MEMBERS (EXCEPT AHP)

Physicians, Dentists, Podiatrists, PhD Clinical Pathologists and PhD Clinical Psychologists who are Non-members who desire to practice in the Medical Center may be granted limited privileges only as specifically permitted by the Credentials Manual or required by the Credentials Committee. Non-members may be issued Clinical Privileges in one of the following categories: Consulting Privileges, Visiting Privileges, Telemedicine or Contract Physicians.

6.4  PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals, as defined in these Bylaws are privileged under a separate process that is specified in the Allied Health Professionals Manual. They are subject to the applicable sections of these Bylaws. Allied Health Professionals shall be required to follow policies and procedures as set forth in the AHP Manual and Medical Center policies and will act under the supervision of a Clinical Staff Member in accordance with all relevant Clinical Staff and UVAMC policies. An official list of current AHPs will be kept in the Clinical Staff Office.

6.5  CONSULTING PRIVILEGES

6.5.1  Description

Non-members who may be granted Consulting Privileges shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Pathologists and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients at the request of a Member of the Clinical Staff, each of whom shall provide information and documentation required by the Credentials Manual and Medical Center policies.

6.5.2  Prerogatives

The prerogatives of the Non-member with Consulting Privileges shall be to consult regarding care to patients at the request of a Member and only as specifically delineated in his or her Clinical Privileges.
6.5.3 Limitations

The Non-member with Consulting Privileges shall not admit patients to an inpatient facility of the Medical Center nor serve as the primary attending of record in Medical Center facilities.

6.6 VISITING PRIVILEGES

6.6.1 Description

Non-members who may be granted Visiting Privileges shall consist of Physicians, Dentists, Podiatrists, PhD. Clinical Pathologists and Ph.D. Clinical Psychologists who will participate in patient care activities for Medical Center patients for a period of time at the request of a Member of the Clinical Staff, with the support of his or her Department Chair, each of whom shall provide information and documentation relevant to his or her privilege specific expertise as may be required by the Credentials Committee.

6.6.2 Prerogatives

The prerogatives of the Non-member with Visiting Privileges shall be to:

A. Participate as applicable in the care of patients within the scope of his or her delineated Clinical Privileges;
B. Exercise Clinical Privileges as specifically delineated; and
C. Attend Clinical Staff, Department and as applicable, Division meetings as invited.

6.6.3 Limitations

The Non-member with Visiting Privileges shall not admit patients to an inpatient facility of the Medical Center nor serve as the primary attending of record in Medical Center facilities.

6.7 TEMPORARY PRIVILEGES

6.7.1 Circumstances Under Which Temporary Privileges May Be Granted

Temporary Privileges shall be granted in only two circumstances:

A. When an important patient care need mandates an immediate authorization to practice, an application for Temporary Privileges will be considered on a case-by-case basis; or
B. When an Applicant with a complete verified application with no indication of adverse information about state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern, the Credentials Committee, after review by the Department Chair, may recommend that the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, grant temporary privileges pending review and approval by the Clinical Staff Executive Committee and approval of the MCOB.
6.7.2 Application and Review

A. Where an important patient care need mandates an immediate authorization to practice as contemplated by 6.7.1 (a), the CEO or designee, with the written concurrence of the Department Chair and the President of the Clinical Staff or designee, may grant Temporary Privileges. Such temporary grant of privileges shall not be made unless the following verifications are present:

1. Letter from the appropriate Department Chair explaining the important nature of the situation and the benefit to a patient or patients as a result of immediate authorization of the specified task(s) and their recommendation for approval;

2. Primary source verification of current license;

3. Listing of delineated privileges requested with appropriate documentation of competence to perform each of the specified tasks;

4. Proof of current liability coverage, showing coverage limits and dates of coverage; and

5. There exist no state licensing actions, DEA registrations, current medical, psychiatric or substance abuse impairments that could affect practice, criminal convictions or verdicts/settlements of concern to the Credentials Committee.

If the above requirements are not satisfied, Temporary Privileges may not be granted. In addition the Credentials Manual may specify additional verifications required before such Temporary Privileges may be granted.

B. For all situations arising under Section 6.7., the CEO or designee, upon recommendation of the President of the Clinical Staff or designee, may grant Temporary Privileges for not more than one hundred twenty (120) days or until such time as the request is officially approved, whichever time is shorter. No such Temporary Privileges may be granted unless there is:

1. Complete application is received and all verifications are received;

2. Evidence of a completed query to the National Practitioner Data Bank and an analysis of the evaluation of the results of such query; and

3. The Applicant satisfies the requirements of Section 6.7.1 b. and has not been subject to involuntary termination of Clinical Staff membership at another organization, has not been subject to involuntary limitation, reduction, denial or loss of Clinical Privileges and has not relinquished Clinical Privileges at another organization while under investigation by that organization.

The Credentials Manual may specify additional documentation required before such Temporary Privileges may be granted.
6.7.3 General Conditions

If granted Temporary Privileges, the Applicant shall act under the supervision of the Department Chair, or his or her designee, to which the Applicant has been assigned, and shall ensure that the Department Chair or the Chair’s designee is kept closely informed as to his or her activities within the Medical Center. The Credentials Manual specifies supervisory requirements for the Department Chair or the Chair’s designee when Temporary Privileges have been granted to an Applicant in the Clinical Department.

A. Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Credentials Committee upon recommendation of the Department Chair, the President of the Clinical Staff or the CEO, or unless affirmatively renewed, up to a maximum of 120 days, following the procedure set forth in Section 6.7.2

B. Requirements for proctoring and monitoring, including FPPE, shall be imposed on such terms as may be appropriate under the circumstances upon any Member granted Temporary Privileges by the Chair of the Credentials Committee after consultation with the Department Chair or his or her designee.

C. At any time, Temporary Privileges may be terminated by the Clinical Staff Executive Committee. In such cases, the appropriate Department Chair shall assign a Member to assume responsibility for the care of such Practitioner’s patient(s). The preferences of the patient shall be considered in the choice of a replacement Member.

D. A person shall not be entitled to the procedural rights afforded by Article IX because a request for Temporary Privileges is refused or because all or any portion of Temporary Privileges are terminated or suspended for reasons not related to competence or conduct. Termination or suspension of Temporary Privileges which lasts longer than 14 days and for reasons or competence or conduct shall afford fair hearing and appeal rights.

E. All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws, the Credentials Manual, and the policies, procedures, of the Medical Center.

6.8 EMERGENCY PRIVILEGES

In the case of a medical emergency, any currently privileged Practitioner is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the Practitioner’s license, regardless of Clinical Service affiliation, staff category, or level of privileges. A Practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.9 DISASTER PRIVILEGES

In the case of unpredictable emergencies, including but not limited to those caused by natural disasters and bioterrorism, which result in the activation of the Medical Center Emergency Management Plan, any clinician, to the degree permitted by his or her license and regardless of service or staff status or the lack thereof, shall perform services to save the life of a patient, using every facility of the Medical Center necessary, including the calling of any consultation.
appropriate or desirable. The VP and CEO, the President of the Clinical Staff, or the Chair of the Credentials Committee may grant Emergency Privileges for the period required to supplement normal patient care services during the emergency as more specifically provided in the Credentials Manual. Before a volunteer clinician is considered eligible to function as a licensed independent Practitioner, the Medical Center will obtain his or her valid government issued photo identification (for example, a driver’s license or passport). When the emergency situation no longer exists, any such clinician must apply for the staff privileges necessary to continue to treat patients. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent Practitioner presents himself or herself to the Medical Center whichever comes first. In the event such privileges are denied or are not requested, the patients shall be assigned to another Member.

A. If the Medical Center Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs, the CEO or other individuals as identified in the Medical Center Emergency Management Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These Practitioners must present 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:

1. A current picture Medical Center ID card that clearly identifies professional designation;
2. A current license to practice;
3. Primary source verification of the license;
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
6. Identification by a current Medical Center or Clinical Staff member (s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent Practitioner during a disaster.

B. The Clinical Staff has a mechanism (i.e., badging) to readily identify volunteer Practitioners who have been granted disaster privileges.

C. The Clinical Staff oversees the professional performance of volunteer Practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
D. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer Practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

E. Once the immediate situation has passed and such determination has been made consistent with the Medical Center Emergency Management Plan, the Practitioner’s disaster privileges will terminate immediately.

F. Any individual identified in the Medical Center Emergency Management Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Medical Center and will not give rise to a right to a fair hearing or an appeal.

6.10 TELEMEDICINE CREDENTIALING AND PRIVILEGING

6.10.1 Receipt of Telemedicine Services From Other Sites

All Members who diagnose or treat patients via telemedicine link are subject to the credentialing and privileging processes of the organization that receives the telemedicine service.

Telemedicine is the provision of clinical services to patients by Practitioners from a distance via electronic communications. The originating site is the site where the patient is located; the distant site is the site where the Practitioner is physically viewing the telemedicine images. Practitioners providing only telemedicine services to the Medical Center from a distant site will not be appointed to the Clinical Staff but must be granted privileges at the Medical Center. The Clinical Staff may recommend privileges to the MCOB through one of the following mechanisms:

A. The Medical Center uses the credentialing and privileging decision made by the distant-site to make a final privileging decision. For the Clinical Staff to rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and Practitioners providing such services, the MCOB ensures, through the Medical Center’s written agreement with the distant-site hospital, that all of the following provisions are met:

1. The distant site providing the telemedicine services is a Medicare-participating and Joint Commission-accredited hospital or ambulatory care organization;
2. The individual distant-site physician or Practitioner is privileged at the distant-site providing the telemedicine services for those services to be provided at the originating site, and the distant site provides a current list of the distant site physician’s or Practitioner’s privileges at the distant-site hospital or ambulatory care organization;
3. The individual distant-site physician or Practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located; and
4. With respect to a distant-site physician or Practitioner who holds current privileges at the Medical Center, the Medical Center has evidence of an internal review of the distant-site physician’s or Practitioner’s performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or Practitioner. At a minimum, this information must include all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided by the distant-site physician or Practitioner to the Medical Center’s patients; and all complaints the Medical Center has received about the distant-site physician or Practitioner.

B. The Clinical Staff privileges Practitioners using credentialing information from the distant site if the distant site is a Joint Commission accredited organization. Once the Clinical Staff makes its recommendation regarding the privileging of the telemedicine provider, it then must go through the remainder of the credentialing process for a decision regarding approval by the MCOB as set forth in Article VII of these Bylaws.

6.10.2 Provision of Telemedicine Services to Other Sites

Practitioners providing telemedicine services to other hospitals from the Medical Center must be granted privileges at the Medical Center for any services that are rendered via telemedicine to other site(s). If this service is rendered by Residents or Fellows, then any telemedicine interpretation must be overseen by a Practitioner with appropriate clinical privileges before the reading can be furnished to the other site(s).

6.11 EXPEDITED CREDENTIALING

6.11.1 Eligibility:

An expedited review and approval process may be used for initial appointment and for reappointment. All initial applications for membership and/or privileges will be designated as eligible for expedited credentialing or not. A completed application that does not raise concerns, as identified by the lack of any of the criteria noted below, is eligible for expedited credentialing:

A. The application is deemed to be incomplete;
B. The final recommendation of the CSEC is adverse or with limitation;
C. The Applicant is found to have experienced an involuntary termination of clinical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
D. The Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;
E. The Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action in excess of $250,000;
F. The Applicant has one or more reference responses that raise concerns or questions;
G. A discrepancy is found between information received from the Applicant and references or verified information;
H. The Applicant has an adverse National Practitioner Data Bank report;
I. The request for privileges is not reasonable based upon applicant’s experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
J. The Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
K. The Applicant has potentially relevant physical, mental and/or emotional health problems;
L. Other reasons as determined by a clinical staff leader or other representative of the Medical Center which raise questions about the qualifications, competency, professionalism or appropriateness of the Applicant for membership or privileges.

6.11.2 Approval Process:

Applicants for expedited credentialing will be granted Clinical Staff membership and/or privileges after review and action by the following: the Department Chair, the Credentials Committee, and CSEC with a quorum as defined for expedited credentialing and a committee of the MCOB consisting of at least two individuals.

ARTICLE VII
APPOINTMENT AND REAPPOINTMENT

7.1 PROCEDURE FOR INITIAL APPOINTMENT

When the Dean and a Department Chair have mutually agreed upon a candidate (hereinafter referred to as “Applicant”) for his or her Department, the Dean and the Chair jointly shall forward a copy of the offer letter and a request for appointment and privileges to the Credentials Committee for an initial period not to exceed one (1) year. All required information and documentation shall be submitted in accordance with the Credentials Manual, including the deadlines set forth therein using the application form or other forms required thereby. No application shall be considered until all required information and documentation is completed within the timeframes specified in the Credentials Manual.

The Credentials Committee shall then follow the credentialing procedures set forth in the Credentials Manual including the process related to the information required in an application for initial appointment and the processing of the application. Upon receipt and review of all necessary credentialing documentation, the Credentials Committee, upon recommendation of the Department Chair, shall recommend to the Clinical Staff Executive Committee that such Applicant should either be granted or denied initial privileges in the Medical Center. The Clinical Staff Executive Committee shall then review the Credentials Committee’s recommendation and all applicable documentation. If the Credentials Committee and the Clinical Staff Executive Committee are both in favor of granting privileges to the Applicant, the favorable recommendation shall be forwarded to the MCOB for final action.

In the case of an application for Associate Membership, the procedures outlined in the Credentials Manual shall be considered until all required information and documentation is completed within the timeframes specified in the Credentials Manual.
7.2  PROVISIONAL APPOINTMENT STATUS

Initial appointments and all initially granted Clinical Privileges for all Practitioners shall be provisional for a period of one year. During this provisional period, the individual’s performance and clinical competence shall be observed and evaluated through FPPE and OPPE by the Department Chair, Division Chair, or Peer designee of the applicable Clinical Department. If at the end of the year the Practitioner satisfies the requirements to become a Clinical Staff Member or have a privileging status as provided in the Credentials Manual, the provisional status ceases. If at the end of the year the Practitioner does not satisfy the requirements as specified in the Credentials Manual, then membership in the Clinical Staff and Clinical Privileges for that individual shall cease. Failure to achieve the appropriate status from provisional status, when due to a lack of clinical volume, shall not give rise to the procedural rights, afforded by Article IX of these Bylaws. Failure to achieve the appropriate status from provisional status, due to issues of competency or conduct, shall give rise to the procedural rights afforded by Article IX of these Bylaws.

All initial Clinical Staff appointees to the Active or Associate Categories and all Non-member appointees to the Consulting/Visiting, Contract Physician, Telemedicine, Visiting/Re-entry Postgraduate Trainee, or AHP categories, and all re-appointees to these categories after termination of a prior appointment, shall serve a provisional status period of no less than one (1) year. During this time proctoring must be satisfactorily completed unless a specific exception is applied for by the Department Chair and approved by the Credentials Committee as specified in section B below. Each Member in provisional status shall be assigned to a Department in which their performance shall be evaluated through proctoring to determine their eligibility for advancement to non-provisional status in the appropriate Clinical Staff category.

A.  Responsibilities

A Practitioner in provisional status shall have all of the responsibilities of the membership category.

B.  Proctoring

Each provisional appointee shall complete such proctoring (Focused Professional Practice Evaluation) as required by the Clinical Service and approved by the Credentials Committee in accordance with Medical Center Policy No. 0279 (“Professional Practice Evaluations for Members of the Clinical Staff”) and Medical Center Policy No. 0280 (“Allied Health Professionals Practice Evaluations”).

7.3  PROCEDURE FOR REAPPOINTMENT

Periodic redetermination of Clinical Privileges for Active Clinical Staff Members, and the increase or curtailment of same, shall be based upon the reappointment procedures set forth in the Credentials Manual, including deadlines for submission of information and documentation and the forms required thereby. Criteria to be considered at the time of reappointment may include specific information derived from the Department’s direct observation of care provided, information gathered through FPPE and OPPE, review of records of patients treated in this or
other medical centers, review of the records of the Departmental Clinical Staff as compared to
the records of the particular Member and an appropriate comparison of the performance of the
Member with his or her professional colleagues in the Department. If a Member chooses not to
seek reappointment or renew privileges, the procedures set forth in Article IX shall not apply.

7.4 END OF PROVISIONAL STATUS

A Member in provisional status may become an Active or Associate Member upon the
satisfactory conclusion of provisional status as provided in these Bylaws and the Credentials
Manual, which appointment shall be for no more than two (2) years at a time and as more
specifically provided in the Credentials Manual.

7.5 CHANGES IN QUALIFICATION

If during the course of any period of appointment, the qualifications of the Member change, or
the Department learns of Adverse Action taken by an official licensing or certification body or
Medicare or Medicaid, then those changes in qualification or Adverse Action must be reported
immediately to the Member's Department Chair and the Credentials Committee who will
review the information and determine whether the Member's privileges should be revoked,
revised, or suspended. The provisions of Section 8.6 or Article IX will apply.

7.6 NEW OR ADDITIONAL CLINICAL PRIVILEGES

Applications for new or additional Clinical Privileges must be in writing and submitted by the
Applicant as well as by the appropriate Department Chair. All applications for new or additional
Clinical Privileges shall be submitted on a form prescribed by the Credentials Committee upon
which the type of Clinical Privileges desired and, among other things, the Member’s relevant
recent training and/or experience are set out, together with any other information required by the
Credentials Manual or the Credentials Committee. Such applications shall be processed as
provided in the Credentials Manual, including the timeline for processing. Licensure and the
National Practitioner Data Bank will be queried at any request for new privileges. The
Credentials Committee shall determine the conditions and requirements upon which any new or
additional Clinical Privileges shall be granted, including but not limited to, how current
competence will be demonstrated and any proctoring or other monitoring requirements, and will
recommend the requirements to the Clinical Staff Executive Committee for consideration. In turn
CSEC shall make appropriate recommendations regarding new or additional Clinical Privileges
to the MCOB for final determination. A decision not to approve a new or additional Clinical
Privilege to be performed within the Medical Center and/or to be added to the Medical Center
privilege list shall not be deemed an Adverse Action or a denial of privileges nor entitle any
individual to the hearing rights set forth in Article IX of these Bylaws. The Applicant’s
performance and clinical competence shall be observed and evaluated through FPPE by the
Department Chair, Division Chief, and Peer designee of the applicable Clinical Department and
documentation is completed within the timeframes specified in the Credentials Manual.
7.7 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment of membership and for Clinical Privileges, the Applicant shall have the burden of producing information for an adequate evaluation of the Applicant’s qualifications and suitability for the Clinical Privileges requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the Applicant’s expense, if deemed appropriate by the Department Chair, the President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Medical Center or the Dean of the School of Medicine. The President of the Clinical Staff, the Chair of the Credentials Committee, the Chief Executive Officer of the Medical Center, or the Director of the Clinicians Wellness Program shall select the examining physician, program, and/or site of the examination.

The Applicant or Member has a duty to advise the Credentials Committee, within fifteen (15) days, of any change in information previously submitted related to his or her credentials. The Applicant’s failure to sustain these duties shall be grounds for denial of the application or termination of a Member’s Clinical Staff membership and a Member or Non-member’s Clinical Privileges.

ARTICLE VIII
CORRECTIVE ACTION FOR MEMBERS AND NON-MEMBERS WITH CLINICAL PRIVILEGES

8.1 CRITERIA FOR INITIATION

A Member’s or Non-member’s Clinical Privileges may be reduced, suspended or revoked for activities or professional conduct considered to be lower than the standards of the Medical Center and the Clinical Staff, or to be disruptive to operations of the Medical Center, or for violation of these Bylaws, directives of the Clinical Staff Executive Committee or the MCOB, the Code of Conduct, or policies, procedures, rules or regulations of the Medical Center or the applicable Clinical Service. Any person may provide information to a Department Chair, the Clinical Staff Executive Committee, the Chief Executive Officer, the Dean, the Chief Medical Officer, the President, the Vice President, the MCOB or any member of the administration of the Medical Center about the conduct, performance, or competence of any Member or Non-member who has been granted Clinical Privileges.

A request for initiation of investigation or action against such Member or Non-member shall be made by written request from any other Member, including the President, or from the Chief Executive Officer. Upon receipt of a written request for investigation or action, the individual or entity that received such request shall immediately forward the matter to the Credentials Committee for investigation when the information provided indicates that such Member or Non-member may have exhibited acts, demeanor, or conduct reasonably likely to be: (a) detrimental to worker safety, patient safety or to the delivery of quality patient care; (b) unethical; (c) contrary to the Medical Center’s policies and procedures, these Bylaws, or the Code of Conduct; (d) disruptive to the operation of the Medical Center; (e) below applicable professional standards; or (f) the result of impairment of the Member or Non-member by reason of illness, use
of drugs, narcotics, alcohol, chemicals or other substances or as a result of any physical or mental condition that impairs the Member’s or Non-member’s clinical practice. To the extent possible, the identity of the individual requesting initiation of investigation shall not be disclosed. In order to safeguard the privileged peer review status of a peer review investigation, the individual requesting an investigation may not be entitled to receive information about the course or findings of the investigation. The Chair of the Credentials Committee may inform the individual requesting an investigation about the status of the investigation (ongoing or concluded) and the expected date of completion.

8.2 ROUTINE ACTION

Initial collegial efforts may be made prior to resorting to formal corrective action, when appropriate. Such collegial interventions on the part of Clinical Staff leaders in addressing the conduct or performance of an individual shall not constitute formal corrective action, shall not afford the individual subject to such collegial efforts to the right to a fair hearing, and shall not require reporting to the National Practitioner Data Bank, except as otherwise provided in these Bylaws or required by law. Alternatives to formal corrective action may include:

A. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in these Bylaws or Medical Center policies that may be taken to address disruptive conduct;

B. Written letters of guidance, or warning regarding the concerns about conduct or performance;

C. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

D. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;

E. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or

F. Requirements to seek assistance for impairment, as provided in these Bylaws.

8.3 INITIATING EVALUATION AND/OR INVESTIGATION OF POSSIBLE IMPAIRING CONDITIONS

At any time, a Department Chair, the President, the Chief Executive Officer, the Dean, the Chair of the Credentials Committee, or the Director of the Clinicians’ Wellness Program may require that a Member or Non-member who has been granted Clinical Privileges undergo a physical and/or mental examination(s) by one or more qualified Practitioners or programs specified by the individual requiring the evaluation; see also Medical Center Policy No. 0242 (“Clinicians Wellness Program”). If the Member or Non-member refuses to undergo the examination, his/her Clinical Privileges shall be automatically inactivated and there shall be no further consideration of continued privileges until the examination is performed. The Member or Non-member shall authorize the qualified Practitioner(s), to submit reports of the evaluation(s), as appropriate, to the Chair of the Credentials Committee, the Department Chair, the President, the Chief Executive Officer, the Dean, the Director of the Clinicians' Wellness Program. Any time limit
for action by the Credentials Committee, as specified in Section 8.4 below, shall be extended for the number of days from the request for the examination(s) to the receipt of the examination report(s).

The MCOB and the Clinical Staff Executive Committee recognize the need to assist Members or Non-members who have been granted Clinical Privileges regarding their physical and mental health issues as well as to protect patients and staff members from harm. Accordingly, upon the recommendation of the Department Chair, the President, the Dean or the Chief Executive Officer, or on its own initiative, the Credentials Committee shall arrange for the evaluation by the Clinical Wellness Program any Member or Non-member who appears to suffer from a potentially impairing condition. Any such Member or Non-member is encouraged to seek assistance from the Clinicians’ Wellness Program and/or the Faculty and Employee Assistance Program or any successor program thereto.

The Credentials Committee may also require periodic monitoring after completion of any evaluation treatment/ or rehabilitation. If the Member or Non-member does not complete the initial treatment/rehabilitation program or does not comply with the required monitoring, the provisions of Article 8.4 or 8.5 automatic relinquishment shall be applicable. In addition, the Credentials Committee shall strictly adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

The purpose of the evaluation and investigation process concerning potential impairing conditions is to protect patients and others working with the affected practitioner and to aid the Member or Non-member in retaining or regaining optimal professional functioning. Non-member

If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Member or Non-member is unable to safely perform the Clinical Privileges he or she has been granted, the Credentials Committee shall proceed in accordance with Sections 8.4 or 8.5, as appropriate, below. Additionally, the Credentials Committee shall adhere to any state or federal statutes or regulations containing mandatory reporting requirements.

8.4 INITIATING EVALUATION AND RECOMMENDATION FOR FORMAL CORRECTIVE ACTION

8.4.1 Investigation

Upon receipt of the request for initiation of formal corrective action, the Credentials Committee shall conduct a thorough investigation of the Member or Non-member who has been granted Clinical Privileges in question. The Member or Non-member shall be notified in writing that an investigation is being conducted. In addition the applicable Department Chair, the Dean, and the Chief Executive Officer shall be notified of the investigation. The Member or Non-member shall provide to the Credentials Committee all available information that it requests. Failure to provide such requested information will itself be considered grounds for corrective action. The Credentials Committee may, but is not obligated to, review medical files or other documents and conduct interviews with witnesses; however, such investigation shall not constitute a “hearing” as that term is used in Article IX, nor shall the procedural rules with respect to hearings or appeals apply. The Credentials Committee may, in its sole discretion, request an interview with
the Member or Non-member under investigation and, during such interview, question the
Member or Non-member about matters under investigation. A record of such interview shall be
made by the Credentials Committee. Within forty (40) days of the receipt of the request for
initiation of investigation, the Credentials Committee shall report to the Clinical Staff Executive
Committee on the progress of the investigation and the estimated time required to complete the
investigation. In most instances, the investigation shall not last longer than ninety (90) days.
However, for good cause, the Chair of the Credentials Committee may ask the Clinical Staff
Executive Committee to extend the time for completion of the investigation. At the completion
of the investigation, the Chair of the Credentials Committee shall submit to the Clinical Staff
Executive Committee the Credentials Committee’s findings and recommendations resulting from
the investigation.

The Clinical Staff Executive Committee may accept, reject or modify the findings and
recommendations of the Credentials Committee and recommend to the MCOB approval of a
final action. The Member and the Department Chair to which the Member is assigned shall be
notified in writing of the recommendation of the Clinical Staff Executive Committee.

8.4.2 Recommendation

The Credentials Committee’s written recommendation to the Clinical Staff Executive
Committee of action to be taken on the matter may include, without limitation:

A. Determining that no further action is necessary on the matter;

B. Issuing a warning, a letter of admonition, or a letter of reprimand;

C. Recommending terms of probation or requirements of consultation;

D. Recommending reduction, suspension or revocation of Clinical Privileges;

E. Recommending suspension or revocation of Clinical Staff membership;

F. Recommending concurrent monitoring or retrospective auditing;

G. Requiring additional training;

H. Requiring evaluation by a clinician assessment organization or individual; or

I. Requiring a Proctor for all procedures.

Any corrective action in accordance with subsections (c) through (f) of this Section shall entitle
the Member to the procedural rights provided in Article IX of these Bylaws.

8.4.3 Cooperation with Investigation

All Members and Non-members shall cooperate as necessary for the conduct of any
investigation.
8.5 PRECAUTIONARY SUMMARY SUSPENSION

Whenever the conduct of a Member or a Non-member who has been granted Clinical Privileges reasonably appears to pose a threat that requires that action be taken to protect the health, life or safety of patients or prospective patients, or any other person in or associated with the Medical Center, or whenever the conduct of a Member or a Non-member who has been granted Clinical Privileges reasonably appears to pose a substantial harm to the life, health and safety of any patient, prospective patient, or staff member then in any such event the President, the Chair of the Credentials Committee, the Department Chair, or the Chief Executive Officer may summarily restrict or suspend the Clinical Staff membership or Clinical Privileges of such Member or Non-member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition, and the person responsible shall promptly give written notice of the suspension or restriction to the Member or Non-member in question and to the, the Department Chair and the Division Head, if applicable, to which the Member is assigned. The Chief Executive Officer, the Clinical Staff Executive Committee, and President of the Clinical Staff shall also be promptly notified. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if not so limited, shall remain in effect until resolved by the procedures specified in Article IX with respect to Members and Non-members who are Physicians and Dentists only. An alternative fair hearing and appeal plan is available for Non-members who are not Physicians or Dentists and for AHPs as noted in Section 9.5.1. Unless otherwise indicated by the terms of the summary restriction or suspension, the Clinical Department Chair or his/her designee shall assign the patients of the Member or Non-member in question to another Member. Should the member or Non-member who is subject to a precautionary summary suspension, upon being notified of the suspension, decide to voluntarily request inactivation of his/her privileges during the duration of the investigation required by 8.4.1, the precautionary summary suspension may be voided and withdrawn at the direction of the President of the Clinical Staff. A request for voluntary inactivation of privileges must be submitted in writing to the President within three business days of notification regarding precautionary summary restriction or suspension.

8.5.1 PROCEDURE FOR MEMBERS

No later than 30 days after the date of the precautionary summary suspension and if the precautionary summary suspension still remains in effect, the Chair of the Clinical Staff Executive Committee shall designate a panel of its members to convene for review and consideration of the action; provided, however, that the Clinical Staff Executive Committee may extend the 30 day period for review for good cause if so requested by either the Member or the Chair of the Credentials Committee. Upon request and on such terms and conditions as the panel of the Clinical Staff Executive Committee may impose, the Member may attend and make a statement concerning the issues that led to the precautionary summary suspension, although in no event shall any meeting of the panel of the Clinical Staff Executive Committee, with or without the Member, constitute a “hearing” within the meaning of Article IX, nor shall any procedural rules apply except those adopted by the panel of the Clinical Staff Executive Committee. The panel of the Clinical Staff Executive Committee may recommend to the Clinical Staff Executive Committee that the summary restriction or suspension be modified, continued or terminated. The Clinical Staff Executive Committee shall consider this recommendation at its next scheduled meeting and shall furnish the Member with written notice of its decision.
Unless the Clinical Staff Executive Committee terminates the summary restriction or suspension within fourteen (14) working days of such restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article IX of these Bylaws.

8.5.2 PROCEDURE FOR NON-MEMBERS

When a Non-member’s Clinical Privileges are summarily suspended pursuant to Section 8.5 the Non-member shall be notified in writing of the restriction or suspension and the grounds for the suspension. The Chair of the Credentials Committee shall refer the matter to the Credentials Committee at its next scheduled meeting. The Non-member, who is not a Physician or a Dentist, shall not be entitled to the procedural rights afforded by Article IX of the Bylaws. An alternative fair hearing and appeal plan is available for Non-members who are not Physicians or Dentists and for AHPs, as noted in Section 9.5.1

8.6 AUTOMATIC ACTIONS

The Member’s or Non Member’s clinical privileges or Clinical Staff membership may be subject to automatic actions as follows:

8.6.1 CHANGE IN LICENSURE

8.6.1.1 Revocation or Suspension

Whenever a Member’s or Non-member’s license authorizing practice in the Commonwealth of Virginia is revoked or suspended by the applicable health regulatory board, Clinical Privileges shall be automatically revoked or suspended as of the date such action becomes effective.

8.6.1.2 Probation and Other Restriction

If a Member’s or Non-member’s license authorizing practice in the Commonwealth of Virginia is placed on probation by the applicable health regulatory board, his or her 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 duration.

Whenever a Member’s or Non-member’s license authorizing practice in the Commonwealth of Virginia is limited or restricted by the applicable health regulatory board, any Clinical Privileges that the Member or Non-member has been granted by the Medical Center that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such licensing or certifying authority’s action becomes effective and throughout its duration.

8.6.2 Change in DEA Certificate Status

8.6.2.1 Revocation or Suspension

If a Member’s or Non-member’s DEA certificate is revoked, limited, or suspended, the Member or Non-member shall automatically be divested of the right to prescribe medications covered by
the certificate as of the date such action becomes effective and throughout its term.

8.6.2.2 Probation

If a Member’s or a Non-member’s DEA certificate is subject to probation, the Member’s or Non-member’s right to prescribe such medications automatically shall become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.6.3 LACK OF REQUIRED PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in amounts and of a type required by the MCOB, as such amounts shall be defined from time to time, shall be a basis for automatic suspension of a Member’s or a Non-member’s Clinical Privileges. If within 30 days after written warnings of such delinquency, the Member or Non-member does not provide evidence of the required professional liability insurance, and prior acts coverage for the uninsured period, such individual’s Clinical Privileges shall be automatically terminated.

8.6.4 FEDERAL PROGRAM EXCLUSION

If a Member of a Non-member is convicted of a crime pursuant to the Medicare and Medicaid Protection Act of 1987, Pub. L. 100-93, or a crime related to the provision of health care items or services for which one may be excluded under 42 U.S.C. Section 1320a7(a), or is suspended, excluded, debarred or otherwise declared ineligible to participate in Medicare or Medicaid or other federal or state health care or other programs, such Member’s or Non-member’s Clinical Privileges shall be automatically suspended as of the date such conviction or action with respect to the Medicare or Medicaid federal program becomes effective.

8.6.5 LOSS OF FACULTY APPOINTMENT OR TERMINATION OF EMPLOYMENT

If a Member’s or Non-member’s faculty appointment in the School of Medicine or contract with UPG is terminated for any reason or for any length of time, his/her membership and Clinical Privileges shall be automatically revoked or suspended as of the date such loss of faculty appointment or termination of UPG contract becomes effective. Loss of faculty appointment or termination of UPG contract shall not give rise to a hearing under Article IX as such appointment is a prerequisite being granted clinical privileges. Due process procedures applicable to contesting the loss of a faculty appointment are set forth in the University of Virginia Faculty Handbook. In the case of AHP’s, if Medical Center employment or UPG employment is terminated for any reason or any length of time, his/her Clinical Privileges within the Medical Center shall automatically be revoked or suspended as of the date of such termination. Loss of privileges due to such termination shall not give rise to a hearing appeal under Article 9.5. Due process procedures applicable under these circumstances are specified by applicable Medical Center HR Policy or UPG contract.

8.6.6 FAILURE TO UNDERGO PHYSICAL AND/OR MENTAL EXAMINATION

If a Member or Non-member fails or refuses to undergo a physical and/or mental examination or fails to complete the evaluation, treatment, rehabilitation program or does not comply with
the required monitoring as required by Section 8.3 of these Bylaws, such failure or refusal shall result in automatic suspension of the Clinical Privileges of the Member or Non-member. Refusal to comply with health screening and/or infection control policies shall also result in automatic inactivation of Clinical Privileges.

**8.6.7 MATERIAL MISREPRESENTATION ON APPLICATION/REAPPLICATION**

Whenever a Member or Non-member has made a material misrepresentation on the application/reapplication for Clinical Privileges, the application/reapplication processing will stop (if still in progress) or membership and/or privileges will be automatically inactivated if they have already been granted prior to discovery of the material misrepresentation.

**8.6.8 FAILURE TO COMPLY WITH MEDICAL RECORDS COMPLETION REQUIREMENTS**

Whenever a Practitioner has failed to comply with the medical records completion requirements per Medical Center Policy No. 0094 (“Documentation of Patient Care (Electronic Medical Record)”), the Practitioner may have his/her membership and/or Clinical Privileges inactivated until he/she is compliant with those requirements.

**8.6.9 FAILURE TO BECOME BOARD CERTIFIED OR FAILURE TO MAINTAIN BOARD CERTIFICATION**

The Clinical Privileges of a Practitioner who fails to become board certified or to maintain board certification shall be inactivated, unless the Practitioner has been granted an exception to these requirements by the Credentials Committee under the process outlined in Medical Center Policy No. 0221 (“Board Certification Requirements for Medical Center Physicians”).

**8.6.10 CONVICTION OF A FELONY OR OTHER SERIOUS CRIME**

Conviction of a crime as set out in Va. Code Section 37.2-314 shall result in automatic suspension of Clinical Privileges and inactivation of Clinical Staff membership.

**8.6.11 ARTICLE IX INAPPLICABLE**

When a Member’s or Non-member’s privileges are restricted pursuant to any of the circumstances set out in this Section 8.6, the hearing and appeal rights of Article IX shall not apply and the action shall be effective for the time specified. If the Member believes that any such automatic restriction of privileges is the result of an error, the Member may request a meeting with the Clinical Staff Executive Committee. A Non-member shall have no right to a meeting with the Clinical Staff Executive Committee.

**8.6.12 CLINICAL PRIVILEGES AND CLINICAL STAFF MEMBERSHIP LINKAGE**

Except when explicitly stated otherwise in these Bylaws, the automatic inactivation of clinical privileges also results in automatic inactivation of Clinical Staff Membership.
ARTICLE IX
HEARING AND APPELLATE REVIEW FOR MEMBERS

9.1 GENERAL PROVISIONS

The provisions of Article IX do not apply to those actions specified in Section 8.6 or to the informal actions specified in Section 8.2 of Article VIII.

Non-members who are not Physicians, Clinical Psychologists or Dentists shall be governed by the procedures set out in Section 9.5 below.

9.1.1 Right to Hearing and Appellate Review

A. When any Member, or a Non-member who is a Physician or Dentist, receives notice of a recommendation of the Clinical Staff Executive Committee that, if approved by the MCOB, will adversely affect his or her appointment to or status as a Member or his or her exercise of Clinical Privileges, he or she shall be entitled to a hearing before a hearing committee appointed by the Chair or Vice Chair of the Clinical Staff Executive Committee. If the recommendation of the Clinical Staff Executive Committee following such hearing is still adverse to the affected Member, he or she shall then be entitled to an appellate review by the MCOB or a committee appointed by the Chair of the MCOB, before the MCOB makes a final decision on the matter. Such review shall be made based on the evidentiary record, unless the MCOB or the committee appointed by the MCOB to hear the appeal requests additional information.

B. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in Article IX to assure that the affected Member is accorded all rights to which he or she is entitled.

9.1.2 Exhaustion of Remedies

If Adverse Action described in Section 9.2 is taken or recommended, the Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action. For purposes of Article IX, the term “Member” may include “Applicant”, as appropriate under the circumstances.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, the following recommended actions or actions shall be deemed Adverse Actions and constitute grounds for a hearing, if such action is based on professional conduct, professional competence, or character:

A. Denial of Clinical Staff Membership;

B. Denial of Clinical Staff reappointment (excluding failure to obtain active status following provisional status);

C. Suspension or Revocation of Clinical Staff Membership;
D. Denial of requested Clinical Privileges (excluding Temporary Privileges) for a Member;

E. Involuntary reduction of current Clinical Privileges for a Member;

F. Suspension of Clinical Staff Membership or Clinical Privileges for a Member if the duration of the suspension is for greater than 14 days and the reason for the suspension is one of competence or conduct; or

G. Suspension or Revocation of Clinical Privileges (excluding loss of faculty appointment) for a Member.

Actions described above in this Section that are the result of automatic relinquishment imposed pursuant to Section 8.6 of these Bylaws, shall not be considered an Adverse Action for purposes of Article IX.

9.3 REQUESTS FOR HEARING; WAIVER

9.3.1 Notice of Proposed Action

In all cases in which a recommendation has been made as set forth in Section 9.2, the Chair or Vice Chair of the Clinical Staff Executive Committee shall send a Member affected by an Adverse Action written notice of (a) his or her right to a hearing if requested by him or her within thirty (30) days of the Member’s notice, (b) reasons for the Adverse Action recommended, including the acts or omissions that form the basis of recommendation and a list of the patients in question if applicable, and (c) his or her rights at such a hearing, including the hearing procedures described in Section 9.4. Such notice shall be sent by hand delivery or certified mail, return receipt requested.

9.3.2 Request for Hearing

The Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chair of the Clinical Staff Executive Committee. The request shall contain a statement signed by the Member that the Member shall maintain confidentiality of all documents provided to the Member during the hearing process and shall not disclose or use the documents for any purpose outside the hearing process. Unless the Member is under summary suspension, he or she shall retain existing rights and privileges until all steps provided for in Sections 9.4 through 9.4.8 of Article IX of these Bylaws below have concluded. If, however, the Member’s reappointment term is scheduled to expire during the hearing process, the Member’s membership and privileges shall expire unless (i) the Clinical Staff Executive Committee reappoints the Practitioner until the hearing is concluded, or (ii) the Member is reappointed according to final action by the MCOB.

The Credentials Committee and the affected Practitioner shall be parties to the hearing.
9.3.3 Waiver of Hearing

In the event the Member does not request a hearing within the time and manner described, the Member shall be deemed to have waived any right to a hearing and to have accepted the recommendation involved. The recommendation of the Clinical Staff Executive Committee shall then become final and effective as to the Member when it is approved by the MCOB.

9.3.4 Notice of Time, Place and Procedures for Hearing

Upon receipt of a request for hearing, the Chair or Vice Chair of the Clinical Staff Executive Committee shall schedule a hearing and give notice to the Member of the time, place and date of the hearing, which shall not be less than thirty (30) days after the date of the notice. Each party shall provide the other with a list of witnesses within fifteen (15) days of the hearing date, unless both parties agree otherwise. Witness lists shall be finalized no later than five (5) working days before the hearing. Notwithstanding the foregoing, the Hearing Entity shall have the right to call such witnesses as it deems appropriate and necessary. Unless extended by the Chair of the Hearing Entity, described in Section 9.3.5 below, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the date of receipt of the request for a hearing; provided, however, that when the request is received from a Member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made and provided further that the parties may agree to a mutually convenient date beyond the ninety (90) day period.

9.3.5 Hearing Entity

The Chair of the Clinical Staff Executive Committee may, in his or her discretion and in consultation with the Chair of the Credentials Committee, the Chief Executive Officer and other members of CSEC as he or she deems appropriate, direct that the hearing be held: (1) before a panel of no fewer than three (3) Members who are appointed by the Chair of the Clinical Staff Executive Committee and the Chief Executive Officer and if possible are Peers of the Member in clinical practice or academic rank and are not in direct economic competition with the Member involved, nor have been involved in the request for corrective action, any subsequent investigative process, or the decision to proceed with corrective action, or (2) by an independent Peer Review panel from outside the Medical Center whose members are not in direct economic competition with the Member involved, or (3) a panel consisting of a combination of (1) and (2). Each type of panel described in the preceding sentence shall be referred to hereinafter as the “Hearing Entity.” Knowledge of the matter involved shall not preclude a Clinical Staff Member from serving as a member of the Hearing Entity; however each member must certify at the time of appointment and also on the record at the hearing that any prior knowledge he or she may have does not preclude rendering a fair and impartial decision. The Chair of the Clinical Staff Executive Committee shall designate the chair of the Hearing Entity. At least three-quarters of the members of the Hearing Entity shall be present when the hearing takes place and no member may vote by proxy. In the event of any conflict involving the Chair of the Clinical Staff Executive Committee, the Chief Executive Officer or designee shall be responsible for performing the duties described in this paragraph.
9.3.6 Failure to Attend and Proceed

Failure without good cause of the affected Member to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations involved and his or her request for a hearing shall be deemed to have been withdrawn.

9.3.7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Entity, or its chairperson, acting upon its behalf. Such decisions are solely within the discretion of the Hearing Entity or its presiding officer and may be granted only for good cause.

9.4 HEARING PROCEDURE

9.4.1 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency or character. If requested by either the affected Member or the Credentials Committee in accordance with Section 9.4.2, however, both sides may be represented by legal counsel. In lieu of legal counsel, the Member may be represented by another person of the Member’s choice.

9.4.2 The Hearing Officer

The President of the Clinical Staff may appoint a hearing officer to preside at the hearing. In the sole discretion of the President, the hearing officer may be an attorney qualified to preside over a quasi-judicial hearing. If requested by the Hearing Entity, the hearing officer may participate in the deliberations of the Hearing Entity and be an advisor to it, but the hearing officer shall not be entitled to vote.

9.4.3 The Presiding Officer

The Hearing Entity shall have a presiding officer. If the President of the Clinical Staff appoints a hearing officer pursuant to Section 9.4.2, then the hearing officer shall serve as the presiding officer. If no hearing officer is appointed, then the Chair of the Hearing Entity shall serve as the presiding officer. The presiding officer shall strive to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The presiding officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence. If the presiding officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances.
9.4.4 Record of the Hearing

An official reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the reporter shall be borne by the Medical Center, the cost of the transcript, if any, shall be borne by the party requesting it.

9.4.5 Rights of the Parties

Within reasonable limitations imposed by the presiding officer, the Credentials Committee, the Hearing Entity and the affected Member may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues and otherwise rebut evidence. The Member may be called by the Credentials Committee or the Hearing Entity, as appropriate, and be examined as if under cross-examination.

A. Burden of Proof. The Credentials Committee shall appoint one of its members to represent it at the hearing, to present facts in support of its adverse recommendation and to examine witnesses. Where the issue concerns the denial of initial Clinical Staff membership, it shall be the obligation of the affected Practitioner to present appropriate evidence in support of his or her application, but the Credentials Committee representative shall then be responsible for showing that evidence exists to support the decision and that the Credentials Committee appropriately exercised its authority under these Bylaws and other applicable rules or regulations of the Medical Center. In all other situations outlined in Section 9.2 above, it shall be the obligation of the Credentials Committee representative to present appropriate evidence in support of the adverse recommendation, but the affected Member shall then be responsible for supporting his or her challenge to the adverse recommendation by providing appropriate evidence showing that the grounds for the decision lacked support in fact or that such grounds or action based upon such grounds is either arbitrary or capricious.

B. Written Statement. Each party shall have the right to submit a written statement at the close of the hearing.

C. Written Decision. The affected Member shall be informed in writing by the Clinical Staff Executive Committee of the recommendation of the Hearing Entity, including a statement of the basis for the recommendation, and shall be informed in writing of the decisions of the Clinical Staff Executive Committee and the MCOB, including a statement of the basis for the decision.

9.4.6 Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under Article IX of these Bylaws. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Entity may question the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Entity may request both parties to file written arguments.
9.4.7 Recess and Conclusion

After consultation with the Hearing Entity, the presiding officer may recess the hearing and reconvene the same at such times and intervals as may be reasonable, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and documentary evidence and the receipt of any closing written arguments, the hearing shall be closed. The Hearing Entity shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Hearing Entity may seek legal counsel during its deliberations and the preparation of its report. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

9.4.8 Decision of the Hearing Entity

Within fifteen (15) days after final adjournment of the hearing, the Hearing Entity shall render a decision, which shall be accompanied by a report in writing and shall be delivered to the Clinical Staff Executive Committee. If the affected Member is currently under summary suspension, the Hearing Entity shall render a decision and report to the Clinical Staff Executive Committee within five (5) working days after final adjournment. A copy of the decision shall also be forwarded to the MCOB and the affected Member. The report shall contain a concise statement of the reasons supporting the decision.

9.4.9 Decision of Clinical Staff Executive Committee and MCOB

At its next scheduled meeting, the Clinical Staff Executive Committee shall review the report and decision of the Hearing Entity and shall, within thirty (30) days of such meeting, give written notice of its recommendation to the MCOB and the Member. The Clinical Staff Executive Committee may affirm, modify or reverse the decision of the Hearing Entity.

9.4.10 Appeal

The Member may submit to the Chief Executive Officer a written appeal statement detailing the findings of fact, conclusions, and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written appeal statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be delivered by hand or by certified or registered mail to the Chief Executive Officer and received no later than fourteen (14) days after the Member’s receipt of the recommendation of the Clinical Staff Executive Committee. The Chief Executive Officer shall provide a copy of the Member’s statement to the MCOB and the Chair of the Clinical Staff Executive Committee. In response to the statement submitted by the affected Member, the Clinical Staff Executive Committee may also submit a written statement to the MCOB and shall provide a copy of any such written statement to the Member.

9.4.11 Decision by the Operating Board

A. At a meeting following receipt of the Member’s written appeal statement (or after the expiration of the time in which the Member had the opportunity to submit a written statement) and the Clinical Staff Executive Committee’s written statement, the MCOB shall reach a final decision, shall render a decision in writing, and shall forward copies thereof to
B. The MCOB may affirm, modify, or reverse the decision of the Clinical Staff Executive Committee. The MCOB may also refer the decision back to the Clinical Staff Executive Committee for reconsideration, or remand the matter to the hearing entity for further review. If the matter is remanded to the Hearing Entity for further review and recommendation, such Hearing Entity shall conduct its review within sixty days and make its recommendations to the MCOB. This further review and the time required to report back shall not exceed sixty (60) days except as the parties may otherwise agree, for good cause, as jointly determined by the Chair of the MCOB and the Hearing Entity or Clinical Staff Executive Committee. MCOB shall thereafter make its final decision.

C. The decision of the MCOB as reflected in paragraphs (a) or (b) above shall constitute final action. This decision shall be immediately effective and shall not be subject to further hearing, or appellate review.

9.4.12 Right to One Hearing and One Appeal

No Member shall be entitled to more than one evidentiary hearing and one appeal on any matter that shall have been the subject of Adverse Action or recommendation.

9.5 HEARING AND APPEAL PLAN FOR NON-MEMBERS

9.5.1 Hearing Procedure

Allied Health Professionals and other Non-members who are not Physicians, Clinical Psychologists or Dentists are not entitled to the hearing and appeals procedures set forth in the Clinical Staff Bylaws. In the event one of these Practitioners receives notice of a recommendation by the Clinical Staff Executive Committee that will adversely affect his/her exercise of Clinical Privileges, the Practitioner and his/her supervising physician, as applicable, shall have the right to meet personally with two Physicians and a Peer assigned by the President of the Clinical Staff to discuss the recommendation. The Practitioner and the supervising physician, as applicable, must request such a meeting in writing to the Clinical Staff Office within 10 working days from the date of receipt of such notice. At the meeting, the Practitioner and the supervising physician, as applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Clinical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected Practitioner, CSEC, and the MCOB.

9.5.2 Appeal

The Practitioner and the supervising physician, as applicable, may request an appeal in writing to the CEO within 10 days of receipt of the findings of the review body. Two members of the Clinical Staff assigned by the chair of the CSEC shall hear the appeal from the Practitioner and the supervising physician as applicable. A representative from the Clinical Staff leadership and from Medical Center leadership may be present. The decision of the appeal body will be forwarded to the MCOB for final decision. The Practitioner and the supervising physician will be notified within 10 days of the final decision of the MCOB.
ARTICLE X
OFFICERS OF THE CLINICAL STAFF

10.1 IDENTIFICATION OF OFFICERS

The Officers of the Clinical staff shall be:

A. President
B. Vice President

10.2 QUALIFICATIONS OF OFFICERS

Officers must be Physician or Dentist Members of the Active Clinical Staff in good standing at the time of their election and must remain Members of the Active Clinical Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.3 NOMINATIONS

All nominations for Officers shall be made by the Nominating Committee (which is described in Article XIII of these Bylaws) with the concurrence of the Chief Executive Officer and the Dean. Any Active Clinical Staff or Ph.D. Clinical Pathologist Staff may submit the name or names of any Member(s) of the Active Clinical Staff to the Nominating Committee for consideration as an Officer candidate. The Nominating Committee shall nominate one or more candidates for each office at least thirty (30) days prior to the election.

The Nominating Committee shall report its nominations for Officers to the Clinical Staff Executive Committee, with the approval of the Chief Executive Officer and the Dean, prior to the election and shall mail or deliver the nominations to the Clinical Staff at least ten (10) days prior to the election. Nominations for Officers shall not be accepted from the floor at the time of the election if voting occurs at a meeting.

10.4 ELECTIONS

The Officers shall be elected by electronic ballot. Only members of the Active Clinical Staff and Ph.D. Clinical Pathologist Staff shall be eligible to vote. The nominee receiving the most votes shall be elected. In the case of a tie, a majority vote of the Clinical Staff Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

10.5 TERMS OF OFFICE

The Officers shall take office on the first day of July following election to office. The Officers shall serve for terms of three (3) years, unless any one of them shall resign sooner or be removed from office. The Officers each shall be eligible for re-election for one additional three (3) year term.
10.6 VACANCIES IN OFFICE

If there is a vacancy in the office of the President, the Vice President shall serve during the vacancy. If there is a vacancy in the office of the Vice President, the Clinical Staff Executive Committee shall appoint an Active Member of the Clinical Staff to serve as Vice President until a special election to fill the position shall occur at a special meeting of the Clinical Staff, called for such purpose, or at a regular Clinical Staff meeting. The replacement Officer shall serve out the term of the original Officer.

10.7 REMOVING ELECTED OFFICERS

Elected Officers may be removed by a two-thirds (2/3) vote of the Members of the Active and Ph.D. Clinical Pathologist Staff, or by a majority vote of the MCOB.

Permissible bases for removal of an elected Officer of the Clinical Staff include, but are not limited to:

A. Failure to perform the duties of the position in a timely and appropriate manner;
B. Failure to satisfy continuously the qualifications for the position;
C. Having an automatic or summary suspension, or corrective action imposed that adversely affects the Officer's membership or privileges;
D. Failure to follow the Clinical Staff Bylaws, Credentials Manual, the Code of Conduct, the Compliance Code of Conduct, or Medical Center policies, procedures, rules, or regulations; or
E. Conduct or statements inimical or damaging to the best interests of the Clinical Staff or the Medical Center, including but not limited to violations of state or federal law or Medical Center policy related to conflict of interest or relationships with vendors (see, for example, Medical Center Policy No. 0013 “Interactions with Vendors, Sales and Service Representatives”).

10.8 DUTIES OF OFFICERS

10.8.1 Duties of the President

The President shall be the spokesperson for the Clinical Staff and shall:

A. Act in coordination and cooperation with the Chief Executive Officer and Medical Center senior leadership in all matters of mutual concern within the Medical Center;
B. Call, preside at, and be responsible for the agenda of all general meetings of the Clinical Staff;
C. Subject to the desire by the MCOB, serve on the MCOB as a nonvoting advisory member;
D. Serve as the Chair of the Clinical Staff Executive Committee and as ex-officio member of all other Clinical Staff committees;
E. Represent the views, policies, needs and grievances of the Clinical Staff to the MCOB, the Clinical Staff Executive Committee, and senior administration of the Medical Center, including the presentation to the MCOB of a report of the Clinical Staff at every meeting of the MCOB or as otherwise requested by the MCOB;

F. Provide oversight of Clinical Staff affairs, including the Clinical Staff application process, committee performance, compliance with The Joint Commission and licensure requirements as they pertain to clinical practice and physician and patient concerns regarding clinical services;

G. Jointly with the Chief Executive Officer, appoint individuals to committees of the Clinical Staff, unless otherwise provided in these Bylaws; and

H. Perform such other functions as may be assigned to him or her by these Bylaws, the Clinical Staff Executive Committee or the MCOB.

10.8.2 Duties of the Vice President

The Vice President shall serve as the Chair of the Credentials Committee and the Vice-Chair of the Clinical Staff Executive Committee. In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. The Vice President shall perform such other duties as the President may assign or as may be delegated by these Bylaws, the Clinical Staff Executive Committee or the MCOB.

ARTICLE XI
CLINICAL STAFF EXECUTIVE COMMITTEE

11.1 DUTIES OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

Subject to the overall authority of the MCOB, the Clinical Staff Executive Committee shall be the executive committee of the Clinical Staff with the following duties to:

A. Monitor, oversee and, where appropriate, manage the quality of clinical care delivered within the Medical Center;

B. Communicate to Members and Non-members of the Clinical Staff regarding clinical practice issues and present the interests of the Clinical Staff to the MCOB;

C. Act for and on behalf of the Clinical Staff in the intervals between Clinical Staff meetings and independently with respect to those matters over which CSEC is given authority in these Bylaws;

D. Establish, review, and enforce the policies applicable to the Clinical Staff, including the Bylaws, the Code of Conduct, and all other Medical Center clinical policies regarding patient care;

E. Control and monitor the membership of the Clinical Staff through oversight of the
appointment, credentialing, and privileging process;

F. Coordinate the activities and general clinical policies of the Medical Center to support an institutional and integrated approach to patient care within the Medical Center;

G. Oversee the functions of performance improvement of the professional services provided by the Clinical Staff within the Medical Center;

H. Advise the Medical Center management regarding the allocation and distribution of clinical resources, including assignments of beds, clinics, operating rooms, and other elements that are important to efficient and effective medical care within the Medical Center;

I. Provide Clinical Staff representation and participation in any Medical Center deliberation affecting the discharge of Clinical Staff responsibilities;

J. Report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff and makes specific recommendations to the MCOB relating to the clinical efforts of the Medical Center;

K. Approve the creation of and oversee committees of the Clinical Staff as necessary for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff;

L. Receive and act on reports and recommendations from the Clinical Staff committees and Departments;

M. Develop a procedure for managing such conflict as may arise between the Clinical Staff and the Clinical Staff Executive Committee on issues related to the adoption of or amendment to Clinical Policies of the Medical Center;

N. Notify Members of the Clinical Staff of its adoption of or amendment to Clinical Staff Policies of the Medical Center, and

O. Perform such other duties as may be assigned to it by the MCOB.

11.2 MEMBERSHIP OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The membership of the Clinical Staff Executive Committee shall consist of the following individuals, all of whom shall be voting members:

- President of the Clinical Staff
- Vice President of the Clinical Staff
- Chief Executive Officer of the Medical Center
- Chief Medical Officer of the Medical Center
- Chief Nursing Officer of the Medical Center
- Chief of Quality and Performance Improvement
- Dean of the School of Medicine
- Designated Institutional Officer for Graduate Medical Education
- Chairs of the Departments of the Medical Center
- Chair, Children’s Hospital Clinical Practice Committee
- Five (5) Clinical Staff Representatives selected by the Clinical Staff and AHPs as provided in Section 11.3
- President of the Nursing Staff

In addition, the President(s) of the GME Executive Council, the Associate VP for Hospital and Clinic Operations, and the Chief Medical Officer of University of Virginia Transitional Care Hospital Post-Acute Division shall serve on the Clinical Staff Executive Committee as a non-voting, ex-officio member(s). When the Department Chair is unable to attend a CSEC meeting, the Deputy may attend and vote in place of the Department Chair. The Deputy will count in establishing a quorum.

In the event that any of the positions listed above are renamed, then the newly named position shall be substituted automatically in lieu of the old position without the necessity for an amendment of these Bylaws.

11.3 SELECTION OF THE CLINICAL STAFF REPRESENTATIVES

There shall be one Member representative on the Clinical Staff Executive Committee from each of the five following areas (the “Clinical Staff Representatives”):

- Primary Care (drawn from General Internal Medicine, General Pediatrics, Family Medicine, Regional Primary Care, and Community Medicine)
- Medical Specialties (drawn from Internal Medicine, Pediatrics, Neurology, Psychiatry, and PM&R)
- Surgical Specialties (drawn from Surgery, Orthopedic Surgery, Neurological Surgery, Urology, Ophthalmology, Otolaryngology, Plastic Surgery, Dentistry, Dermatology, and Obstetrics and Gynecology)
- Hospital-Based Specialties (drawn from Anesthesiology, Pathology, Radiology, Radiation Oncology, and Emergency Medicine)
- AHP Representative (drawn from AHP’s with UVAMC privileges)

All Clinical Staff Representatives, excluding the AHP representative, shall be Active Members of the Clinical Staff in Good Standing, but may not be Department Chairs of the Clinical Departments of the Medical Center. The Nominating Committee may specify requirements necessary to complete nominations for Clinical Staff Representatives. The Nominating Committee shall solicit nominations for the Clinical Staff Representatives from the Clinical Staff as necessary from time to time. The Nominating Committee shall nominate one or more candidates for each Clinical Staff Representatives for which the term is ending, and the Clinical Staff Office shall mail or deliver the nominations to the Clinical Staff at least ten (10) days prior to the election. At a meeting called for such purpose or by electronic means, each Member or AHP shall vote for one nominee from the area applicable to their specialty. The nominees receiving the most votes in each of the five (5) enumerated areas shall become the Clinical Staff Representatives of the Clinical Staff Executive Committee.

Each Clinical Staff Representative shall serve for a term of three (3) years and shall serve until the earlier to occur of (a) the end of such period and until his or her successor is appointed, or (b)
the resignation or removal of such Clinical Staff Representative. A Clinical Staff Representative may be removed upon a two-third (2/3) vote of the Clinical Staff or upon a majority vote of the MCOB. No Clinical Staff Representative shall serve on the Clinical Staff Executive Committee in the capacity of Clinical Staff Representative for more than two (2) consecutive terms.

11.4 MEETINGS OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff Executive Committee shall meet at least (10) times per year at a time and place as designated by the Chair of the Clinical Staff Executive Committee, and the expectation is the each member of the Clinical Staff Executive Committee will attend these meetings. Fifty-one percent (51%) of the membership of the Clinical Staff Executive Committee shall constitute a quorum. Attendance at the Clinical Staff Executive Committee meetings is not assignable for voting purposes. A substitute who is not a deputy may attend a meeting for purposes of information sharing but may not vote by proxy and will not count in the quorum.

11.5 DUTIES OF THE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The President shall serve as the Chair of the Clinical Staff Executive Committee. The duties of the Chair are to:

A. Set the agenda for meetings of the Clinical Staff Executive Committee;

B. Preside at the meetings of the Clinical Staff Executive Committee;

C. Jointly with the Chief Executive Officer, coordinate and appoint committee members to all standing, special and multi-disciplinary committees of the Clinical Staff Executive Committee;

D. Report as appropriate to the Clinical Staff on the activities of the Clinical Staff Executive Committee;

E. In conjunction with the Chief Executive Officer, appoint individuals to serve on the Clinical Staff Committees described in Article XIII or otherwise created by the Clinical Staff Executive Committee; and

F. Report to the MCOB, as required, on the activities of the Clinical Staff Executive Committee and the Clinical Staff.

11.6 DUTIES OF THE VICE CHAIR OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Vice President shall serve as the Vice Chair of the Clinical Staff Executive Committee. The duties of the Vice Chair are to:

A. Preside at the meetings of the Clinical Staff Executive Committee in the absence of the Chair;
B. Present each Credentials Committee report to the Clinical Staff Executive Committee;

C. Assume all the duties and have the authority of the Chair in the event of the Chair’s temporary inability to perform his/her duties due to illness, absence from the community or unavailability for any other reason;

D. Assume all the duties and have the authority of the Chair in the event of his/her resignation as until such time as a successor is designated; and

E. Perform such other duties as may be assigned by the Chair.

11.7 DUTIES OF THE SECRETARY OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Chair of the Clinical Staff Executive Committee shall appoint a Secretary of the Clinical Staff Executive Committee. The Secretary is not required to be a Member. The duties of the Secretary are to:

A. Keep accurate and complete minutes of the meetings of the Clinical Staff Executive Committee;

B. Maintain a roster of the members of the Clinical Staff Executive Committee;

C. Send notices of meetings to the members of the Clinical Staff Executive Committee;

D. Attend to all correspondence of the Clinical Staff Executive Committee; and

E. Perform such other duties as ordinarily pertain to the office of secretary.

11.8 DELEGATING AND REMOVING AUTHORITY OF THE CLINICAL STAFF EXECUTIVE COMMITTEE

The Clinical Staff may from time to time propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose to approve such proposals as provided in this Section.

A. Any Member of the Active Clinical Staff may propose the delegation of additional duties to the Clinical Staff Executive Committee and/or the removal of any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible by notifying the President of the Clinical Staff, in writing, of the proposal.

B. Upon receipt of the proposal the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposal.
C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposal to all members of the Active Clinical Staff for review.

D. In accordance with the provisions of Article XIV of these Bylaws, if not less than fifteen percent (15%) of the Active Clinical Staff request a special meeting to consider any proposal to delegate additional duties to the Clinical Staff Executive Committee and/or to remove any of the duties specified in Article XI for which the Clinical Staff Executive Committee is responsible, the President shall call a special meeting of the Clinical Staff. If not, any such proposal shall not proceed.

E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, any decision to add or remove any duties of the Clinical Staff Executive Committee shall require a majority vote in favor of the proposal by those Active Clinical Staff present at the special meeting.

F. Any such proposal to add or remove any of the duties of the Clinical Staff Executive Committee shall also require the approval of the Medical Center Operating Board.

ARTICLE XII
CLINICAL DEPARTMENTS

12.1. Organization of Clinical Departments

A. The Medical Center and the School of Medicine are components of an academic Medical Center at the University of Virginia. The Members of the Clinical Staff of the Medical Center have faculty appointments in the School of Medicine, and all Clinical Staff are required to have faculty appointments in the School of Medicine or an employment contract with UPG as a condition of appointment to the Clinical Staff. Exceptions to this requirement will be considered only when practitioners are requesting Temporary Privileges under emergency circumstances to meet patient care needs as provided in the Bylaws, for Honorary Members, or such other exceptional circumstances as may be approved by the Chief Executive Officer, the President or the Chair of the Credentials Committee.

B. The Clinical Staff is divided into clinical Departments, and some Departments are further subdivided into clinical Divisions. Each Department is organized as a separate component of the Clinical Staff and shall have a Chair selected and entrusted by the Dean, with the authority, duties and responsibilities specified in Section 12.6. A Division of a Department is directly responsible to the Department within which it functions, and each Division has a Division Chief selected and entrusted with the authority, duties and responsibilities specified in Section 12.9.

C. Departmental status, including the creation, elimination, modification or combination thereof, shall be designated by the Dean. Division status shall be designated upon recommendation of the Chair or Chairs of the applicable Department(s) and approved by the Dean.
12.2 Current Departments

12.2.1 Departments

The current clinical Departments are:

(a) Anesthesiology
(b) Dentistry
(c) Dermatology
(d) Emergency Medicine
(e) Family Medicine
(f) Medicine
(g) Neurological Surgery
(h) Neurology
(i) Obstetrics and Gynecology
(j) Ophthalmology
(k) Orthopedic Surgery
(l) Otolaryngology – Head and Neck Surgery
(m) Pathology
(n) Pediatrics
(o) Physical Medicine and Rehabilitation
(p) Plastic and Maxillofacial Surgery
(q) Psychiatric Medicine
(r) Radiation Oncology
(s) Radiology
(t) Surgery
(u) Urology

12.2.2 Other Clinical Enterprises

For purposes of these Bylaws, Community Medicine and Regional Primary Care shall be treated as “Departments.” The Chief Medical Officer shall be considered the “Chair” of Community Medicine, and the Medical Director of Regional Primary Care shall be considered the “Chair” of Regional Primary Care. The EVPMA on behalf of the MCOB may designate other clinical enterprises within the Medical Center from time to time that shall be considered Departments for purposes of these Bylaws. In such event, the EVPMA on behalf of the MCOB shall designate the person to serve as “Chair.”

12.3 Assignments

Each Member shall be assigned to at least one Department, and if applicable, to a Division within such Department. Members may be granted membership and/or Clinical Privileges in more than one Department or Division consistent with practice privileges granted. For Members with joint appointments in two Departments, the Chairs from each Department shall sign off on the faculty appointment and recommendation of Clinical Privileges.
12.4 Functions of Departments and Divisions

The general functions of each Department and Division, as applicable, include:

A. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department and Division. The number of such reviews to be conducted during the year shall be as determined by the Clinical Staff Executive Committee in consultation with other appropriate committees. The Department, and as applicable, the Division, shall routinely collect information about important aspects of patient care provided in the Department or Division, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department or Division, regardless of whether the Member whose work is subject to such review is a member of that Department or Division;

B. Recommending to the Credentials Committee criteria for the granting of Clinical Privileges (both core privileges and privileges outside the core as well as new or additional Clinical Privileges) and the performance of specified services within the Department or Division;

C. Evaluating and making appropriate recommendations regarding the qualifications of Applicants seeking appointment or reappointment to the Clinical Staff and Clinical Privileges within that Department or Division;

D. Reviewing and evaluating departmental adherence to Clinical Staff and Medical Center policies and procedures and sound principles of clinical practice;

E. Coordinating and integrating patient care provided by the Department’s or Division’s members with patient care provided in other Departments or Divisions and with nursing and ancillary patient care services;

F. Submitting written reports to the Clinical Staff Executive Committee concerning: (i) the Department’s and/or Division’s review and evaluation of activities, actions taken thereon, and the results of such actions; and (ii) recommendations for maintaining and improving the quality of care provided in the Department and/or Division and the Medical Center;

G. Having at least quarterly meetings for the purpose of considering patient care review findings and the results of the Department’s other review and evaluation activities, as well as reports on other Department and Clinical Staff functions;

H. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

I. Accounting to the Clinical Staff Executive Committee for all professional activities within the Department;

J. Appointing such committees or other mechanisms as may be necessary or appropriate to conduct the clinical functions of the Department;
K. Formulating recommendations for Departmental or Division rules and regulations reasonably necessary for the proper discharge of its clinical responsibilities, subject to compliance with Medical Center policies; and

L. Encouraging the continuing education of Members of the Clinical Staff in the Department.

12.5 Department Chairs

A. Each Department other than Community Medicine and Regional Primary Care shall have a Chair who is a Member of the Active Clinical Staff and is appointed by the Dean of the School of Medicine. Department Chairs shall be certified as diplomats of their specialty board or be equivalently qualified. Each Chair shall report and be accountable to the Dean and shall also be accountable to the Clinical Staff Executive Committee and the MCOB for all clinical matters in his or her Department.

B. For purposes of these Bylaws, the Chair for Community Medicine shall be the Chief Medical Officer, and the Chair for Regional Primary Care shall be its Medical Director. The Chief Medical Officer and the Regional Primary Care Medical Director shall have the same responsibilities as to Department Chairs set forth in these Bylaws or the Credentials Manual with respect to Community Medicine and Regional Primary Care.

12.6 Duties of Department Chairs

Each Chair has the following authority, duties, and responsibilities and shall otherwise perform such duties as may be assigned to him or her:

A. Act as presiding officer at Departmental meetings, which shall be held at least quarterly for the purpose of quality monitoring and reporting and such other purposes as may be required by the Department;

B. Attend monthly meetings of the Clinical Staff Executive Committee and other special meetings of the Clinical Staff Executive Committee as may be called from time to time;

C. Report to the Dean and be accountable to the Clinical Staff Executive Committee and the MCOB regarding all professional, clinical and appropriate administrative activities within the Department;

D. Make recommendations regarding the overall clinical policies of the Clinical Staff and the Medical Center;

E. Make specific recommendations regarding criteria-based privileges and suggestions regarding physician faculty within his or her Department and Divisions therein;

F. Assure compliance within his or her Department and any Divisions therein with these Bylaws, the Credentials Manual, and Medical Center policies, and procedures, including but not limited to, implementing a process for effectively communicating to Members of his or her Department and Divisions therein any amendment or revision of these Bylaws, the Credentials Manual, the Code of Conduct, the Compliance Code of Conduct, and any new
or revised Medical Center policy, procedure, rule or regulation;

G.   Sign off and transmit to the Credentials Committee the Department’s recommendations concerning and required documentation in support of Member appointment and classification, reappointment, criteria for Clinical Privileges, results of any investigation or corrective action with respect to Members with Clinical Privileges in his or her Department. Chairs may delegate this responsibility to a senior level designee within the Department subject to prior written notification to and approval by the Chair of the Credentials Committee. Chairs shall ensure that files on each of their faculty with Clinical Privileges that include documentation of FPPE and OPPE data and other activities are securely maintained and support the specifically delineated Clinical Privileges requested;

H.   Implement within his or her Department appropriate actions taken by the Clinical Staff Executive Committee, the MCOB, or the MCOB Quality Subcommittee;

I.    Monitor the quality of patient care and outcomes of care and professional performance rendered by Members with Clinical Privileges in the Department through a planned and systematic process, including but not limited to, FPPE and OPPE, and oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Clinical Staff Executive Committee, the Dean or the President, including evaluating the quality of clinical work performed by each practitioner in the Department at least annually;

J.    Develop, support and implement Departmental programs for retrospective patient care review, ongoing monitoring of clinical and ethical practice, credentials review and privileges delineation, medical education, utilization review, and quality assurance and performance improvement, all as part of the Peer Review process;

K.    Abide by the supervisory requirements when temporary privileges have been granted to a Member in his or her Department or Division;

L.    Participate in every phase of administration of his or her Department, including cooperation with the nursing service and the Medical Center administration in matters such as personnel, supplies, and special regulations, standing orders, and techniques;

M.    Prepare and submit reports pertaining to his or her Department as may be required by the Credentials Committee, the Clinical Staff Executive Committee, the MCOB, or the MCOB Quality Subcommittee;

N.    Responsible for the teaching, education, and research programs in his or her Department;

O.    Ensure that Members and Graduate Medical Trainees within his or her Department and the Divisions therein practice within the scope of their Clinical Privileges, are educated to deliver patient-centered and family-centered care as members of interdisciplinary teams, emphasizing professional and ethical conduct, evidence-based practice, quality improvement approaches and use of informatics to support practice;
P. Facilitate Graduate Medical Trainees’ education and training to achieve those competencies identified as necessary by the ACGME or other applicable entity;

Q. Keep appropriate records of all Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologist practicing within his or her Department;

R. Assess and recommend to the Medical Center resources such as space, number of clinical staff Members, and contract services needed to provide for patient care or treatment;

S. Integrate the Department into the primary functions of the Medical Center to include coordination and integration of interdepartmental and intradepartmental services; and

T. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Dean, the President, the Clinical Staff Executive Committee, the MCOB, or the MCOB Quality Subcommittee.

12.7 Committees of the Departments

The affairs of each Department may be delegated to a designee or to a committee of Department members appointed by the Chair of the Department.

12.8 Division Chiefs

Each Division shall have a Chief who shall be a Member of the Active Clinical Staff in good standing and a member of the Division which he or she is to head, and shall be qualified by training, experience and demonstrated current ability in the clinical area covered by the Division. The Chair of the Department in which the Division functions shall select and remove the Division Chief, and the Division Chief either reports to the Chair of the Department or directly to the Dean in some cases. Division Chiefs shall be certified as diplomats of their specialty Board or be equivalently qualified.

12.9 Duties of Division Chiefs

Each Division Chief shall:

A. Act as presiding officer at Division meetings, to be held as reasonably necessary;

B. Assist in the development and implementation, in cooperation with Department Chairs, of programs to carry out the quality review and evaluation and monitoring functions of the Division, including credentials review and criteria-based privilege delineation, medical education, utilization review, and outcomes for quality and performance improvement, all as part of the Peer Review process;

C. Evaluate the quality of clinical work performed and outcomes for each practitioner in the Division at least annually;

D. Conduct investigations and submit reports and recommendations to the Department Chair regarding complaints from other Members, Non-members, or others regarding Members of the Division as well as regarding the Clinical Privileges to be exercised within his or her
Division by Members or Applicants;

E. Submit reports of the patient care and quality monitoring activities of his or her Division to the Department Chair as required by the Department Chair;

F. Perform any of the duties of the Department Chair described in Section 11.6 above if the Chair has delegated such duties to the Division Chief;

G. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Dean, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, or as otherwise contemplated by these Bylaws or the Credentials Manual; and

H. Sign off and transmit to the Chair the Division’s recommendations concerning and required documentation in support of Member appointment and classification, reappointment, criteria for Clinical Privileges, results of any investigation or corrective action with respect to Members with Clinical Privileges in his or her Division. Division Chiefs shall ensure that files on each of their faculty with Clinical Privileges that include documentation of FPPE and OPPE data and other activities are securely maintained and support the specifically delineated Clinical Privileges requested.

12.10 Medical Directors

The Medical Director coordinates, directs and evaluates all aspects of patient care rendered by the Licensed Independent Providers (faculty, nurse practitioners, and physician assistants) and GME trainees in the assigned Service area. In collaboration with other clinical departments and operational manager, the Medical Director oversees the care of patients being treated in assigned service area.

The Medical Director partners with the Medical Center manager to serve as co-leader of the Unit Based Clinical Leadership (UBL) team for their service area.

12.11 Duties of the Medical Directors

Medical director responsibilities include: regularly attending and leading weekly UBL team and leadership meetings, participating in unit-based patient reviews to identify opportunities for improvement, and have peer to peer dialogues with colleagues as required by Medical Center Policy 0262, “Standards for Professional Behavior”, including the investigation and analysis of adverse events, clinical errors, and incidents, utilizing the institution’s Be Safe program and methods.

Departments and Medical Directors are expected to work together to accomplish the goals of the UVAMC and the Health System.
ARTICLE XIII
CLINICAL STAFF STANDING COMMITTEES

13.1 STRUCTURE

The standing Committees of the Clinical Staff are as set forth in these Bylaws.

13.1.1 Reporting and Accountability to Clinical Staff Executive Committee

All Clinical Staff Committees report, and are accountable, to the Clinical Staff Executive Committee. The Chair of each Clinical Staff Committee shall maintain minutes of each meeting and shall report its activities to the Clinical Staff Executive Committee by submitting a written report on an annual basis or as it is otherwise requested by the Chair or Vice Chair of the Clinical Staff Executive Committee, or as otherwise provided by these Bylaws.

13.1.2 Membership

The membership of the Clinical Staff Committees may consist of Members, Allied Health Professionals, Medical Center administrative staff members, and other professional staff or employees of the Medical Center appointed as provided in these Bylaws. The President and the Chief Executive Officer shall be ex-officio members of all Clinical Staff Committees unless otherwise provided in these Bylaws.

13.1.3 Appointments

Except as otherwise provided in these Bylaws, all chairpersons and members of Clinical Staff Committees shall be appointed jointly by the President and the Chief Executive Officer. Appointments to Clinical Staff Committees shall be for an indefinite period, subject to the discretion of the President and the Chief Executive Officer, or the resignation of the Clinical Staff Committee member. Each appointment shall be annually reviewed by the President of the Clinical Staff and the Chief Executive Officer.

13.1.4 Quorum, Voting and Meetings

A quorum for each Clinical Staff Executive Committee shall be thirty percent (30%) of the members currently serving, unless the decision involves privileging, and/or corrective action of an individual Practitioner or governance in which the quorum shall be fifty-one percent (51%).

All voting and decisions ordinarily shall occur in meetings of the Clinical Staff Committees, but decisions may be made by electronic means as may be reasonably necessary from time to time.

Except as otherwise provided in these Bylaws, all Clinical Staff Committees shall meet at least four (4) times per year, or as otherwise defined in these Bylaws, and as otherwise called by the chair of the Clinical Staff Committee.
13.1.5 Subcommittees

Each Standing Committee may, with the approval of the Clinical Staff Executive Committee, form Subcommittees or Task Forces as appropriate to carry out the charge of the Standing Committee. All such groups shall be considered Committees of the Clinical Staff.

The chair of each Subcommittee shall report its activities to the appropriate Clinical Staff Committee by submitting a written report on an annual basis and maintaining minutes with attendance for each meeting. Subcommittees shall meet at least four (4) times per year and as otherwise called by the chair of the Subcommittee.

13.2 BYLAWS COMMITTEE

The Bylaws Committee shall ensure that the Bylaws of the Clinical Staff are consistent with the Medical Center’s operational needs, current Joint Commission Standards, applicable CMS Conditions of Participation and other CMS requirements and the policies, procedures, rules and regulations of the Medical Center. In performing this function, the Bylaws Committee shall: (a) review the Bylaws on at least on a biannual basis; (b) review proposed Bylaws amendments that may be proposed by Members of the Clinical Staff; (c) develop draft revisions and recommendations regarding proposed amendments to the Bylaws; (d) present proposed revisions to the Clinical Staff Executive Committee and the MCOB for review and approval; and (e) provide each Member a current copy of the Bylaws.

The Bylaws Committee shall meet as necessary, but not less than annually. The President of the Clinical Staff shall serve as Chair of the Bylaws Committee. Only Members of the Clinical Staff serving on the Bylaws Committee shall be eligible to vote on Bylaws Committee matters.

The Bylaws Committee has the power to adopt revisions that are, in its judgement, non-substantial modifications for the purpose of clarifying, reorganizing or updating references, or to correct titles, punctuation, spelling or errors of grammar or expression.

13.3 CREDENTIALS COMMITTEE

The Credentials Committee shall review and evaluate the qualifications of each Applicant for initial appointment, reappointment or modification of appointment to the Clinical Staff in accordance with the procedures outlined in the Credentials Manual and these Bylaws. The Credentials Committee shall recommend to the Clinical Staff Executive Committee and the MCOB appointment or denial of all Applicants to the Clinical Staff and the granting of Clinical Privileges. When appropriate, the Credentials Committee shall interview a Member or Applicant and/or the Chair of the involved Department in order to resolve questions about appointment, reappointment, or change in privileges. The Credentials Committee shall review and make recommendations for revisions to the Credentials Manual from time to time; provided however the Chair of the Credentials Committee, in consultation with the President and the Chief Executive Officer, shall have authority to amend the Credentials Manual. The Credentials Committee shall also serve as the investigatory body for all matters set forth in Article VIII of these Bylaws. The Credentials Committee shall also independently assess the departmental Peer Review process for Members of the Clinical Staff and for Allied Health Professionals in order to ensure that data related to qualifications and performance of individual Practitioners is collected,
regularly assessed, compared to Peers, and acted upon by the Department in a timely manner. When appropriate, the Credentials Committee shall also refer Practitioners to the Physician Wellness Program or Employee Assistance Program, and shall work with these programs to determine appropriate privileges for each Practitioner’s individual circumstances. The Vice President shall serve as chair of the Credentials Committee. Only Members of the Clinical Staff serving on the Credentials Committee shall be eligible to vote on Credentials Committee matters.

13.4 NOMINATING COMMITTEE

The Nominating Committee shall nominate Members to serve as Officers of the Clinical Staff and shall nominate Members for the Clinical Staff Representatives, as provided in these Bylaws. The Nominating Committee shall consist of (i) the immediate past president of the Clinical Staff, who shall serve as Chair of the Nominating Committee, and (ii) six (6) Members of the Active Clinical Staff chosen by the President, subject to confirmation by the Chief Executive Officer and the Dean.

13.5 CANCER COMMITTEE

The Cancer Committee oversees the cancer care delivered within the Medical Center and reports to the Clinical Staff Executive Committee. The Committee promotes a coordinated multidisciplinary approach to patient care management and ensures that an active, supportive care system is in place for patients, families and staff, and will follow the requirements outlined in the most current American College of Surgeons Commission on Cancer Program Standards.

13.6 ETHICS COMMITTEE

The Ethics Committee is an interdisciplinary committee charged with assisting leadership in ensuring consistency between mission and values, organizational behaviors and clinical practice. It has three primary functions, which include conducting education on ethical issues, recommending policies that are ethically important and conducting case reviews with respect to ethical issues.

13.7 GRADUATE MEDICAL EDUCATION COMMITTEE

The Graduate Medical Education Committee oversees all aspects of GME training and patient care practices within the Medical Center. It ensures that each GME Trainee program provides quality educational experiences and meets the requirements set forth in the ACGME Institutional, Common and individual program requirements. Further, the Committee monitors and coordinates issues applicable or common to all programs, such as those raised by external accreditation agencies (AMA, AAMC, ACGME, and NRMP).

13.8 CHILDREN’S HOSPITAL CLINICAL PRACTICE COMMITTEE

The UVA Children’s Hospital Practice Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for children in both the inpatient and outpatient setting. This Committee addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (e.g., pediatric medicine and
surgery, nutrition, nursing, pharmacy, therapies, social work, etc.) in all settings across the continuum of care. The Committee is responsible for review, coordination, and submission of policies and practices that directly impact all aspects of the clinical and family-centered care of children. The Committee provides organizational guidance regarding faculty, staff, Graduate Medical Trainee, nursing, and other clinician training and competency for the clinical care of children.

13.9 OPERATING ROOM COMMITTEE

The Operating Room Committee is an interdisciplinary committee charged to coordinate and standardize the care of patients undergoing surgical or other invasive procedures. This Committee oversees clinical practice related to Pre, Peri and Post procedure care. It has the authority to establish clinical procedure and policy within the Medical Center Operating Rooms and recommend policy related to those procedures outside of the Operating Room. It works collaboratively with other Committees to monitor and improve care and ensure patient safety.

13.10 CLINICAL INFORMATION TECHNOLOGY OVERSIGHT COMMITTEE

The Clinical Information Technology Oversight Committee (CITOC) is charged with providing clinical oversight for the continued development of a comprehensive, integrated clinical information system for the University of Virginia Medical Center. CITOC will make recommendations about the use and functionality of all current and future information systems that support clinical care. This will include but not be limited to Epic applications, MedHost, PACS and other clinical information systems. This oversight will assure that system change requests, enhancement requests and deployment across systems promotes integrated work and information flows throughout the clinical areas. The Committee will lead the design of processes and programs which strategically use clinical information systems to transform and continually improve the way clinical care is rendered with the primary purposes of enhancing patient safety, improving the quality of care and outcomes, facilitating clinical education and clinical research. Secondary goals are to improve efficiency and reduce the cost of care.

13.11 PATIENT CARE COMMITTEE

The Patient Care Committee is an interdisciplinary committee charged with coordination and implementation of the Plan for Provision of Care for both the inpatient and outpatient setting. This Committee addresses clinical practice issues that extend beyond the scope of practice for a single professional discipline (e.g., medicine, nutrition, nursing, pharmacy, therapies, social work, etc.) in all settings across the continuum of care.

13.12 QUALITY COMMITTEE

The Quality Committee is responsible for defining, prioritizing, overseeing and monitoring the performance improvement activities, including patient and environmental safety, within the Medical Center. The primary duties of the Quality Committee include analyzing and aggregating institutional performance data, monitoring performance improvement efforts for effectiveness, and making recommendations to the Patient Care Committee and the Clinical Staff Executive Committee for changes in clinical practice and to Medical Center Executives for changes in operations. The Quality Committee coordinates the acquisition of performance
improvement information from Regional and Departmental teams to improve organizational performance.

13.13 PATIENT SAFETY COMMITTEE

The Patient Safety Committee is an interdisciplinary committee charged with the coordination and implementation of programs for ensuring patient safety within the Medical Center, including directing and overseeing proactive risk reduction and patient safety. This Committee conducts a survey of clinical and medical center staff to identify areas for improvement in the understanding of patient safety principles and actions. The Patient Safety Committee evaluates trends from quality reports, adverse event analysis and other sources and recommends appropriate actions to improve patient safety throughout the medical center.

13.14 PATIENT GRIEVANCE COMMITTEE

The Patient Grievance Committee provides oversight to the processes set forth in Medical Center Policy No. 0070 (“Patient Concerns and Grievances”), and assures compliance with all other applicable laws and regulations. The Committee identifies trends and patterns in grievances and recommends corrective action when indicated. The Patient Grievance Committee reports matters of significance to the Quality Subcommittee of the Medical Center Operating Board.

13.15 PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Subcommittee is an interdisciplinary committee charged with the institutional oversight of the use of pharmaceutical and other therapeutic products. This Committee reports to the Clinical Staff Executive Committee and is authorized to develop and maintain a Medical Center formulary that is financially responsible and clinically effective.

13.16 OTHER COMMITTEES

The Chief Executive Officer and the President of the Clinical Staff may designate such other standing committees of the Clinical Staff Executive Committee as may be necessary from time to time for compliance with accreditation standards, regulatory requirements and governance of the Clinical Staff. In such event, each such committee shall be subject to the provisions of Section 13.1. In addition, the Medical Center may create, from time to time, any committees deemed necessary.

ARTICLE XIV
MEETINGS OF THE CLINICAL STAFF

14.1 REGULAR MEETINGS

Regular meetings of the Clinical Staff shall be held at a time mutually determined by the President and the Chief Executive Officer. One week prior to the time of the meeting a written or printed notice shall be delivered either personally, by mail or by electronic mail to each Member stating the date, time and place of the meeting. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting.
14.2 SPECIAL MEETINGS

The President or Vice President of the Clinical Staff, the Chief Executive Officer, the Clinical Staff Executive Committee, or the MCOB may call a special meeting of the Clinical Staff at any time. The President of the Clinical Staff shall call a special meeting within fourteen (14) days after receipt by him or her of a written request for same signed by not less than fifteen percent (15%) of the Active Clinical Staff and stating the purpose for such meeting.

At least twenty-four (24) hours prior to the meeting a written or printed notice stating the date, time and place of the special meeting of the Clinical Staff shall be delivered, either personally, by mail, or by electronic mail to each Member. The attendance of a Member at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

14.3 QUORUM

Except as otherwise provided herein where a higher quorum is required, the presence of fifty (50) Members entitled to vote at any regular or special meeting shall constitute a quorum. No official business may be taken without a quorum except as otherwise provided herein.

14.4 ATTENDANCE REQUIREMENTS

Each Member of the Active Clinical Staff is encouraged to attend all regular Clinical Staff meetings in each year unless unusual circumstances prevent their attendance as well as meetings of all committees to which they have been appointed as members. The Honorary Clinical Staff are encouraged to but are not required to attend.

14.5 ACTION BY ELECTRONIC MEANS

Unless otherwise required by these Bylaws, whenever these Bylaws require the vote of or action by the Clinical Staff or by the Clinical Staff Executive Committee, such vote or action may be taken by electronic means.

ARTICLE XV
CONFIDENTIALITY, IMMUNITY, AND RELEASES

15.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising Clinical Privileges within this Medical Center, an Applicant:

A. Authorizes the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives, to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant’s professional ability and qualifications and any other matter within the scope of this Article;
B. Authorizes all persons and organizations to provide information concerning such Applicant to the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, and their members and authorized representatives;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any third party, the Clinical Staff, the Medical Center, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives, for any matter within the scope of this Article; and

D. Acknowledges that the provisions of this Article are express conditions to an application for Clinical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at the Medical Center.

15.2 Confidentiality of Information; Breach of Confidentiality

A. Clinical Staff, Department, Division, Committee, Clinical Staff Executive Committee, MCOB, MCOB Quality Subcommittee, Board of Visitors, or any other applicable minutes, files, and records within the scope of this Article shall, to the fullest extent permitted by law, be confidential. Dissemination of such information and records shall only be made where permitted by law, or pursuant to officially adopted policies of the Medical Center or Clinical Staff, or, where no officially adopted policy exists, only with the express approval of the Clinical Staff Executive Committee or its designee, or to the appropriate University personnel and officers in connection with the discharge of their official duties.

B. Because effective Peer Review and consideration of the qualifications of Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Clinical Staff Departments, Divisions, or committees, is outside appropriate standards of conduct for this Clinical Staff and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the Clinical Staff Executive Committee may undertake such corrective action as it deems appropriate.

15.3 Immunity

The Clinical Staff, the Medical Center, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, and the Board of Visitors, along with their members and authorized representatives and all third parties, shall be immune, to the fullest extent permitted by law, from liability to an Applicant or Member for damages or other relief for any matter within the scope of this Article.

For the purpose of this Article, “third parties” means both individuals and organizations from whom information has been requested by the Medical Center, the Clinical Staff, the Clinical Staff Executive Committee, the MCOB, the MCOB Quality Subcommittee, or the Board of Visitors, or any of their members or authorized representatives.
15.4 Scope of Activities and Information Covered

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization’s activities concerning, but not limited to:

A. The application for appointment to the Clinical Staff for the granting of Clinical Privileges;

B. Periodic reappraisals for reappointment to the Clinical Staff or renewals of Clinical Privileges;

C. Corrective action, including summary or automatic revocation or suspension;

D. Hearings and appeals;

E. Medical care evaluations;

F. Utilization reviews;

G. Other Medical Center, Department, or Division, committee, or Clinical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

H. FPPE, OPPE and other Peer Review activities and organizations Virginia Board of Medicine, the National Practitioner Data Bank pursuant to HCQIA, and similar reports; and

I. To the greatest extent permitted by law, all other actions taken in pursuit of activities provided for under these Bylaws.

The acts, communications, reports, recommendations, and disclosure referred to in this Section may relate to a Practitioner’s professional qualifications, clinical competency, character, mental and emotional stability, physical condition, ethics, malpractice claims and suits, and any other matter that might directly or indirectly have an effect on patient care.

15.5 Releases

Each Applicant or Member shall, upon request of the Clinical Staff or Medical Center, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.
ARTICLE XVI
AMENDMENT OF BYLAWS AND CLINICAL POLICIES

16.1 AMENDMENT OF BYLAWS

The Allied Health Professional Credentialing Manual is part of the Clinical Staff Bylaws and shall have the same option and amendment process as these Bylaws.

16.1.1 Annual Update

The Clinical Staff Bylaws shall be reviewed at least annually by the Bylaws Committee and updated as necessary.

16.1.2 Proposals to the MCOB

The Clinical Staff shall have the ability to adopt Bylaws, and amendments thereto, and to propose them directly to the MCOB as provided in these Bylaws.

16.1.3 Process for Amendment

A. Consideration shall be given to amendment of these Bylaws upon the request of the President, the Vice President, the Chief Executive Officer, the Clinical Staff Executive Committee, the MCOB, upon a written petition signed by at least ten percent (10%) of the Active Clinical Staff entitled to vote, or upon recommendation by the Bylaws Committee.

B. All proposed amendments to the Bylaws shall be delivered to the Clinical Staff Executive Committee, which shall review and approve, disapprove, or offer modification, as appropriate.

C. In the event the Clinical Staff Executive Committee does not approve a request for amendment of the Bylaws that is requested by at least ten percent of the Active Clinical Staff members seeking the amendment may ask the President of the Clinical Staff to present the request for amendment to the MCOB. The President of the Clinical Staff shall present the petition seeking amendment of the Bylaws to the MCOB at the next scheduled meeting of the MCOB. The MCOB shall review the petition and approve, disapprove, or modify the request for amendment of the Bylaws.

D. Any amendment(s) to the Bylaws adopted by the Clinical Staff Executive Committee shall be submitted to the Active Clinical Staff and the MCOB for review and approval, disapproval or modification, as appropriate.

E. A minimum of fifty (50) Members of the Active Clinical Staff shall vote in favor or against any proposed amendments to the Bylaws. In order to approve amendments to the Bylaws, a majority of those members of the Active Clinical Staff who vote must vote in favor. Any vote regarding amendments to the Bylaws may be by electronic means.
16.1.4 Review and Action by the MCOB

Proposed Bylaws or amendments shall become effective when approved by the MCOB or on another date as mutually agreed to by the MCOB and Clinical Staff Executive Committee. In the event proposed Bylaws or amendments are not approved or are substantially changed upon MCOB review, such Bylaws or amendments shall be referred to the Bylaws Committee, which shall attempt to resolve the differences among the Clinical Staff or the Clinical Staff Executive Committee and the MCOB. The Clinical Staff, Clinical Staff Executive Committee, or the MCOB may not unilaterally amend these Bylaws.

16.2 Proposing, Adopting and Amending Clinical Policies of the Medical Center

In addition to the policy and procedures set forth in Medical Center Policy No. 0001 (“Medical Center Policy on Policy Development, Review and Approval”) regarding the adoption of or amendment to Medical Center policies, the Clinical Staff may from time to time propose the adoption of or amendment to clinical policies of the Medical Center whenever the Active Clinical Staff votes at a special meeting of the Clinical Staff called for such purpose to approve such proposals as provided in this Section 16.2.

A. Any Member of the Clinical Staff may propose the adoption of a new Medical Center clinical policy or the amendment of a current Medical Center clinical policy by notifying the President of the Clinical Staff, in writing, of the proposed policy or policy amendment.

B. Upon receipt of the proposed policy or policy amendment, the President will seek legal review of the proposal to ensure legal sufficiency and compliance. Any changes necessitated by law or regulation shall be made to the proposed policy or policy amendment.

C. Once the legal review is complete, the Clinical Staff Office shall circulate the proposed policy or policy amendment to all members of the Active Clinical Staff for review.

D. In accordance with the provisions of Article XIV of these Bylaws, if not less than ten percent (10%) of the Active Clinical Staff request a special meeting to consider the policy or policy amendment, the President shall call a special meeting of the Clinical Staff. If not, the policy or policy amendment shall not proceed.

E. A quorum for any such special meeting of the Clinical Staff shall be as provided in Section 14.3 of these Bylaws. If a quorum is present at the special meeting, and a majority of the Active Clinical Staff present at the special meeting approves the proposed policy or policy amendment, then the proposal shall be submitted to the Committee of the Clinical Staff (e.g., Credentials Committee, Quality Committee, Patient Care Committee, etc.) that is responsible for the clinical area to which the proposal relates in accordance with Medical Center Policy No. 0001.

F. If the appropriate Clinical Staff Committee approves the proposed policy or policy amendment, it shall be forwarded to the Clinical Staff Executive Committee for proposed adoption in accordance with the provisions of Medical Center Policy No. 0001.
16.3 Distribution of Bylaws

Each Member shall be provided with on-line access to these Amended and Restated Clinical Staff Bylaws. If at any time amendments are made to the Bylaws, each Member shall be notified and provided with on-line access to such amendments.