

LALLIE KEMP MEDICAL CENTER STAFF BYLAWS

Table of Contents

	Page
Preamble	3
Article I: Name and Purpose	4
Article II: Definitions	6
Article III: Medical Staff Membership	8
A. Medical Staff Appointment	8
B. Criteria and Qualification for Membership	8
C. Nondiscrimination	9
D. Duties and Responsibilities	9
Article IV: Duration of Membership, Conditions, and Categories	11
A. Duration Of Membership And Conditions	11
B. Categories of the Medical Staff	11
1. Member of Medical Staff	11
a. Provisional Membership	11
b. Active Membership	12
c. Courtesy Membership	12
d. Consulting Membership	13
2. Non-Members of the Medical Staff	13
a. HCSA Affiliated Medical Staff	13
b. Non-HCSA Affiliated Medical Staff	13
c. Graduate Medical Education Incumbents	14
Article V: Credentialing Procedure: Appointment and Re-appointment	15
A. Appointment Process	15
1. Processing of Application for Initial and Reappointments	15
2. Presentation of the completed application	18
3. Department Chairperson Review:	19
4. Credential's Sub-Committee Review and Recommendation Action	19
5. Medical Executive Committee Action	20
6. Governing Board Action	20
7. Basis for Recommendation for Action	20
8. Conflict Resolution	20
9. Notice of Final Decision	20
B. Reappointment Process	21
1. Procedure for Reappointment	21
C. Provisional Appointment Review (Upgrade) Process	23
Article VI: Clinical Privileges	24
A. General Clinical Privileges	24
B. Temporary Clinical Privileges	24
C. Telemedicine Clinical Privileges	25
D. Disaster Clinical Privileges	25
E. Process for Developing Criteria for Granting New Privileges	27
Article VII: Organization of Departments and Officers	28
A. Organization of Departments	28
B. Chairperson Qualification	28
C. Election of Department Chairpersons	28

D. Roles and Responsibilities of the Department Chairperson	28
E. Meetings of the Department	29
F. Meeting Attendance Requirements	29
G. Tenure of the Department Chairperson	29
Article VIII. Committees	30
A. Medical Executive Committee:	30
1. Composition/Committee Structure	30
2. Term of Office	30
3. Election of Officers	30
4. Eligibility of Officers	30
5. Duties of Officers	31
6. Duties of Medical Director	31
7. Quorum	32
8. Meetings	32
9. Special Meetings	32
10. Removal from Office	32
11. Duties	32
B. Quality Sub-Committee	32
C. Credentials Sub-Committee	34
1. Duties of the Credentials Sub-Committee	35
2. Meeting Quorum	35
3. Reporting	36
Article IX: Fair Hearing	36
A. Right to Fair Hearing	37
B. Notice of proposed action	37
C. Scheduling of Fair Hearing	38
D. Composition of Hearing Committee	38
E. Representation	38
F. Process/Agenda	38
Article X: Corrective Action	40
A. Reporting and investigating	40
B. Procedure after investigation	40
Article XI: Suspensions	41
A. Temporary Suspensions	41
1. Cause	41
2. Effective time frames	41
3. Duty to Enforce	41
4. Notice to practitioner	41
5. Imposition of Temporary Suspension	41
B. Automatic Suspension and Automatic Termination	41
1. Cause	41
2. Effective upon imposition	42
3. Entitlement to fair hearing process	42
C. Summary Suspensions	42
1. Causes	42
2. Effective upon imposition	43
3. Reporting Procedure	43
4. Care of the Suspended Practitioner Patients	43
Article XII. Review, Revision, and Amendment	43
A. Bylaws, review revision, adoption and amendment	44
B. Rules and Regulations and other related Medical Staff Policies and Procedures: Review, Revision, adoption, and amendment	44
Article XIII. Adoption	44

**Louisiana State University/Health Care Services Division
LALLIE KEMP MEDICAL CENTER
MEDICAL STAFF BY-LAWS**

PREAMBLE

Recognizing that the, Medical Staff has the primary function to approve and amend medical staff bylaws, to provide oversight of the quality of care, treatment and services, and accepts this responsibility, subject to the ultimate authority of the hospital Governing Body (the Louisiana State University Board of Supervisors), and that the best interest of the patients are protected by concerted effort, the physicians practicing in LSU-HCSD Lallie Kemp Medical Center hereby organize themselves in conformity with the Bylaws, Rules and Regulations, and Polices hereinafter stated.

LSU- HCSD Lallie Kemp Medical Center, Independence, Louisiana (“Hospital”) is not a corporation but is a unit of the Health Care Services Division of the Louisiana State University. The functions of the Governing Body are carried out by persons statutorily designated and legally responsible for the conduct of the Hospital. The Administrator of LSU- HCSD Lallie Kemp Medical Center, the Executive Vice President/Chief Executive Officer of the Health Care Services Division, and the Senior Staff, constitute representatives of the Governing Body who have established principles of regulation by which the Hospital is, and shall be, operated. These individuals serve at the pleasure of the Board of Supervisors of Louisiana State University in accordance with rules and regulations of the State Department of Civil Service and by policies, rules, and regulations of the Louisiana State University Health Care Services Division. A statutorily created Community Advisory Committee serves as a liaison between the Hospital and the community. The Hospital Director shall have actual authority of administration of the Hospital and shall serve as liaison between the Medical Staff and Governing Body (the term “Governing Body” shall apply to the Board of Supervisors of the Louisiana State University).

The mission of Lallie Kemp Hospital is to provide accessible quality primary health care.

ARTICLE I: NAME AND PURPOSE OF THE MEDICAL STAFF

- A. The name of this organization is the “MEDICAL STAFF OF LALLIE KEMP MEDICAL CENTER”
- B. The purpose of this organization is:
1. To promote the health of the people of Louisiana by providing a leadership role in the delivery of medical care through organization performance improvement activities to enhance the quality and safety of care, treatment, and services provided to patients in an efficient manner in support of the hospital’s mission statement. This includes assuming the responsibility to oversee care, treatment, and services provided by practitioners with clinical privileges, so as to protect patients from harm as well as the responsibility of being accountable to and supporting the mission of the Louisiana State University/Health Care Services Division (LSU/HCS);
 2. To support this work, the organized medical staff of Lallie Kemp Medical Center will have a process to initiate, develop, amend, and approve medical staff bylaws, rules and regulations, and policies that describe the organizational structure of the medical staff and the rules for its self-governance;
 3. To select and remove medical staff officers;
 4. To determine the mechanism for establishing and enforcing criteria and standards for medical staff membership;
 5. Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges;
 6. To determine the mechanisms for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges;
 7. To protect the medical staff as well as individual members from being so ineffective that traditional prerogatives cannot be maintained and to protect members from abuse of authoritative positions;
 8. To protect the hospital as well as LSU/HCS from legal problems that might arise if the agency does not fulfill its fiduciary responsibility for the qualifications and performance of all individuals providing health care services within the hospital and clinics.
 9. To provide an efficient structure and methodology for accomplishing medical staff functions;
 10. To provide for the thoughtful selection, orientation, and evaluation of medical staff leaders;
 11. To acknowledge and commit the medical staff’s integrated relationship to the rest of the hospital through the continuous quality improvement/performance improvement and general quality management plans;

12. To establish a framework for self-governance of medical staff activities and accountability to the Board;
13. To provide education about practitioner health, address prevention of physical, psychological, or emotional illness, and facilitate confidential diagnosis, treatment, or rehabilitation of practitioner-colleagues who suffer from a potentially impaired condition.
14. To provide leadership in activities related to patient safety;
15. To provide oversight in the process of analyzing and improving patient satisfaction.

ARTICLE II: DEFINITIONS

- A. **Advanced Practice Registered Nurse (APRN):** a licensed registered nurse who is certified by a nationally recognized certifying body, such as the American Nurses Credentialing Center, as having an advanced nursing specialty and who meets the criteria for advanced practice registered nurse as established by Louisiana State Board of Nursing. A nurse licensed as an APRN shall include, but not be limited to the following functional roles: Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP) and Registered Nurse Anesthetist (RNA).
- B. **Board:** the LSU/HCSO officials and designees who serve as the governing authority.
- C. **Chief Executive Officer “CEO”**, the administrative head of Lallie Kemp Medical Center also known as the Hospital Administrator, who acts as the local agent for the Board.
- D. **Chief of Staff:** the highest ranking elected member of the medical staff and is Chairperson of the Medical Executive Committee with the right to appoint members of the Medical Staff to serve on sub-committees and workgroups.
- E. **Department:** one of three groupings of the medical staff organized for the purpose of accomplishing medical staff functions.
- F. **Faculty:** staff physicians who have completed residencies and hold faculty appointments in a school of Medical Education.
- G. **Fellow:** physicians who have completed residency and are pursuing further training in other subspecialties.
- H. **HCSO or Health Care Services Division:** the LSU branch which has budgetary and administrative oversight over the hospital.
- I. **Licensed Independent Practitioner (LIP):** Any individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges. Practitioners with advanced degrees are included, such as psychologists, optometrists, and podiatrists.
- J. **Medical Director:** a physician appointed by the Governing Board to act as liaison among the medical staff, hospital CEO, and Governing Board Officials of LSU/HCSO.
- K. **Medical Student:** those who are currently enrolled in medical school. They do not have an M.D. degree.
- L. **Medical Executive Committee or MEC:** the medical governing organ of the hospital composed of elected and appointed members of the medical staff as detailed in this document. This committee is accountable to the Governing Board.

- M. **Medical Staff:** licensed physicians, dentists, oral surgeons, podiatrists, optometrists, nurse practitioners, and certified registered nurse anesthetist who as practitioners have been granted appointment and privileges by the Governing Board and who operate professionally in this hospital under these bylaws, rules and regulations, and policies.
- N. **Patient:** an individual who receives care, treatment, and services.
- O. **Patient encounters:** any admission, formal consultation, invasive diagnostic or therapeutic procedure.
- P. **Practitioner:** Any individual who is qualified to practice health care profession (for example, a physician or advanced practice nurse) and is engaged in the provision of care and services. (Practitioners are required to be licensed as defined by law).
- Q. **Peer:** an individual in the same professional discipline.
- R. **Resident:** physicians have completed medical school and have earned an M.D. degree. They practice medicine in a supervised setting for a specified number of years to complete training in a specific field.
- S. **Surgery Services Department Chairperson, Medicine Service Department Chairperson, Ambulatory Services Department Chairperson:** the principal person of each service responsible for organizing and monitoring all clinical and administrative activities, clinical privileges, and quality management activities within the service.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

A. Medical Staff Appointment:

Appointment to the Medical Staff of the Hospital is a privilege that shall be extended only to competent professionals who continuously meet the qualifications, standards, and requirements as set forth in these Bylaws and associated policies of the Medical Staff and Hospital.

B. Criteria and Qualifications for Membership

1. Appointees to the medical staff will include licensed independent practitioners including physicians (doctors of medicine and/or osteopathy), dentists, oral surgeons, optometrists, podiatrists, and other non LIP, such as advanced practice registered nurses, holding a license to practice in the state of Louisiana, who can document their background, experience, training, judgment, individual character, and demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure the Medical Staff, MEC, and LSU/HCS D Board that any patient treated by them will be given high quality patient care.
 - Advanced Practice Registered Nurses are credentialed and privileged through the bylaws, rules and regulations, and policies of the Medical Staff:
 - may vote and participate fully at all department and committee meetings to which he/she is assigned
 - may not vote at any meetings of the full medical staff or hold elected office
2. Appointees to the medical staff will be in accordance with the Bylaws, Rules and Regulations, and other policies as recommended by the MEC and the LSU/HCS D Governing Board.
3. All practitioners must have either a written contract or an employee-employer relationship with the hospital and HCS D as a requirement for medical staff membership. Hence, Lallie Kemp Medical Center has a closed medical staff.
4. Decisions for medical staff inclusions are based on the need and ability of the institution to carry out its mission.
5. All appointees have clinical privileges that define the scope of the patient care services that they may provide independently in the hospital and clinics.
6. Advance Practice Registered Nurses who are members of the Medical Staff must provide for a valid collaborative agreement with a physician who is a member of the Lallie Kemp Medical Center Medical Staff annually.
7. Telemedicine practitioners, unless credentialed and privileged as set forth in these bylaws, will not be considered as members of the medical staff.
8. The Governing Board has the right and authority to interpret standards for medical staff membership and may make standards for membership more stringent provided that the higher standards are applied fairly and on a non-discriminatory basis.

C. NONDISCRIMINATION:

Medical staff appointments or privileges will never be denied on the basis of sex, race, religion, creed, color, sexual orientation, national origin, or on the basis of any criterion unrelated to the delivery of quality patient care in the Hospital, to professional qualifications, to the Hospitals purposes, needs and capabilities.

D. DUTIES AND RESPONSIBILITIES

Medical Staff membership implies the following non-exclusive list of duties:

1. Provide patients with continuous, timely, safe, and appropriate care at or greater than the generally recognized professional level of quality and efficiency required and supervise the work of any allied health professional under his/her direction.
2. Follow hospital compliance policies and plan, the code of ethics, the Rules of Conduct as well as the provisions for conflict resolution as promulgated by this hospital and LSU/HCSO. It is noted that failure to adhere to compliance policies and plan may expose medical staff members to a termination of his/her contract and/or employee-employer relationship with the hospital and HCSO.
3. Abide by all Bylaws, Policies, and Rules and Regulations of the Medical Staff and hospital as they exist from time to time during the term of appointment.
4. Shall meet the qualification of continuing medical education as set forth by their respective licensing board and should be relevant to his/her area of practice. The practitioner may submit the CME certificates or he/she may sign the Continuing Medical Education attestation statement, attesting he/she has fulfilled the requirements set forth by their licensing board and acknowledging that failure to provide proof of program certificates will constitute a misrepresentation, or misstatement in or, omission from the application and which will constitute cause for denial of appointment or cause for summary dismissal from the medical staff.
5. Maintain patient privacy and confidentiality in all matters including the prohibition of releasing one's passwords and/or PIN numbers to others in computerized information systems.
6. All members of the medical staff are required, when requested, to participate in all hospital quality management and performance improvement activities; medical staff and non-medical staff work groups and committees, and hospital committees.
7. Members are encouraged to attend meetings of the Medical Staff, Departmental Meetings, and Workgroups to which they have been assigned. Meeting attendance will not be used in evaluating members at the time of reappointment.
8. Burden of Providing Information:
 - A. The applicant shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. Information such as:

- hospital affiliation(s)/appointment(s) or medical staff membership(s) and clinical privileges (including voluntary or involuntary suspension, diminution, or non-renewal)
- Licensure status (including current or pending investigations/challenges, or voluntarily or involuntarily suspensions, revocations, or restrictions)
- letters of reference, including peer references,
- medical mal-practice information (including liability claims involvement),
- any removal from a managed care organization's provider panel for quality-of care reasons or unprofessional conduct,
- any current criminal charges pending, and any past charges and convictions of misdemeanors or felonies, and
- other items deemed necessary for the process.

B. Should information provided in the application form change during the course of the appointment term, the appointee has the burden to **immediately** provide information about such change to the hospital Medical Staff Office, Medical Director, and/or Chief Executive Officer. The following requires immediate notification:

- 1) professional license or registration in any state is voluntarily or involuntarily suspended, revoked, restricted, or has expired which requires an automatic and immediate suspension, revocation, or restriction respectively of his/her staff appointment and clinical privileges.
- 2) medical staff membership or clinical privileges at another facility that are voluntary or involuntary suspended, reduced, or non-renewed; or medical staff privileges or membership at another facility that voluntary or involuntary suspended, diminution, revocation or non-renewed while under investigation or in return for not conducting an investigation which requires automatic and immediate suspension, revocation, or restriction respectively of his/her staff appointment and clinical privileges.
- 3) Federal Drug Enforcement Agency (DEA) license or State Narcotics license has been suspended, revoked or restricted or placed on probation, which requires automatic and immediate suspension revocation, restriction, or probation placement respectively on the right to prescribe controlled substances;
- 4) Notice of proposed or pending sanctions against the member in connection with Medicare, Medicaid, or Champus participation which may result in loss of contract/employment to participate in this hospital.
- 5) Notice of being dropped from participation with managed care organization in contract with the hospital.
- 6) Failure to maintain malpractice insurance, if required to do so, which requires automatic and immediate suspension of staff appointment and clinical privileges.
- 7) any current criminal charges pending, and any past charges and convictions of misdemeanors or felonies.

None of the sanctions which automatically result from such conditions listed above are subject to the right of fair hearing.

ARTICLE IV: DURATION OF MEMBERSHIP, CONDITIONS, AND CATEGORIES

A. DURATION OF MEMBERSHIP AND CONDITIONS

1. All initial appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Governing Board shall act on appointments and reappointments only after there has been a recommendation from the Credentials Sub-Committee and the Medical Executive Committee.
2. All appointments to the Medical Staff will be considered valid for a maximum of 24 months from the date of last appointment.
3. Temporary status appointments are valid for one hundred twenty (120) days.
4. Termination of Membership: Professional Staff membership may be voluntarily terminated by written notification to the Medical Director or designee or the Credentials Sub-Committee. Medical Staff membership is automatically terminated at termination of employment.

B. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff membership shall be divided into 1) Provisional, 2) Active, 3) Courtesy, and 4) Consulting. The following practitioners will not be considered members of the hospital medical staff: (1) HCSD Affiliated Practitioners, (2) Graduate Medical Education Incumbents.

All initial appointees, regardless of staff category, will be in provisional status for a minimum period of twelve months prior to being eligible for advancement.

1. Member

a. PROVISIONAL MEMBERSHIP:

1) Qualifications:

- i) All initial applicants to the medical staff shall be assigned provisional status category of membership twenty-four (24) months from the date of the initial appointment.
- ii) The Governing Board may approve advancement after twelve (12) months upon the recommendation of the Medical Executive Committee, during which time the activities of the member shall be reviewed. The review shall be to evaluate the members (1) proficiency in the exercise of clinical privileges initially granted; and (2) overall eligibility for continued membership and advancement within staff categories.
- iii) If the provisional staff member has satisfactorily demonstrated the ability to exercise clinical privileges initially granted and otherwise appears qualified for continued membership, the member shall be eligible for placement in the active, courtesy, or consulting staff, as appropriate, upon recommendation of the Medical Executive Committee and upon approval of the Governing Board.
- iv) Continuation to the provisional staff appointment may be made by the Governing Board but may not exceed one additional twelve (12) month term, at which time the failure to advance from provisional staff to the active, courtesy, or consulting staff shall be deemed a termination of the practitioner's staff appointment. A recommendation by the Medical Executive Committee or a decision by the

Governing Board that a practitioner not be advanced from provisional staff which recommendation or decision would result in the termination of the practitioner's membership, shall be an adverse recommendation or adverse decision; and the practitioner shall be given notice of such action and shall have rights to the fair hearing process; however, continuation of provisional status shall not be deemed to be an adverse recommendation or adverse decision.

- v) Provisional medical staff members with admitting privileges provide either personally, or through another qualified member, (equally-credentialed practitioner), timely and continuous care for their patients in the hospital.

2) *Prerogative:*

- i) Provisional status members may fully participate and vote at assigned department and committee meetings.
- ii) Provisional status members may not vote at any meetings of the full medical staff and may not hold any elected office or medical staff department chair position.

b. ACTIVE MEMBERSHIP:

1) *Qualifications:*

- i) Active status members are those practitioners who routinely serve as attending physicians, admit patients to the hospital or who provide other clinical services for patients at the hospital. Members of the active staff shall be required to attend ten (10) patients within a two (2) year reappointment cycle. Practitioners who do not serve as attending practitioners must have worked a minimum of ten (10) days within the two (2) year reappointment cycle.
- ii) Active medical staff members with admitting privileges provide either personally or through another qualified member, (equally-credentialed practitioner) timely and continuous care for their patients in the hospital.

2) *Prerogative:*

Active medical staff members, who are LIPs, are eligible to vote, nominate and hold elected offices and medical staff department chairperson positions and serve on medical staff committees as a voting member.

c. COURTESY MEMBERSHIP:

1) *Qualifications:*

- i) Practitioners who do not wish to become members of the active staff and do not routinely admit patients, attend patients, or provide other clinical services for patients.
- ii) Courtesy staff membership allows the appointee to have no more than ten (10) admissions or surgical procedures a two (2) year reappointment cycle.
- iii) Medical staff members in this category, with admitting privileges provide either personally, or through another qualified member, (equally credentialed practitioner), timely and continuous care for their patients in hospital

2) *Prerogative:*

- i) Courtesy staff membership allows the practitioner to attend and participate in medical staff meetings (departmental and full medical staff) without voting rights

- ii) Courtesy status members may not hold any elected office or medical staff department chair position.

d. CONSULTING MEMBERSHIP:

1) *Qualifications:*

Consulting staff membership status is a special appointment established for those practitioners who provide their expertise to consult with practitioners on the medical staff concerning medical care and treatment of their patients. Because of their very limited and specialized activity in the hospital, these practitioners may not be permitted to admit patients. They are recognized by the healthcare community as an authority within his/her specialty, usually on the faculty of a healthcare teaching institution.

2) *Prerogatives:*

Appointees to the consulting staff may attend by invitation as a visitor all medical staff or department meeting, but may not vote, may not hold office or serve on any committees except for special workgroups.

2. NON-MEMBERS OF THE MEDICAL STAFF

a) HCSD AFFILIATED MEDICAL STAFF:

1) *Qualifications:*

i) HCSD affiliated practitioners consists of those Physicians, Dentists, Clinical Psychologists, Podiatrists, and other Licensed Practitioners

(a) whose association with this facility is for the sole purpose of referring patients for ancillary testing, consultation, and other non-admit patient services. Such an appointee must provide Lallie Kemp Medical Center contact information, including after hours and emergency contact information. (b) whose sole association with Lallie Kemp Medical Center is for total or shared responsibility for patient care, treatment, and services via telemedicine consultation. Such an appointee must provide Lallie Kemp Medical Center, as originating site, authorization to procure credentialing, privileging, and performance documents from the Joint Commission accredited distant site, so as to enable the originating site to render a privileging decision.

2) *Prerogatives.* Members in this staff category :

- i) do not have admitting privileges
- ii) are not eligible to attend Medical Staff meetings
- iii) are not eligible to vote or to hold elective offices
- iv) are not required to participate in Medical Staff Committees

b) NON- HCSD AFFILIATED MEDICAL STAFF:

1) *Qualifications:*

i) Non-HCSD affiliated practitioners consists of those Physicians, Dentists, Clinical Psychologists, Podiatrists, Nurse Practitioners, Physician Assistants, and other Licensed Practitioners from the community whose association with this facility is for the sole purpose of referring patients for ancillary testing, consultation, and other non-admit patient services.

ii) Such an appointee must provide all requested personal identifying data for inclusion in the doctor master; contract information, including after hours and emergency

contact information; ICD-9 codes or diagnosis (es) and completed order for referred patients. Refer to “Non-HCSD Affiliated Practitioner Policy.”

- 2) *Prerogatives*. Members in this staff category :
- i) do not have admitting privileges
 - ii) are not eligible to attend Medical Staff meetings,
 - iii) are not eligible to vote or to hold elective offices
 - iv) do not participate in Medical Staff Committees

c) **GRADUATE MEDICAL EDUCATION INCUMBENTS**

Lallie Kemp Medical Center is considered a participating “host” hospital in the graduate medical education program.

- Participants in approved training programs in the Hospital, in the role of a medical student, intern, resident and/or fellow, are not appointed as members of the Medical Staff.
- Participants provide patient care/services within the scope of individual competency and prescribed program structure. Each participant shall be supervised by a Licensed Independent Practitioner who is a member of the medical staff of Lallie Kemp Medical Center, with appropriate clinical privileges.
- Participants are required to complete an application process and orientation.
- Minimum verification includes primary source licensure verification and verification of positive Federal Participation status
- The credentialed member of the Medical Staff retains responsibility for the management of each patient’s care, treatment, and services.

ARTICLE V: CREDENTIALING PROCEDURE: APPOINTMENT AND RE-APPOINTMENTS

The credentialing and privileging process will involve the collection, verification, and evaluation of data relevant to a practitioner's professional performance. These data/documents will serve as the foundation of objective, evidence-based decisions regarding initial appointment and reappointments to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, each applicant's – license, education, training, current competence, and physical ability to discharge patient care responsibilities will be established.

The processing of all medical staff applications and granting of clinical privileges will be affected in compliance with the bylaws, Rules and Regulations and policies approved by the Credential Sub-committee, Medical Executive Committee and Governing Board and will be effected with equal standards only after the medical staff office has obtained a completed, verified application. Such requests shall be processed in conjunction with procedures approved by the Board upon recommendation by the Credentials Sub-Committee/MEC. Such decisions must consider criteria that are directly related to the quality of care and are subject to fair hearing and appeal processes

A. Appointment Process

1. Procedure for processing initial applicants for staff appointment

- a.** An application for appointment to the Medical Staff shall only be sent to the potential eligible applicant at the direction of Hospital Administrator or Medical Director.
- b.** All initial appointments of the Medical Staff shall be provisional status category for a period not to exceed twenty-four (24 months) from the date of the initial appointment. The Governing Board may approve advancement after twelve (12) months upon the recommendation of the Medical Executive Committee as outlined below in "III. Provisional Appointment Review Process."
- c.** All applications shall be in writing, shall be signed by the practitioner in all areas provided for a signature and shall be submitted on a form approved by the hospital. The application package shall include the following:
 - i. An application for appointment to the medical staff
 - ii. A privileges request form(s) and criteria for privileges
 - iii. A detailed list of requirements for completing the application
 - iv. Consent and release form to obtain background information
 - v. Health questionnaire and attestation
 - vi. Medicare and Champus regulation acknowledgement form
 - vii. Request for verification of malpractice insurance coverage when applicable
 - viii. A copy of the medical staff bylaws, rules, and regulation, and policies
- d.** It shall be the practitioner responsibility to produce adequate information for proper evaluation of the practitioner's competence, charter, ethics and other qualifications and for resolving any doubts about such qualifications.

- e. Upon receipt of a completed application, the medical staff office will begin the data collection/primary source verification to prepare the application for presentation to the Credentials Sub-Committee within one hundred twenty (120) days. Detailed information concerning the applicant's professional qualifications will include:
 - Primary sources include, but not limited to, Medical School, Internship, Residency, Fellowship, Hospital Affiliations, Medical License, State CDS, Federal DEA, Board Certification, National Practitioners Data Bank Report, Medicare/Medicaid Sanctions, and the American Medical Association profile if applicable.
- f. Completed application includes the following information
 - i. Completed, legible and signed application form.
 - ii. Completed request for clinical privileges.
 - iii. Any written explanation of those items indicated, if applicable.
 - iv. Copy of a valid picture ID issued by a state, federal or regulatory agency to ensure that the individual requesting approval is the same individual identified in the credential documents.
 - v. Copy of current Louisiana Medical license.
 - vi. Copy of current DEA certificate (if applicable).
 - vii. Copy of current Louisiana state narcotics license (if applicable).
 - viii. Proof of current medical malpractice insurance policy: Private practitioners not considered to be employees of the State of Louisiana or of Louisiana State University/Health Care Services Division and not covered for professional liability insurance through the State Office of Risk Management must provide proof of professional liability insurance in the amounts of \$1,000,000/\$3,000,000 (or \$100,000/ \$300,000 if they are participants in the Patient Compensation Fund).
 - ix. The names and complete addresses of at least three (3) practitioner references who can provide adequate written reference pertaining to the applicant's current professional competence and ethical character.
 - x. Written explanation for any malpractice claim settled for sums greater than \$100,000 (>\$200,000 for an obstetrician-gynecologist).
 - xi. Any claim in Louisiana in which there was a Medical Review Panel finding that a case involved anything but reasonable care should be explained in writing.
- g. In signing the application and submitting the application, the applicant:
 - i. Attests to the accuracy and completeness of all information on the application and any accompanying documents and agrees that any inaccuracy, omission or commission is grounds for terminating the application process.
 - ii. Signifies his/her willingness to appear for interviews regarding his/her application, focused and ongoing professional practice review(s) and hospital quality improvement activities;
 - iii. Authorizes the hospital and medical staff representatives to consult with prior and current associates and with others who might have information bearing on his or her current professional competence, character, experience and ability to perform the requested privileges, professionalism, ethical

- iv. Three (3) Peer References at the time of initial granting and renewal of privileges. The peer recommendation will include written information regarding the practitioner's current:
 - o Patient care
 - o Medical/clinical knowledge
 - o Practice-based learning and improvement
 - o Interpersonal and communication skills
 - o Professionalism
 - o Systems-based practice

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioners specific data collected from various sources for the purpose of validating current competence.

- v. Inquires are made to the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges and when a new privilege is requested;
 - vi. Inquires are made to appropriate state and federal exclusion and sanctions resources;
 - vii. Verified with primary source all hospital affiliations, and past practice settings for the previous 10 years for all initial appointments, and all current hospital affiliations for practitioners seeking renewal of clinical privileges;
 - viii. Verified documentation of the applicant's past clinical work experience;
 - ix. Board Certification, if applicable (through the AMA, American Board of Medical Specialties, D.D.S or certification board as applicable);
 - x. Information of American Medical Association (AMA) Physician Profile;
 - xi. The other option for primary source verification will be the participation in any centralized credentialing agency or other agency that will be used in the future by the LSUHCS system as a whole.
- j. At any time during the appointment process should the applicant voluntarily withdraw the application the Medical Staff Office shall retain the original application on file for a period of 3 years.

2. Presentation of the completed application:

Once the application is deemed complete, the Medical Staff Office shall facilitate the presentation process of the completed application to the Department Chairperson, Credentials Sub-Committee, Medical Executive Committee and the Governing Board as outlined below.

No application may be presented to the Department Chairperson or the Credentials Sub-Committee without first having Hospital Administration confirmation of a valid contract with LSUHCS, even if no monies are being transferred or an employee/employer relationship.

3. **Department Chairperson Review:**

The department chairperson will review the file to ensure that the applicant fulfills the established standards for membership and there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested clinical privileges. The department chair has the option of participating at the credentials sub-committee in reviewing and recommending actions. The department chairperson will submit a written recommendation to both membership on the medical staff and privileges requested by the applicant and this shall be made part of the credential file.

- a. *Favorable recommendation:*** The Department Chairperson favorable recommendation will be forwarded to Credentials Sub-Committee.
- b. *Adverse recommendation:*** The Department Chairperson should document his/her rationale and all references to any unmet criteria. The application will promptly be reviewed by the Credentials Sub-Committee and the recommendation of both (Department Chair and Credential Sub-Committee) will be presented to the MEC as a whole. If the MEC upholds the Department Chair's unfavorable recommendation, the applicant will be notified of such and offered recourse via the Fair Hearing Process. If the MEC accepts the application, their recommendation will be forwarded to the Governing Board for final approval

4. **Credential's Sub-Committee Review and Recommended Action:**

Promptly after the Department Chairperson has reviewed the file, the Credentials Sub-Committee will review the appointee's file, Department Chairperson's recommendation, reports, and all other relevant information. The Credentials Sub-Committee members may request to personally meet with the applicant to solicit information to complete the credential file or clarify previously provided information. The written recommendation shall be forwarded to the Medical Executive Committee for:

- Appointment,
- Staff category,
- Clinical privileges, and
- Department assignment

- a. *Favorable Recommendation:*** When the Credentials Sub-Committee's recommendation is favorable to the applicant in all respects, the Credentials Sub-Committee shall forward its recommendation to the MEC (Medical Executive Committee).
- b. *Adverse Recommendation:*** Regardless of the Department Chair's recommendation, the Credentials Sub-Committee should forward all recommendations and documents to the full MEC for final disposition
- c. *Deferral of Recommendation:*** If the Credential Sub-Committee defers the application for further consideration, the committee must make recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff, department affiliations and scope of clinical privileges within 30 days. The Medical Staff office will notify the applicant by written notice.

5. Medical Executive-Committee Action

The Credential's Sub-Committee recommendation along with the recommendation of the department chairperson will be forwarded to the MEC

- a. *Favorable Recommendation:*** When the MEC's recommendation is favorable to the applicant in all respects, the recommendation shall be forwarded to the board.
- b. *Adverse Recommendation:*** When the MEC's recommendation is adverse to the applicant, a special notice shall be sent to the applicant. No such adverse recommendation will be forwarded to the Board until after the practitioner has exercised or has waived his or her right to a hearing as provided in the medical staff bylaws.
- c. *Deferral of Recommendation:*** If the MEC defers the application for further consideration, the committee must make recommendations as to approval, or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations and scope of clinical privileges within 30 days. The Chief of Staff shall promptly notify the applicant by special written notice.

6. Governing Board Action:

The Medical Executive Committee recommendation will be forwarded to the Governing Board for approval.

- a. *Favorable Recommendation:*** Favorable action by the Governing Board is effective as its final decision.
- b. *Adverse recommendation:*** If after complying with the requirements, the Governing Board's action is adverse to the applicant, a special written notice will be sent to the applicant and he/she shall be entitled to the procedural rights as stated in the fair hearing provision in the medical staff bylaws

7. Basis for Recommendation and Action:

Each individual or group that is required to act on an application, including the Board, must state the reasons for each recommendation or action taken, with specific reference to the completed application and any other relevant documentation. Any dissenting views at any point in the process must also be documented, supported by reasons and references, and transmitted with majority report.

8. Conflict Resolution:

If the Board determines that its decision will contradict the MEC's recommendations, it will submit the matter to a Conference Committee comprising an equal number of MEC and Board members. The Committee shall review the information and submit its recommendation to the board within 30 days of the date on which the board submitted the matter.

9. Notice of Final Decision:

- a.** The practitioner shall receive a written notice from the Hospital Administrator as agent for the Board of appointment within thirty (30 days), and special notice of any adverse final decisions, as defined in Article IX. Fair Hearing B. Notice of Proposed Action. A decision and notice of appointment includes:

- i. appointed category;
 - ii. assigned department;
 - iii. clinical privileges granted, denied, revised, or revoked;
 - iv. any special conditions attached to the appointment
- b. If there is a favorable recommendation by the Governing Board, an orientation shall be arranged for those initial applicants.
- c. The Medical Staff Office shall, upon receipt of notification from the Board, notify all division directors, chief of staff, and CEO of new and renewed medical staff membership appointments and disseminate copies of current clinical privileges to all appropriate departments of the hospital.

B. Reappointment Process:

1. Procedure for Reappointment:

- a. General: All terms, conditions, qualifications and procedures related to initial appointment apply to an individual's ongoing appointment and clinical privileges and to reappointment. Reappointments will occur every two (2) years on the anniversary date of the practitioner's last appointment.
- b. Application:

Each practitioner (appointee) who is eligible to be reappointed to the Medical Staff will be notified of the date of the expiration and supplied with an application for reappointment packet at least four months (16 weeks) prior to the expiration date of the medical staff appointment. This packet will be sent to the practitioner (appointee) via certified mail with receipt requested. The reappointment packet will include the following:

 - i. Reappointment application form;
 - ii. Consent and release form;
 - iii. Health questionnaire and attestation;
 - iv. Request for verification of malpractice insurance when applicable;
 - v. New privilege list request form; and
 - vi. CME attestation form.
- c. Upon failure of the appointee to return the reappointment packet at 12 weeks before expiration date of last reappointment (4 weeks after original notice), the medical staff office will send a reminder letter via certified mail with return receipt requested to the appointee.
- d. Upon failure of the appointee to return the completed reappointment application with requested documents to the medical staff office (as outlined above) at 4 weeks before expiration date of appointment (2 months after reminder letter posted), the application will no longer be accepted for reappointment purposes. If the appointee fails, without good cause, to provide the completed reappointment packet the implication is a desire not to be reappointed. The Hospital will deem the failure as an automatic voluntary resignation from the medical staff, and the appointment will automatically expire. This action is not subject to any fair hearing or review processes.

- e. The appointee shall receive a written notification of such actions.
- f. For completed reappointment applications, the Medical Staff Office shall review and verify the above information according to the Initial Appointment process as outlined in this article (I. Appointment Process, A. Procedure For Processing Applicants To The Medical Staff, 5. Completed application includes.....)
- g. The Medical Staff Office will verify this information and notify the appointee of any inadequacies in the information or verification problems. The appointee will have the burden of producing adequate information and resolving any doubts about the data.
- h. The practitioner's profile with the ongoing professional practice evaluation/data and studies will be compiled by the Medical Staff Office. The practitioner's profile shall contain performance and conduct information related to the following:
 - i. patterns of care
 - ii. assessment/performance improvement activities
 - iii. clinical judgment and skills in the treatment of patients
 - iv. behavior and cooperation with hospital personnel, patients, and visitors
 - v. medical records/hospital reports completion
 - vi. completion of 40 hours of continuing medical education activities
 - vii. timely and accurate completion of medical records
 - viii. history of clinical privilege increase, reduction, or termination
 - ix. peer review and performance data
 - x. compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and staff
- i. Once the application is deemed complete, the Medical Staff Office shall facilitate the presentation process of the completed application to the Department Chairperson, Credentials Sub-Committee, Medical Executive Committee and the Governing Board as outlined in Section "B. Presentation of the Completed Application" with the addition of the following to the Governing Board Action:
 - xi. An "adverse recommendation" by the board will mean recommendation or action to:
 - 1. deny reappointment
 - 2. deny a requested change in the appointee's staff category or department assignment
 - 3. change, without the staff appointee's consent, his or her staff category or department assignment, or
 - 4. deny or restrict requested clinical privileges.

***NOTE:** The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "appointee" and "reappointment".*
- j. The following sections of the initial application process shall apply:
 - Basis for Recommendation and Action (section B.)
 - Conflict Resolution (section C.)
 - Notice of Final Decision (section D.)

C. Provisional Appointment Review (Upgrade) Process:

1. All initial applicants to the medical staff shall be assigned provisional status category of membership twenty-four (24) months from the date of the initial appointment.
2. At the end of the twelve-month period in provisional status, the practitioner's file will automatically be forwarded for presentation to the Department Chairperson, Credentials Sub-Committee, Medical Executive Committee and the Governing Board as an automatic request for membership upgrade to active, courtesy or consulting status.
3. If the provisional staff member has satisfactorily demonstrated the ability to exercise clinical privileges initially granted and otherwise appears qualified for continued membership, the member shall be eligible for placement in the active, courtesy, or consulting staff, as appropriate, upon recommendation of the Medical Executive Committee and upon approval of the Governing Board.
4. To document the successful conclusion of the provisional period, the following will be presented according to the outlined procedures in the "Presentation of an Application":
 - a. A statement and status report from the department chair, _____attesting that the practitioner has demonstrated qualifications for staff appointment and for upgraded staff category, has not abused his/her prerogatives, and has met his/her appointment obligations.
 - b. Performance Improvement/Compliance data
 - c. Data from proctoring and evaluations will be reviewed, if applicable.
5. Final processing follows the procedures set forth in the "Appointment Process."
6. The Governing Board may approve advancement after the initial twelve (12) months upon the recommendation of the Medical Executive Committee to active, courtesy, or consulting membership status not to exceed an additional twelve (12) month period.
7. Continuation to the provisional staff appointment may be made by the Governing Board but may not exceed one additional twelve (12) month term, at which time the failure to advance from provisional staff to the active, courtesy, or consulting staff shall be deemed a termination of the practitioner's staff appointment. A recommendation by the Medical Executive Committee or a decision by the Governing Board that a practitioner not be advanced from provisional staff which recommendation or decision would result in the termination of the practitioner's membership, shall be an adverse recommendation or adverse decision, and the practitioner shall be given notice of such action and shall have rights to the fair hearing process. However, continuation of provisional status for a second 12 month period shall not be deemed to be an adverse recommendation or adverse decision.
8. The following sections of the initial application process shall apply:
 - Basis for Recommendation and Action (section B.)
 - Conflict Resolution (section C.)
 - Notice of Final Decision (section D.)

ARTICLE VI: CLINICAL PRIVILEGES

A. General Clinical Privileges:

1. Each applicant to the medical staff appointment or reappointment shall contain a request for the specific clinical privileges desired by the applicant. Only those clinical privileges specially granted by the Board after recommendation by the MEC may be practiced by the practitioner.
2. Except where limited by law, all practitioners appointed to the medical staff shall have ~~the~~ clinical privileges of performing medical assessments of patients including both medical histories and physical examinations.
3. Only practitioners expressly granted admitting privileges may admit patients to the hospital.
4. All grants for clinical privileges for initial appointments, re-appointments, and a request for additional privilege(s), will be ~~effected~~affected in compliance with those procedures approved by the Credential Sub-Committee, Medical Executive Committee and the Governing Board.
5. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically recommended to and approved by the Governing Board.
6. Only during emergencies, the practitioner with clinical privileges will be permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm-regardless of his or her medical staff status or clinical privileges-provided that the care, treatment and services provided are within the scope of the individual's license.
7. The ordering of any diagnostic test or procedure by a Non-HCSD Affiliate Staff practitioner may be allowed if it can be validated that the request originates from a practitioner possessing a current and valid license to order such test(s); and the ordering practitioner acknowledges adherence to all compliance regulations; and, if arrangements can be made for reliable transmission of the test result(s) within an appropriate time frame.

B. Temporary Clinical Privileges:

The granting of temporary privileges may be utilized under the following circumstances:

1. To fulfill an important patient care, treatment, or service need.
 - Requires verification of current licensure and competence
2. New applicant: Temporary privileges may be granted while awaiting review and approval by the organized medical staff upon receipt of a complete application that raises no concerns and verification of the following:
 - Current licensure
 - Relevant training or experience,
 - Current competence
 - A query and evaluation of the NPDB information

- Verification of positive Federal Participation status
 - A complete application
 - All reference evaluations are completed and received
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of medical staff membership at another organization.
 - No subjection to involuntary limitation, reduction, denial or loss of clinical privileges.
3. Temporary privileges are granted on the recommendation of the medical director or authorized designee.
 4. Temporary privileges are granted by the Chief Executive Officer or authorized designee.
 5. Temporary privileges are granted for no more than one hundred twenty (120) days.

C. Telemedicine Clinical Privileges

1. The telemedicine services focus on licensed independent practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by the authority to write orders and direct care, treatment, and services).
2. Through the process of credentialing and privileging by proxy and upon receipt of a signed “Release of Information” form, Lallie Kemp Medical Center, as the originating site, procures copies of the Joint Commission accredited distant site information useful to assess the practitioner’s quality of care, treatment, and services, and performance improvement data for use in the privileging decision. Requested information includes:
 3. Current licensure
 4. Relevant training or experience,
 5. Current competence
 6. A query and evaluation of the NPDB information
 7. Verification of positive Federal Participation status
 8. Lallie Kemp Medical Center provides the distant site information that may be useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement, including all adverse outcomes related to sentinel events that result from the telemedicine services provided; and complaints from patients, other LIPs, or staff.

D. Disaster Clinical Privileges:

1. Granting of disaster privileges: In circumstances of disaster(s), in which the emergency management plan has been activated, the chief executive officer or medical director may grant emergency privileges to volunteer individuals subject to the credentialing and privileging process. The option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. Disaster privileges shall be valid for the duration of said disaster. Minimal elements necessary to grant emergency disaster privileges are those as follows:
 - a) Disaster privileges may be granted only when the following two conditions are present:
 - The emergency management plan has been activated, and

- The hospital is unable to meet immediate patient needs.
- b) Identification of volunteers:**
Volunteers shall wear identification badges with “Volunteer Physician, etc” for the benefit of hospital and medical staff. The Medical Director and his/her designee shall disseminate lists of volunteers and their disaster privileges to all departments as time allows.
- c) Record Keeping:**
A file shall be made for each volunteer, including dates and times of arrivals and departures.
- d) Immediate Credentialing:**
Volunteers eligible to act as licensed independent practitioners must present, a valid government-issued photo identification issued by a state or federal agency such as drivers license or passport, a current license to practice medicine, and at least one of the following:
- i. A current picture hospital photo ID Card that clearly identifies professional designation
 - ii. Primary source verification of the license
 - iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or groups.
 - iv. 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)
 - v. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster
 - vi. The name of any hospital or medical staff member who has vouched for the volunteer shall go in the file.
- e) Oversight of professional practice of volunteer:**
The professional performance of the volunteer practitioner who received disaster privileges will be monitored and evaluated using direct observation, mentoring, and/or clinical record reviews. Any concern regarding the volunteers clinical competence shall immediately be reported to the Medical Director or his/her designee.
- f) After-the-fact Credentialing:**
- i) 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 facility.
 - ii) In the extraordinary circumstance that primary source verification cannot be completed within seventy-two (72) hours, (e.g., no means of communication or lack of resources) it will be completed as soon as possible and there will be documentation of the following:

- *Why primary source verification could not be performed in the required time frame*
 - *Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services;*
 - *An attempt to rectify the situation as soon as possible.*
- NOTE: Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.*

g) Termination of disaster privileges:

- (i) The Medical Director may, at his/her discretion, terminate a volunteer's disaster privileges at any time without reason or cause.
- (ii) The declaration by the Chief Executive Officer of Lallie Kemp ~~Hospital, or his/her~~ Medical Center or his /her designee that the emergency is over will automatically terminate all disaster privileges. Termination of disaster privileges shall not give rise to appeal rights under the medical staff bylaws or any other authority.

E. Process for developing criteria for granting new privileges:

1. Only clinical privileges that have the necessary space, equipment, staffing, and financial resources in place to support the requested privilege will be granted.
2. It will be the responsibility of the respective Department Chairperson to recommend to the Medical Executive Committee clinical privilege(s) only after it has been determined whether sufficient space, equipment, staffing and financial resources are in place to support each requested privilege.
 - i. The practitioner will submit in writing the request for additional clinical privilege with evidence of training, competences to perform requested privilege to the department chairperson.
 - ii. The respective department chairperson will review the request clinical privilege(s) and submit his/her recommendation to the Credential Sub-Committee.
 - iii. The Credentials Committee shall review and make a recommendation to the MEC which may include proctoring or preceptor ship for the requested privilege.
 - iv. The MEC shall review the practitioner's request for the clinical privilege, along with the recommendation of the Credential Committee.
 - v. The recommendation of the MEC shall be forwarded to the Governing Board which has final authority for granting renewing, revising, or denying privileges.
3. Notice of Final Decision: The following sections of the initial application process shall apply:
 - Basis for Recommendation and Action (section B.)
 - Conflict Resolution (section C.)
 - Notice of Final Decision (section D.)

ARTICLE VII: ORGANIZATION of DEPARTMENTS AND OFFICERS

A. Organization of Departments:

1. The Medical staff shall be divided into departments. The departments at the time of adoption of these bylaws will consist of three (3) service departments: Ambulatory Services Department, Medical Services Department, and Surgical Services Department.
2. The MEC may create new departments, combine, or eliminate departments with approval of the Board.
3. Each appointee to the medical staff will be assigned to only one department for administrative and performance improvement purposes, but may be granted clinical privileges in more than one department. The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the authority of that department chairperson regardless of which department the appointee is assigned.
4. Each department shall be headed by a chairperson elected by the respective active department members.

B. Chairperson Qualification:

1. Each department chairperson shall be a member of the Active Medical Staff, and be willing and able to discharge the functions of his/her office;
2. Each department chairperson shall be a member of the Active Medical Staff.
3. Shall be board certified or shall have been determined to possess equivalent qualifications by the MEC;
4. Additionally he/she shall meet the qualifications and perform the duties/functions as specified in the Department Chairperson Duties.

C. Election of Departmental Chairpersons:

1. Election of departmental chairpersons will be conducted at the June meeting of the medical staff.
2. All members of the active staff who met the qualifications may be eligible to be Department Chairpersons.
3. To assist in the deliberations the MEC may convene an ad hoc nomination committee to present nominees to the June meeting.
4. A quorum for that meeting will be considered those active staff members present. A simple majority suffices for elections.

D. Roles and Responsibilities of the Department Chairperson:

The responsible functions of Department Chairpersons shall include, but are not limited to the following:

1. Serve on the Medical Committee (MEC) representing the licensed independent practitioners and advance practice nurses, if applicable, assigned to his/her department;
2. Be responsible for the organization of all clinically related activities of the department and for the general administration of the service, including both the medical staff criteria for clinical privileges in the service and the continuous assessment and improvement of the quality of care and services provided;
3. Be responsible for all administratively related departmental activities;
4. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

5. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
6. Recommend clinical privileges for each member of the department;
7. Assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
8. The integration of the department or service into the primary functions of the organization;
9. The coordination and integration of interdepartmental and intradepartmental services;
10. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
11. The recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;
12. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, an services;
13. Maintenance of quality control programs, as appropriate;
14. The continuous assessment and improvement of the quality of care, treatment and services provided;
15. The orientation and continuing education of all persons in the department or service;
16. Recommendation for space and other resources needed by the department or service.

E. Meetings of the Department:

Each department will have a ongoing mechanism in place to evaluate performance improvement activities, departmental specific measurement criteria/reports and communication of actions between the department and the Medical Executive Committee.

F. Meeting Attendance Requirements:

Members of the medical staff are encouraged to attend meetings of the Medical Staff. Meeting attendance will not be used in evaluating members at the time of reappointment.

G. Tenure of Department Chairperson:

Their term of office will be for one year or until his/her successor is appointed or assumes office, unless he/she sooner resigns or is removed from office.

ARTICLE VIII: COMMITTEE

A. Medical Executive Committee:

1. Composition/Committee Structure:

The medical staff shall be represented by the officers of the organization as well as one member-at-large.

The officers shall be as follows:

- a. Chief of Staff, who shall be the previous Vice Chief-of-Staff - voting member
- b. Vice-Chief of Staff _____ voting member
- c. Immediate Past Chief of Staff _____ voting member
- d. Member-at-Large _____ voting member

Committee Members as follows:

- d. Surgery Services Department Chairperson _____ voting member
- e. Medicine Service Department Chairperson _____ voting member
- f. Ambulatory Services Department Chairperson _____ voting member
- g. Medical Director _____ voting member
- h. Quality Sub-Committee Chairperson _____ voting member
- i. Credentials Sub-Committee Chairperson _____ voting member
- j. ER Physician Director _____ voting member
- k. CEO/ designee (as ex-officio) representing board _____ non-voting member

2. Term of Office:

Their terms of office will be for one year or until his/her successor is elected or assumes office, unless he/she sooner resigns or is removed from office.
The Medical Staff year runs from July 1st through June 30th.

3. Election of Officers:

The Vice Chief-Of-Staff of the Medical Staff, Member-at-Large, Quality Sub-Committee and Credentials Sub-Committee Chairpersons, and Department Chairpersons will be elected during the June meeting of the Medical Staff.

4. Eligibility of Officers:

All voting members of the Active Medical Staff may be eligible to be officers, chairpersons and/or the member-at-large. To assist in deliberations the MEC may convene an ad hoc nomination committee to present nominees to the June meeting. A quorum for that meeting will be considered those active staff members present. A simple majority suffices for elections.

Restrictions: Oversight of care, treatment, and services rendered by practitioners privileged through the medical staff process is provided by licensed independent practitioners of the organized medical staff.

5. Authority Statement:

The organized Medical Staff delegates authority in accordance with law and regulation to the medical staff executive committee to carry out medical staff responsibilities. The MEC carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The MEC has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process.

6. Duties of Officers:

a. **Chief of Staff:** The Chief of staff will:

- i. Act in coordination and cooperation with the with the administration, Board, Medical Staff, and Nursing Service for the benefit of Lallie Kemp Medical Center as a health care delivery system.
- ii. Call, preside at, and be responsible for the agenda of all meetings of the medical staff.
- iii. Serve as Chairman and voting member of the Executive Committee.
- iv. Monitor and assure enforcement of the Medical Staff Bylaws and the Rules and Regulations in association with the Medical Director.
- v. Represent the perspective of the Medical Staff to the administration of Lallie Kemp Medical Center and the Board.
- vi. In his/her absence, notify the Vice Chief to act on his behalf regarding medical staff business.

b. **Vice Chief of Staff** – The Vice Chief of Staff will:

- i. When notified by the Chief assume all duties and have the authority of the Chief.
- ii. Assume the office of Chief of Staff if there is a vacancy in that office and serve as a member of the Executive Committee.

7. Duties of the Medical Director:

a. Act as a liaison between the hospital staff and the medical staff working as a unifying force in forging a Performance Improvement Plan that is truly patient-centered

b. Specific activities would include:

- i. participation in the Peer Review Process
- ii. counseling medical staff members
- iii. initiating formal disciplinary action via the Medical Executive Committee

c. He/she may attend all important meetings and as such will act as the unifying figure and source of information.

d. The Medical Director is clinically responsible to the Medical Director of the Health Care Services Division, although he/she is functionally responsible to the Medical Executive Committee and the CEO of the hospital.

7. Quorum:

The quorum requirement for the following meetings shall be:

Medical Executive Committee Meeting: 50% of voting members of the committee.

Committee/Department Meetings: those present and voting.

Credentials Sub-Committee: two physicians.

Medical Staff Meeting: those present and voting.

8. Meetings:

a. The meeting will be conducted under the Roberts Rules of Order.

b. The MEC shall meet as often as necessary to fulfill its responsibilities, with minimum of 10 monthly meetings per year, and maintain permanent records of its proceedings and actions for a minimum of three years.

c. Minutes and other such recordings of the MEC may be reviewed by active members of the Medical Staff upon request.

9. Special Meetings of the MEC may be called at any time by the Chief of Staff.

10. Removal from Office: Any officer, chairperson or the member-at-large may be removed from his/her position for failure to fulfill his/her duties by the chief of staff in concordance with the CEO. In such a case, a new election for that position will be called by the MEC as soon as feasible. Any officer (including the Chief-of-Staff) of the MEC, chairperson or member-at-large who fails to perform his/her duties and acts contrary to these bylaws, rules, regulations, or policies may be removed by a 2/3 vote of the active medical staff in a special meeting called by the MEC in response to a petition of 20% of the active medical staff members. In such a case, a new election for that position will be called by the MEC as soon as feasibility allows.

11. Duties

The duties of the Medical Executive Committee will always be focused around being advocates for the patients seen at this hospital and will include the following nonexclusive list consisting of recommendations to the Governing Board of Authority including, but not limited to at least the following:

- a) Receive, review, and act upon reports and recommendations of the departments, hospital services, work-groups, and teams;
- b) Receives, evaluates and acts upon reported concerns regarding a privileged practitioner's clinical practice and/or competence;
- c) Support and act upon recommendations of the Quality Sub-Committee in support of the performance improvement plan, compliance plan and policies, patient safety plan, and other hospital policies and procedures;
- d) Receive, review, and act upon recommendations of the Credentials Sub-Committee in support, development and implementation of the credentialing process and clinical privileges;

- e) Receive certain administrative data from the hospital for its information without recommendation so as to maintain the relationship between the MEC and the Senior Staff of the hospital.
- f) Make recommendations directly to the Board on all matters relating to the mechanisms used for the review of appointments, reappointments, clinical privileging, medical staff structure, medical staff membership, fair hearing procedures, and performance improvement;
- g) Initiate an investigation of any incident, course of conduct, or allegation regarding members of the medical staff, which is in violation of these bylaws, rules and regulations, or duly approved policies and official guidelines in terms of investigating, evaluating data, and recommending sanctions or termination;
- h) Establish and maintain a system of annual inspection and suggested revisions to these Bylaws for presentation to the medical staff. Establish and maintain a system of annual inspection and enactment of Rules, Regulations, and Policies to complement these Bylaws to be presented at the annual June meeting of the medical staff or at any other forum deemed appropriate by the MEC. To accept petitions of at least 20% of the active medical staff at any time requesting changes in the Bylaws and/or Rules And Regulations and responding accordingly;
- i) Account to the Board and to the Medical Staff for the overall quality and efficiency of medical care rendered to all patients (both outpatients and in-patients) at the hospital;
- j) Act as a forum for any member of the medical staff who wishes to petition the committee in order to hear a grievance or other matter that pertains to that member;
- k) To perform such duties preserving the confidentiality and privilege of information, acting and discussing performance improvement issues only in the context of those authorized to deliberate on such issues and only in the confines of official meetings;
- l) To develop, modify, and enforce guidelines and operating procedures for both the Credentials and Quality Sub-Committees of the Medical Executive Committee;
- m) To maintain a process that provides for education about physician health, which addresses prevention of physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.
- n) To provide a system of establishment of a fair hearing process. Such a hearing will be convened in accordance with these Bylaws, and Policies of the MEC and

LSUHCS D. This type of hearing is separate from any hearing structure in place by civil service for the purpose of position termination;

- o) To oversee and arrange the annual medical staff meeting in June of each year for the purpose of electing a Vice Chief of Staff, a member-at-large, departmental chairpersons and sub-committee chairpersons;
- p) To participate with the senior management through the offices of the Chief Executive Officer, Medical Director and designees so as to promote effective communication between the medical staff and the administration;
- q) To establish a set of operational guidelines and policies in order to meet the obligations of the Medical Staff in providing safe, competent care and safety to patients and recommend same to the Governing Board;
- r) To act on behalf of the Medical Staff between regular meetings.
- s) To approve, implement, and enforce criteria for a focused evaluation process to monitor and evaluate the performance of the practitioners for the _____ followings:
 - i.) for all initially requested privileges
 - ii.) To evaluate the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified;
- t) To approve, implement, and enforce the Ongoing Professional Practice Evaluation process for practitioners; to identify opportunities for improvement, to promote educational benefit, and when necessary , to effect _____ appropriate changes in management

B. Quality Sub-Committees;

The Quality Sub-Committee Chairperson may be a currently serving member ~~of the~~of the Medical Executive Committee.

- i) **Election of Sub-Committee Chairperson:** Election of the Quality Sub-Committee Chairperson will be conducted at the June meeting of the medical staff. All members of the active medical staff may be eligible to be sub-committee chairpersons.
- ii) The Quality Sub-Committee Chairperson serves as a member of the Medical Executive Committee;
- iii) Facilitates the process of reviewing quality initiatives, performance improvement, and departmental performance data-;
- iv) Makes/solicits recommendations for improvement through group involvement in meetings;
- v) Utilizes tools and techniques for effective display of performance data.
- vi) Monitor the progress of workgroup/team activities through review of presentation of data and activities;

- vii) Provides a summary of activity for approval by the Medical Executive Committee through the Chairperson for eventual reporting to the Governing Board.

C. Credentials Sub-Committee

Election of Sub-Committee Chairperson: The Credential Sub-Committee Chairperson may be a currently serving member of the Medical Executive Committee.

1. Election of the Credential Sub-Committee Chairperson will be conducted at the June meeting of the medical staff. All members of the active medical staff may be eligible to be sub-committee chairpersons.
2. The Credential Sub-Committee Chairperson serves as a member of the Medical Executive Committee;

1. Duties of the Credentials Sub-Committee

The intent of the Credentials Sub-Committee is to ensure that all members of the medical staff function safely within their realm of training, education, and experience for the welfare of the patient.

To develop and maintain a credible process to ensure the competency of the practitioners appointed to the medical staff of Lallie Kemp Medical Center. The Credentials Sub-Committee is responsible for:

- a. reviewing each completed application to its satisfaction and for making recommendations to the MEC regarding staff appointment, reappointment, and the applicant's ability to meet current criteria for the requested clinical privileges at the time of initially requested, renewal of privileges, and when a new a privilege is requested including recommended proctoring and focused reviews;
- b. evaluating the applicant's ability to perform privileges requested via the "Confirmed Health Statement." In instances where there is doubt about the applicant's ability to perform privileges requested, an evaluation by an independent source may be requested;
- c. at its discretion, requiring a clinical interview with new applicants applying for medical staff appointment and clinical privileges;
- d. reviewing, modifying, and updating collaborative practice agreements when necessary and at least annually for advance practice nurses as required by state law;
- e. developing criteria for granting of new privileges based on new skills, new technology, and the needs and capabilities of the institution to support such;
- f. reviewing requests for reappointments and clinical privileges of present medical staff members based on information obtained during each practitioners ongoing professional practice evaluation, performance improvement data, chart review data, risk management data from the Quality Resources/Medical Staff Affairs Office;
- g. continuous upgrading of the privilege formats for the various specialties of the medical staff as well as establishing competency criteria for the maintenance of those privileges based on frequency of performance, educational requirements, and institutional needs and capabilities;
- h. recommending further provisional status as well as recommending remedial processes for a practitioner based on information obtained during each

practitioners focused professional practice evaluation and ongoing professional practice evaluation, performance improvement data and/or peer data; and

- i. The Credentials sub-committee is expected to interact with and report to each department chair as necessary.

2. Meeting Quorum:

- a. The quorum for the Credentials Sub-Committee will be two (2) physicians.
- b. Departmental Chairperson(s) are encouraged to participate in the Credentials Sub-Committee meeting.

3. Reporting

- a. The Credentials Sub-Committee reports to the full MEC and Board.
- b. Reporting will be as needed,

Article IX: Fair Hearing and Appeal Process:

The Hearing Procedure provided for in these Bylaws is for the purpose of resolving, on an intra-professional basis, matters bearing on professional competency and conduct.

A. Right to Fair Hearing

1. All members of the medical staff are entitled to convene a hearing/appeal pursuant to the Fair Hearing Plan in the event any of the following actions are taken or recommended as a result of quality of care, treatment, and services issues:
 - a. Failure to achieve initial appointment
 - b. Failure to achieve re-appointment
 - c. Non-requested reduction of clinical privileges.
 - d. Denial of new privileges requested
 - e. Revocation of staff appointment
 - f. Revocation of clinical privileges
2. A fair hearing cannot be convened if privileges are granted, contingent upon:
 - a. Monitoring requirements
 - b. Proctoring requirements
 - c. Periodic drug testing
 - d. Additional educational requirements
 - e. Physical or psychiatric evaluation
 - f. Those issues listed under Article III D.8.B.1-7
 - g. Failure to comply with the Physicians' Health Program and LSBME contract.
3. Upon recommendation of the MEC, the Board may decide that the appointment or privileges of a practitioner will be terminated or restricted or that new privilege requests will not be allowed. In such cases, the appointee is entitled to a fair hearing if he/she submits a request for a hearing within two weeks of the date he/she received the adverse notice from the Board's agent. The appointee shall not otherwise be entitled to a hearing or review.
4. The purpose of such a hearing is to determine whether an appointee meets the hospital's standards and criteria for continued exercise of his —appointment, present clinical privileges, or added privileges. The scope of the hearing shall be restricted to the problem or inadequacies cited by the Board reaching their conclusion. All evidence relevant to the appointee's qualifications shall be admissible whether or not such evidence was considered at an earlier time.
5. The practitioner shall have the burden of demonstrating his initial and continuing eligibility for the medical staff appointment and requested clinical privileges. The hospital may not infer that the practitioner meets the applicable standards if the practitioner is unable to provide satisfactory references and other proof of qualifications, regardless of whether such inability is within the applicant's control. In any case where there is doubt as to whether the practitioner meets the applicable standards, the doubt shall be resolved against the practitioner in order to safeguard patient care.

B. Notice of proposed Action

1. The Hospital Administrator, as agent for the Board, will promptly notify the practitioner of an adverse recommendation or decision by certified mail, return receipt requested.
2. Notice of an adverse recommendation or decision shall state the nature of the action proposed to be taken against the practitioner, the reasons, for the proposed action, that the practitioner has the right to request a fair hearing on the proposed action within thirty (30) days of his receipt of the notice and a summary of the rights in the hearing enumerated in this Article A. 1.

C. Scheduling of Fair Hearing

1. The CEO shall send to the practitioner by certified mail the place, date and time of the hearing as well as a list of witnesses expected to testify on behalf of the hospital.
2. The hearing date shall be set no later than 60 days after the receipt of the hearing request made by the practitioner.
3. Failure of the appointee to appear without good cause will be interpreted as a waiver of his/her hearing rights and the decision of the Board will be final and non-appealable.

D. Composition of Hearing Committee

The hearing panel shall be selected by the MEC and approved by the Board. Any disagreement will be resolved in favor of the Board's decision selections. They need not practice in the same specialty as the appointee, but they must possess sufficient training or experience to understand and evaluate the issues. Preference shall be given for selecting the panelists from among the LSUHCSD system and Medical Staff.

The hearing panel shall select a non-voting/ non-participating chairperson to maintain decorum and to maintain an open atmosphere for the presentation of arguments. Such a chairperson will make all rulings on matters of procedure and admissibility.

All practitioners involved in the original investigative process, including members of the MEC, will recuse themselves from panel deliberations.

E. Representation:

Each party shall be entitled to be represented by an attorney or other individual of the party's choice.

F. Process/Agenda

Each party shall have the right to:

1. Call, examine and cross-examine witnesses;
2. Present evidence determined to be relevant by the chairperson of the hearing panel. The rules of procedure and evidence admissibility in a court of law do not apply in such a hearing. Hearsay and other types of second-hand information are not admissible;

3. Present oral arguments. Initially the hospital's representative will present evidence in support of the adverse decision followed by the practitioner;
4. Submit a written statement at the close of the hearing;
5. Following the hearing the panel shall conduct deliberations outside the presence of both parties. There shall be no time limit for the deliberation. The final report from the panel should include both a majority report as well as a minority report if there is no unanimity. Copies will be sent to the practitioner as well as the MEC, Board, and Hospital Administrator.
6. Each party will then have 10 days following receipt of the panel's report to submit supplemental written statements.
7. After allowing time for the supplemental reports, the Board shall reach a final decision. Such decision may accept or reject, in whole or in part, the hearing panel's recommendations. The Board will prepare a written decision including a statement regarding the basis for that decision. A copy of this decision shall be sent to the practitioner by certified mail as well as the MEC and Hospital Administrator and will be effective upon sending the letter. The decision shall be final and non-appealable.
8. Under no circumstances shall the appointee participate in any manner in the review of his/her own case.
9. Under circumstances in which Clinical Privileges are left intact (even if the continued exercise of Clinical Privileges is made contingent upon added monitoring, proctoring, periodic drug testing, additional didactic or clinical training and education concurrent with the exercise of clinical privileges, or any similar form of performance Improvement that does not limit the practitioner's ability to exercise the Clinical Privileges) such circumstances **are not** grounds for a Fair Hearing or Appeal.
10. The above process is limited to items as it pertains to clinical privileges and medical staff membership based on medical and clinical criteria. This process is totally separate from civil service and breach of contractual agreements, which are handled in a manner prescribed by law.

ARTICLE X: CORRECTIVE ACTION

A: Reporting and Investigating

1. Every member of the Medical Staff has the responsibility to report the following:
 - a. Professional and/or ethical conduct thought to be at variance with the standards of Lallie Kemp Medical Center;
 - b. Known or suspected violations of Bylaws or Rules and Regulations, or Policies;
 - c. Questions regarding a practitioner's clinical competence, management or treatment of a patient;
 - d. Suspected impairment;
 - e. A report may also be initiated by the Hospital Administrator, Medical Director, or a member of the Board;
2. A report of a suspected violation or request for corrective action shall be made to the Chair of the Executive Committee and shall be supported by references to the specific activities or conduct which constitutes the grounds for the request.
3. All participants in the investigation and review process are expected to act objectively and non-capriciously in the best interest of the patients and the institution and not to be influenced by personal prejudice or motive.

B: Procedure after Investigation

1. In acting after the investigation, the Executive Committee may:
 - a. Determine that no action is justified;
 - b. Issue a written warning;
 - c. Issue a letter of reprimand;
 - d. Impose a terms of probation;
 - e. Recommend a requirement of consultation;
 - f. Recommend a reduction of clinical privileges;
 - g. Recommend suspension of clinical privileges for a period of time;
 - h. Recommend revocation/termination of Medical Staff Appointment;
 - i. Make such other recommendations as it deems necessary or appropriate.
2. If the recommendation of the Executive Committee is adverse, the practitioner shall be entitled to initiate the hearing and appeal procedure as stipulated in ARTICLE IX: Fair Hearing Process.
3. If the recommendation of the Executive Committee is favorable, the recommendation shall be forwarded to the Board for its decision. If the recommendation of the Board is adverse, the practitioner shall be entitled to initiate the hearing and appeal procedure as stipulated in ARTICLE IX: Fair Hearing process.

ARTICLE XI: SUSPENSIONS

A: Temporary Suspensions

1. **Causes:** The following are grounds for temporary suspension of admitting or other clinical privileges including but not limited to operative procedures, consultations, writing orders, and discharging patients and may be the basis for further corrective action:
 - a. Failure to complete medical records following a warning of delinquency in completing medical records;
 - b. Failure to dictate a history and physical or operative note in accordance with the Medical Staff Rules and Regulations.
 - c. Unauthorized removal of medical records or documents from Lallie Kemp Medical Center.
2. **Effective time frames:** Temporary suspensions will remain in effect for a defined period as stated in the rules and regulations or until the ground for suspension has been removed, whichever is shorter.
3. **Duty to Enforce:** It shall be the duty of the Medical Director to enforce all temporary suspensions. The practitioner's patients shall be assigned to another practitioner by the appropriate service chairperson. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
4. **Notice to practitioner:** Notice of suspension shall be given to the practitioner. However, such notice shall not be required for suspension to become effective. Repeated temporary suspensions may be grounds for further corrective action.
5. **Imposition of a temporary suspension:** shall not preclude any other corrective action.

B: Automatic Suspension and Automatic Termination

1. **Cause:** Under the following circumstances, automatic suspension, consisting of suspension of admitting privileges and scheduling of elective surgical cases as well as other limitations on clinical privileges as described below, shall be imposed for the period of time until the Member either meets the applicable requirements or the automatic suspension is terminated by the MEC and the Board.
 - a. The medical staff appointment and clinical privileges of a member of the medical staff whose license to practice his/her profession is terminated or revoked shall automatically and immediately be terminated.
 - b. The medical staff appointment and clinical privileges of a member of the medical staff whose license to practice his/her profession is limited, suspended,

lapsed or placed on probation shall automatically and immediately be suspended, pending further investigation.

- c. The medical staff appointment and clinical privileges of a member of the medical staff whose Medicare, Medicaid, or Champus provider status is suspended or terminated or who is otherwise sanctioned by any of these programs shall be automatically and immediately suspended pending further investigation.
- d. The medical staff appointment and clinical privileges of a member of the medical staff shall automatically be suspended for failure to provide requested proof of CME Certificates within 90 days of request. This significant misstatement in or omissions from the application for reappointment constitutes cause for denial of reappointment or cause for summary suspension from the Medical staff.
- e. The medical staff appointment and clinical privileges of a member of the medical staff whose Drug Enforcement Agency (DEA) and/or Louisiana Narcotics license is terminated, lapsed, revoked, suspended or limited shall be automatically and immediately modified to reflect the restriction in the ability to prescribe medications covered by the license. In such cases, the matter shall be promptly referred for further investigation and action.
- f. The medical staff appointment and clinical privileges of a member of the medical staff shall automatically terminate if his/her term of appointment has expired.
- g. The medical staff appointment and clinical privileges of a member of the medical staff shall automatically terminate at the time of termination of the signed contract with the hospital and HSCD. In such cases the date of termination will be the same date of notification of termination of said contract.
- h. The medical staff appointment and clinical privileges of a member of the medical staff shall automatically terminate if he/she fails to provide any services in the hospital or its clinics for a period of twenty-four (24) months or until the appointment period expires

2. Effective upon imposition: All automatic suspension and termination situations mentioned above shall be effective upon the occurrence of the triggering event even though notice has not been officially given to the medical staff member.

3. Entitlement to fair hearing process: The practitioner is not entitled to a Fair Hearing or other review procedure with respect to any Automatic Termination or Automatic Suspension of Medical Staff Appointment and/or Privileges.

C: Summary Suspensions

1. Causes: The medical director in consultation with the chief of staff and the CEO may summarily suspended for cause all or any portion of the clinical privileges of a medical staff member whenever it is reasonably believed that failure to take such action may

result in an immediate danger to the health and/or safety of any individual or to the orderly operations of Lallie Kemp Medical Center. Grounds for such action would include: arrest and imprisonment for felony offense; violent behavior on the campus of Lallie Kemp Medical Center; gross negligence or disregard for the bylaws rules and regulations and policies such that the life of a patient was jeopardized.

2. **Effective upon imposition:** Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief of Medical Staff, the Medical Director, and the Hospital Administrator, the appropriate hospital service director and the Governing Body. It shall remain in effect unless or until modified by the hospital administrator.
3. **Reporting procedure:**
 - a. Any individual who exercise authority under C. of this Article to suspend summarily clinical privileges shall immediately report this action to the Chair of the Executive Committee so that further action can be taken in the matter.
 - b. A review of the matter resulting in summary suspension shall be completed within fourteen (14) days of the suspension or reasons for the delay shall be transmitted to the Board so that the Board may consider whether the suspension should be lifted. In the event the suspension is lifted by the Board, the Executive Committee may take action as required, and in the manner specified in Article X – Corrective Action.
4. **Care of the suspended practitioner patients**
 - a. Immediately upon the imposition of a summary suspension, the appropriate Department Chairperson shall assign responsibility for the care of the suspended practitioner’s patients still housed in Lallie Kemp Medical Center to another practitioner with appropriate clinical privileges.
 - b. It shall be the duty of all Medical Staff members to cooperate in enforcing all suspension.

Article XII: Review, Revision, and Amendment of Bylaws, Rules and Regulations, and Medical Staff Policies

A. Bylaws: Review, revision, adoption and amendment:

1. Petition to amend the Bylaws may be made at any time by petition by 20% of the active medical staff.
2. The Bylaws will be reviewed annually and as needed by a sub-committee appointed by the MEC.
3. ***Neither the medical staff nor the governing body may unilaterally amend the medical staff Bylaws, Rules and Regulations, or policies.***

**B. Rules and Regulations, and other related Medical Staff Policies and Procedures:
Review, revision, adoption, and amendment**

1. The Medical Executive Committee will recommend to the Board a set of ~~accompanying~~ Rules~~accompanying Rules~~ and Regulations and Medical Staff Policies and Procedures that further defines the general policies contained in these Bylaws.
2. The Rules and Regulations and policies will be reviewed annually and as needed by a sub-committee appointed by the MEC.
3. Upon approval by the Board, the manuals and policies and procedures will be incorporated by reference and become part of these Medical Staff Bylaws subject to same process of review, revision and adoption


ARTICLE XIII: Adoption

- A. Proposed amendments to the Bylaws, Rules and Regulations, and Medical Staff Policies will be reviewed by the Medical Executive Committee prior to presentation for voting at the annual business meeting or other balloting means to active medical staff members.
- B. Approval will be by simple majority vote of those active medical members present and voting at the annual business meeting or simple majority vote of returned ballots when performed via mail or facsimile.

- BOGALUSA MEDICAL CENTER - BOGALUSA
- EARL K. LONG MEDICAL CENTER - BATON ROUGE
- HUEY P. LONG MEDICAL CENTER - PINEVILLE
- LALLIE KEMP REGIONAL MEDICAL CENTER - INDEPENDENCE
- LEONARD J. CHABERT MEDICAL CENTER - HOUMA
- MEDICAL CENTER OF LOUISIANA - NEW ORLEANS
- UNIVERSITY MEDICAL CENTER - LAFAYETTE
- W.O. MOSS REGIONAL MEDICAL CENTER - LAKE CHARLES

MEDICAL STAFF

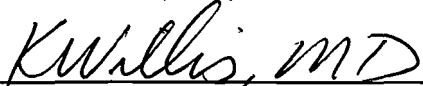
2008-2009 BYLAWS, RULES & REGULATIONS, and POLICIES



Matloob Rehman, MD, Chief of Staff

7/30/08


DATE



Kathleen Willis, MD, Medical Director

7/30/08


DATE



Sherre Pack-Hookfin, Administrator

7/30/08


DATE



Michael Kaiser, MD, Acting Chief Medical Officer
LSU Healthcare Services Division

8/1/08

DATE



Michael K. Butler, M.D., M.H.A., C.P.E.
Acting Chief Executive Officer
LSUHCSG Governing Board Delegate

7/31/08

DATE