



**OCHSNER CLINIC FOUNDATION
MEDICAL STAFF BYLAWS**

ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in these Bylaws:

- (1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than medical staff members who are authorized by law to provide patient care services, whose scope of practice is defined in the Allied Health Professionals Policy.
- (2) "BOARD" means the Board of Directors, which has the overall responsibility for the Hospital, or its designated committee.
- (3) "BOARD CERTIFICATION" is the designation received by a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process including passing an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that medical specialty. This certification may be conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, and the physician, dentist or podiatrist has received notification, in writing, that he/she is "board certified"
- (4) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Foundation.
- (5) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (6) "DAYS" means calendar days.
- (7) "FOUNDATION" means Ochsner Clinic Foundation.
- (8) "HOSPITAL" includes the Main Campus and West Bank Campus.
- (9) "HOUSE STAFF" means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (10) "MEDICAL STAFF" means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.

- (11) "MEMBER" means any physician, dentist, and/or podiatrist who has been granted medical staff appointment and clinical privileges by the Board to practice at the Hospital.
- (12) "SEC" means the Staff Executive Committee.
- (13) "SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

ARTICLE 2
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the following categories:

2.A. ATTENDING STAFF

The Attending Staff shall consist of the Admitting Academic-Active Staff and the Academic-Active Staff without admitting privileges and the Admitting Community-Active Staff.

2.A.1. Admitting Academic-Active Staff:

- (a) The Admitting Academic-Active Staff shall be those so designated by the Board. An application for membership on the Admitting Academic-Active Staff may be made by any qualified physician, podiatrist or dentist who is (1) an employee of the Foundation or any successor organization or (2) affiliated, or who is an employee, shareholder, or partner in a professional corporation or a partnership that is affiliated, under a written agreement, with the Foundation agreed upon specifically to meet unmet patient care needs or needs of the community.
- (b) Admitting Academic-Active Staff membership shall automatically terminate on the earliest of the date on which (1) the member's employment by the Foundation is terminated; (2) the member's affiliation with the Foundation is terminated; (3) the member's employment, shareholder status or partnership with a professional corporation or a partnership that is affiliated with the Foundation is terminated; or (4) the affiliation between the Foundation and the professional corporation or partnership through which the member obtained Admitting Active Staff is terminated, or expires by the terms of the written agreement of affiliation between the Foundation and said partnership or professional corporation.
- (c) Members of the Admitting Academic-Active Staff shall have the privilege of

admitting patients to their care in the Hospital. Within the limits imposed by the laws of Louisiana and this document, each member of the Admitting Academic-Active Staff shall have full discretion in the management of all patients admitted to his or her care. Admitting Academic-Active Staff members agree to (1) accept responsibility for the medical care of any patient admitted to his or her service, including without limitation charity, indigent, and Medicaid patients, (2) take an active part in the education program of the Foundation and (3) serve on a committee if so designated by the President of the Medical Staff.

2.A.2. Academic-Active Staff (Without Admitting Privileges):

- (a) Applications for membership on the Academic-Active Staff may be made by any qualified physician, podiatrist or dentist who is (1) an employee or partner of the Foundation or any successor organization, or (2) affiliated, or who is an employee, shareholder, or partner in a professional corporation or a partnership that is affiliated, under a written agreement with the Foundation, agreed upon specifically to meet unmet patient care needs or needs of the community.
- (b) Academic-Active Staff membership shall automatically terminate on the earliest of the date on which (1) the member's employment by or partnership in the Hospital is terminated; (2) the member's affiliation with the Foundation is terminated; (3) the member's employment, shareholder status or partnership with a professional corporation or a partnership that is affiliated with the Foundation is terminated; or (4) the affiliation between the Foundation and the professional corporation or partnership through which the member obtained Academic-Active Staff privileges is terminated, or expires by the terms of the written agreement of affiliation between the Foundation and said partnership or professional corporation.
- (c) Members of the Academic-Active Staff may admit their patients with supervision of an Admitting Academic-Active Staff member when such patients require hospitalization. Within the limits imposed by the laws of Louisiana and this document, each member of the Active Staff shall refer the management of

patients admitted to the care of the supervising physician. Academic-Active Staff members agree to (1) take an active part in the educational program of the Foundation and (2) serve on a committee if so designated by the President of the Medical Staff.

2.A.3. Admitting Community-Active Staff:

- (a) The Admitting Community-Active Staff shall be those so designated by the Board. An application for membership on the Admitting Community-Active Staff may be made by any qualified physician, podiatrist or dentist who has a written agreement with the Foundation
- (b) Admitting Community-Active Staff membership shall automatically terminate on the date on which the member's affiliation with the Foundation is terminated.
- (c) Members of the Admitting Community-Active Staff shall have the privilege of admitting patients to their care and may take part in the educational program of the Foundation if deemed to be needed by the appropriate Program Director. Within the limits imposed by the laws of Louisiana and this document, each member of the Admitting Community-Active Staff shall have full discretion in the management of all patients admitted to his or her care. Admitting Community-Active Staff members agree to (1) accept responsibility for the medical care of any patient admitted to their service, including without limitation charity, indigent, and Medicaid patients, and (2) serve on a committee if so designated by the President of the Medical Staff.

2.B. CONSULTING STAFF:

- (1) The Consulting Teaching Staff shall consist of physicians, podiatrists or dentists who are faculty at LSU or Tulane or other academic institutions and who would be responsible for certain teaching activities at Ochsner at the discretion of the department chairperson and section head.
- (2) Members of the Consulting Teaching Staff shall not have the privilege of admitting patients to the Hospital for care or treatment, but would have the ability

to attend teaching rounds and offer medical opinions to the Attending Staff.

- (3) Members of the Consulting Teaching Staff are not eligible to vote at meetings of the Medical Staff or to hold office.

2.C. COURTESY STAFF

- (1) The Courtesy Staff shall consist of physicians, podiatrists or dentists who are employed by the Foundation, but who primarily practice in and are appointed to the Active staff of at least one other hospital and shall provide the Hospital with all requested information regarding their exercise of clinical privileges at such other hospitals.
- (2) The Courtesy Staff shall not be responsible for the care of more than twenty-four patients per year at the Main Campus hospital.
- (3) Courtesy staff are not required to attend Medical Staff meetings and may neither vote nor hold office.

2.D. ASSOCIATE STAFF

- (1) The Associate Staff shall consist of doctorate level healthcare professionals who have signified willingness to accept such appointment. Applications for membership on the Associate Staff may be made by any qualified practitioner who is (1) an employee of the Foundation or any successor organization, or (2) affiliated, or who is an employee, shareholder, or partner in a professional corporation or a partnership that is affiliated, under a written agreement with the Foundation.
- (2) Associate Staff membership shall automatically terminate on the earliest date on which (1) the member's employment by the Foundation is terminated; (2) the member's affiliation with the Foundation is terminated; (3) the member's employment, shareholder status or partnership with a professional corporation or a partnership that is affiliated with the Foundation is terminated; or (4) the affiliation between the Foundation and the professional corporation or partnership through which the member obtained Associate Staff privileges is terminated or

expires by the terms of the written agreement of affiliation between the Foundation and said partnership or professional corporation.

- (3) Members of the Associate Staff may attend meetings of the Medical Staff and will be eligible for appointment to standing and special committees of the staff, but will not be eligible to hold office or vote on matters relating to the Medical Staff.

2.E. CONSULTING STAFF

- (1) The Consulting Staff shall consist of recognized specialists who are physicians, podiatrists or dentists who have signified willingness to accept such appointment. Members of the Consulting Staff shall not have the privilege of admitting patients to the Hospital for care or treatment and shall be responsible for the care or treatment of patients only when specifically requested by the Academic Active Staff member seeking consultation. If patient care is necessary, temporary privileges are required for treatment on each patient for whom the consult is requested.
- (2) Consulting staff are not required to attend Medical Staff meetings and may neither vote nor hold office.

2.F. HONORARY STAFF

- (1) The Honorary Staff shall consist of physicians or dentists who have retired or have emeritus positions. These may be physicians or dentists who have retired from active practice or physicians or dentists of outstanding reputation not necessarily resident in the community.
- (2) The Honorary Staff shall have no assigned duties or responsibilities. This appointment may be recommended by the SEC without a formal application from the individual the Medical Staff wishes to honor. Honorary members shall not be eligible to vote or hold office and shall not have the privilege of admitting patients to the Hospital for care or treatment.

2.G. SCIENTIFIC STAFF

- (1) Scientists with a degree of Doctor of Philosophy or physicians, dentists or podiatrists employed by the Foundation and working exclusively in the field of Research may be appointed to the Scientific Staff after appropriate review by the SEC and when sponsored by a member of the Medical Staff. Members of the Scientific Staff shall have no privileges with respect to the admission of patients to the Hospital and shall not have independent privileges with respect to diagnosis and treatment of patients. They will act in an advisory or supportive capacity to physicians, dentists or podiatrists who are members of the Medical Staff. They may direct or undertake laboratory procedures for diagnostic purposes or research projects involving patients, or both, but any such procedures and projects may be carried out only with the consent and under the direct responsibility of the physician, dentist or podiatrist in charge of the patient.
- (2) Members of the Scientific Staff may attend meetings of the Medical Staff and will be eligible for appointment to standing and special committees of the staff, but will not be eligible to hold office or vote on matters relating to the Medical Staff.

ARTICLE 3
OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President, Vice President and Secretary.

3.B. ELIGIBILITY CRITERIA

Only those members of the Admitting Academic-Active Staff or Active-Academic Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff. They must:

- (1) be employed by the Foundation, and appointed in good standing to the Admitting Academic-Active Staff, or Academic-Active Staff and have served on the Academic-Active Staff for at least five years;
- (2) have no pending adverse recommendations concerning medical staff appointment or clinical privileges;
- (3) not presently be serving as a medical staff officer, Board member or Department chair at any other hospital and shall not so serve during their term of office;
- (4) be willing to faithfully discharge the duties and responsibilities of the position;
- (5) attend continuing education relating to medical staff leadership and/or credentialing functions prior to or during the term of the office;
- (6) disclose to the SEC any financial relationship (i.e., an ownership or investment interest in or compensation arrangement) with an entity that competes with the Foundation or any affiliate.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

- (a) act in coordination and cooperation with Hospital management in matters of mutual concern involving the care of patients in the Hospital;
- (b) represent and communicate the views, policies and needs of the medical staff, and

- report on the activities of the Medical Staff to the CEO and the Board;
- (c) call, preside at (with vote), and be responsible for the agenda of all meetings of the Medical Staff and the SEC, Bylaws Committee, and Nominating Committee;
 - (d) appoint all committee chairpersons and committee members;
 - (e) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the Policies and Procedures of the Hospital; and
 - (f) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. Vice President:

The Vice President shall:

- (a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;
- (b) serve on the SEC and
- (c) assume all such additional duties as are assigned to him or her by the President of the Medical Staff or the SEC.

3.C.3. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

- (a) serve on the SEC;
- (b) serve as an advisor to other medical staff leaders; and
- (c) assume all duties assigned by the President of the Medical Staff or the SEC.

3.C.4. Secretary:

The Secretary shall:

- (a) serve on the SEC;
- (b) cause to be kept accurate and complete minutes of all SEC and Medical Staff meetings;
- (c) call medical staff meetings on order of the President of the Medical Staff and record attendance; and

- (d) perform such other duties as ordinarily pertain to the office of Secretary.

3.D. NOMINATIONS

The Nominating Committee shall consist of two Past Presidents of the Medical Staff and the current president for all general and special elections. The Committee shall convene prior to the election. Notice of the nominees shall be provided to the Medical Staff prior to the election. Nominations may also be submitted in writing by petition signed by at least five Academic-Active Staff members prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

3.E. ELECTION

Candidates receiving a majority of votes cast shall be elected. Members of the Attending Staff (Admitting Academic-Active, Academic-Active (without admitting privileges) and Admitting Community-Active) are eligible to vote in elections for officers.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected.

3.G. REMOVAL

- (1) Removal of an elected officer or an at-large member of the SEC may be effectuated by a two-thirds vote of the Medical Staff, SEC; or by the Board for:
 - (a) failure to comply with applicable policies, Bylaws or Rules and Regulations;
 - (b) failure to perform the duties of the position held;
 - (c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
 - (d) any infirmity that renders the individual incapable of fulfilling the duties

of that office.

- (2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical staff, SEC or the Board prior to a vote on removal.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President's unexpired term. In the event there is a vacancy in another office, the SEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the SEC.

ARTICLE 4
STAFF DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff is a single, organized, self governing medical staff, that provides a mechanism to ensure a uniform standard of quality patient care, treatment and services. The Medical Staff is accountable to the Board for the quality of the medical care, treatment and services provided to patients.

The Medical Staff is organized in a manner approved by the Ochsner Clinic Foundation Board of Directors and shall be organized into the Departments and Sections listed in the Organization Manual.

Each section shall be organized as a division of the parent department and shall have as its head, a chief of section, who shall be responsible to the department chairperson. The chief of section shall assume general supervision of the clinical work in his/her section.

4.B. ASSIGNMENT TO DEPARTMENT

- (1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical Department. Assignment to a particular Department does not preclude an individual from seeking and being granted clinical privileges typically associated with another Department.
- (2) An individual may request a change in Department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The Departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the Departments, and (ii) to monitor the practice of all those with clinical privileges in a given Department. Each Department shall develop a schedule for emergency call

coverage for all patients.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND SECTION HEADS

Each Department Chair/Section Head shall:

- (1) To facilitate continuity of care, the hospital's department chair/section head will be the corresponding chair/section head of the New Orleans Ochsner Clinic Foundation Department or Section.
- (2) Be appointed as described in the Ochsner Clinic Foundation Bylaws.
- (3) Be certified by an appropriate specialty board.

4.E. DUTIES OF DEPARTMENT CHAIR

The department chairperson/section head shall be responsible for:

- (1) Clinically related activities of the department.
- (2) Administratively related activities of the department, unless otherwise provided by the hospital.
- (3) Continuing surveillance of the professional performance (either personally or through delegation to appropriate regional leadership) of all individuals in the department who have delineated clinical privileges.
- (4) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.
- (5) Recommending clinical privileges for each member of the department.
- (6) Assessing and recommending to the relevant hospital authority offsite sources for needed patient care, treatment, and services not provided by the department or the organization.
- (7) The integration of the department or service into the primary functions of the organization.
- (8) The coordination and integration of interdepartmental and intradepartmental services.
- (9) The development of implementation of policies and procedures that guide and support the provision of care, treatment and services.

- (10) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and service.
- (11) The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- (12) The continuous assessment and improvement of the quality of care, treatment, and services.
- (13) The maintenance of quality control programs, as appropriate.
- (14) The orientation and continuing education of all persons in the department or service.
- (15) Recommendations for space and other resources needed by the department or service.
- (16) Performing all functions authorized in the Credentials Policy including collegial intervention.

At his/her discretion, a department chair may divide his/her department into sections and appoint a member of the Active Staff to act as chief of section. Each department and section shall meet at the discretion of the chairperson.

ARTICLE 5
MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. STAFF EXECUTIVE COMMITTEE

5.A.1. Composition:

- (a) The Staff Executive Committee ("SEC") shall consist of the President, Vice President and Secretary of the Medical Staff, seven members to be elected from the Admitting Academic-Active Staff or Academic-Active Staff, one of whose practice must be primarily based at one of the Ochsner Clinic satellites, three members of the Admitting Community-Active Staff (selected by the West Bank Campus Operating Committee) and, in addition, the Chairperson of the Main Campus Performance Improvement Committee and Main Campus Departments of Radiology, Anesthesiology, Pathology, Emergency Medicine and Hospital Medicine or Senior Admitting Academic-Active Staff members of these departments designated by the said Chairpersons, respectively. The seven members from the Admitting Academic-Active Staff or Academic-Active Staff shall be elected by majority vote of those present at a meeting of the Medical Staff in a calendar year. The Staff Executive Committee shall be empowered to represent and to act on behalf of the medical staff in all matters, subject only to any limitations imposed by these bylaws. The Committee shall serve in an advisory capacity to the CEO, the Board of Directors of OCF and the Medical Staff.
- (b) The President of the Medical Staff will chair the SEC.
- (c) The COO ("Chief Operating Officer") shall be an ex officio member of the SEC, without vote.
- (d) The Medical Director shall be an ex officio member, without vote.
- (e) The President of the Fellows' Association shall be invited to attend relevant portions of SEC meetings, but shall have no vote.
- (f) The Chief Nurse Executive shall be a member of the SEC, with vote.

- (g) The Vice President of Medical Affairs for the Ochsner Medical Center of New Orleans shall be an ex officio member of the SEC, without vote.
- (h) The Associate Medical Director for the Hospital-Based Departments shall be an ex officio member of the SEC, without vote.

5.A.2. Duties:

The SEC is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement activities regarding the professional services provided by individuals with clinical privileges. The SEC is responsible for the following:

- (a) acting on behalf of the Medical Staff in the intervals between medical staff meetings (the officers are empowered to act in urgent situations between SEC meetings);
- (b) presenting at each regular business meeting of the staff a report of its activities since the last meeting with emphasis on action taken on the basis of reports of standing committees;
- (c) keeping Medical Staff informed of hospital's accreditation program and of accreditation status of the hospital;
- (d) receiving and acting upon reports and recommendations from the Medical Staff Operating Committees, clinical departments/services and assigned activity groups;
- (e) making recommendations to the Board regarding:
 - i. the Medical Staff's structure;
 - ii. the mechanism used to review credentials and to delineate individual clinical privileges;
 - iii. applicants for Medical Staff appointment;
 - iv. delineation of clinical privileges for each eligible individual;
 - v. participation of the Medical Staff in Hospital performance improvement activities;
 - vi. the mechanism by which Medical Staff appointment may be terminated;

and

- vii. hearing procedures;
- (f) annual review of Medical Staff policies and when appropriate and necessary recommend changes to medical staff policies to the medical staff or delegate review of certain policies to appropriate committee or department chairperson;
- (g) consulting with administration on quality related aspects of contracts for patient care services;
- (h) providing oversight in the process of analyzing and improving patient satisfaction;
- (i) reviewing, at least every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable;
- (j) providing leadership in activities related to patient safety;
- (k) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services; and
- (l) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy or other applicable policies.

5.A.3. Meetings:

The SEC shall meet as often as necessary to fulfill its responsibilities, but at least six times per year, and maintain a permanent record of its proceedings and actions.

5.B. PERFORMANCE IMPROVEMENT FUNCTIONS

- (1) The performance improvement functions to improve the clinical and non-clinical processes that require medical staff leadership or participation shall be performed by such committees, Departments and individuals as may be designated by the SEC in consultation with the CEO. When the performance of a process is dependent primarily on the activities of individuals with clinical privileges, the Medical Staff shall provide leadership for and participate in process measurement, assessment, and improvement, including, but not limited to:
 - (a) patient safety, including processes to respond to patient safety alerts, meet

- patient safety goals and reduce patient safety risks;
 - (b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;
 - (c) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;
 - (d) the utilization of blood and blood components, including review of significant transfusion reactions;
 - (e) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - (f) education of patients and families;
 - (g) coordination of care, treatment and services with other practitioners and Hospital personnel;
 - (h) accurate, timely and legible completion of medical records;
 - (i) the use of developed criteria for autopsies;
 - (j) sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - (k) nosocomial infections and the potential for infection;
 - (l) unnecessary procedures or treatment; and
 - (m) appropriate resource utilization.
- (2) A description of the committees that carry out monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Organization Manual.

5.C. CREDENTIALING AND PEER REVIEW FUNCTIONS

Mechanisms for appointment, reappointment, delineation of clinical privileges, collegial and educational efforts, investigations, hearings and appeals that apply to medical staff members shall be contained in the Credentials Policy.

5.D. RESPONSIBILITIES AND RELATED DOCUMENTS

Medical Staff members shall fulfill all applicable responsibilities contained in these Bylaws, the Credentials Policy, Organization Manual, Medical Staff Rules and Regulations and other applicable Bylaws, policies and Rules and Regulations.

5.E. APPOINTMENT OF COMMITTEE CHAIRPERSONS AND MEMBERS

- (1) The Main Campus and West Bank Campus Operating Committees shall report to the SEC. Except as otherwise provided in these Bylaws or the Organization Manual, all committee chairpersons of Main Campus committees shall be employed by the Foundation.
- (2) Except as otherwise provided in these Bylaws or the Organization Manual, all committee chairpersons and members of Main Campus committees shall be appointed by the President of the Medical Staff. A minimum of 2/3 of the voting physician members of each such committee shall be physicians employed by the Foundation.
- (3) The chairpersons and members of committees that report to the West Bank Operating Committee shall be appointed by the Chair of the West Bank Operating Committee.
- (4) Committee chairpersons and members shall be appointed for initial terms of three years, but may be reappointed for additional terms.
- (5) The President of the Medical Staff and the CEO (or their respective designees) shall be members, ex officio, without vote, on all committees reporting to the SEC, unless otherwise stated.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the SEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the SEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be

performed by these Bylaws which is not assigned to an individual, a standing committee, or a special task force shall be performed by the SEC.

5.G. SPECIAL TASK FORCES

Special task forces shall be created and their members and chairpersons shall be appointed by the President of the Medical Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the SEC.

ARTICLE 6
MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least once a year.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the SEC, the Board, or by a petition signed by not less than five members of the Active Staff.

6.C. COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each committee shall meet at least quarterly, at times set by the presiding officer.

6.C.2. Special Meetings:

A special meeting of any committee may be called by or at the request of the presiding officer, the President of the Medical Staff, or by a petition signed by not less than one-fourth of the Academic-Active or Admitting Academic-Active Staff members of the committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

- (a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff prior to the meetings. All notices shall state the date, time, and

place of the meetings.

- (b) When a special meeting of the Medical Staff, and/or a committee is called, all of the provisions in paragraph (a) shall apply.

6.D.2. Quorum and Voting:

- (a) For any regular or special meeting of the Medical Staff, or committee, those voting members present shall constitute a quorum. For meetings of the SEC, the presence of at least 6 voting members of the total Committee shall constitute a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.
- (b) Recommendations and actions of committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present.
- (c) Any matter may be presented by notice and votes returned to the presiding officer by the method designated in the notice. The question raised shall be determined in the affirmative if a majority of the ballots returned have so indicated.
- (d) Recommendations and actions of the medical staff involving vote will require a quorum of 15% academic-active medical staff members present, or 15% of total mail ballots returned.

6.D.3. Agenda:

The presiding officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff or committee.

6.D.4. Minutes, Reports, and Recommendations:

- (a) Minutes of all meetings of the Medical Staff, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the presiding officer.
- (b) A summary of all recommendations and actions of the Medical Staff, and

committees shall be transmitted to the SEC and CEO. The Board shall be kept apprised of the recommendations of the Medical Staff and its departments, sections, and committees.

- (c) A permanent file of the minutes of all meetings at which minutes are kept shall be maintained by the Hospital.

6.D.5. Confidentiality:

Members of the Medical Staff who have access to credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action.

6.D.6. Attendance Requirements:

Each Active Staff member is expected to attend and participate in all medical staff meetings and applicable Department, section, and committee meetings each year.

ARTICLE 7
AMENDMENTS

- (a) All proposed bylaws amendments must be reviewed by the SEC prior to a vote by the Medical Staff. Members of the Admitting Academic-Active Staff and Academic-Active Staff (without admitting privileges) are eligible to vote. The SEC shall provide notice by reporting on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.
- (b) The SEC may present proposed amendments to the voting staff by mail ballot after the proposed amendments have been presented to the staff at a quarterly or specially called meeting. Along with the proposed amendments, the SEC may, at its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast.
- (c) The SEC shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.
- (d) All amendments shall be approved by the Board.
- (e) If the Board has determined not to accept a recommendation submitted to it by the SEC or the Medical Staff, the SEC may request a conference between the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation.

Amended by the Ochsner Clinic Foundation Medical Staff on:

July 12, 2005

August 28, 2006

February 27, 2007

July 24, 2008

Approved by the Ochsner Clinic Foundation Board of Directors on:

July 18, 2005

September 11, 2006

April 9, 2007

July 28, 2008

ARTICLE 8

OTHER MEDICAL STAFF DOCUMENTS

- (a) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures and rules and regulations shall be considered an integral part of the Medical Staff Bylaws.
- (b) Medical Staff documents other than the Medical Staff Bylaws may be amended by a majority vote of the members of the SEC present and voting at any meeting of that committee where a quorum exists.
- (c) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff and any Medical Staff member may submit written comments on the amendments to the SEC.
- (d) All amendments shall be approved by the Board.

ARTICLE 9
INDEMNIFICATION

The Foundation shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairmen, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Foundation's bylaws.

ARTICLE 10
ADOPTION

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on:
June 19, 2002

Approved by the Ochsner Clinic Foundation Board:
July 17, 2002



RULES AND REGULATIONS

RULES AND REGULATIONS

The Active Staff through the representation of the Staff Executive Committee shall adopt such rules and regulations as may be necessary for the proper conduct of its work.

1. The regular business meetings of the Medical Staff shall be held twice each year.
2. Medical Records.
All entries in the medical record shall be legible.

The Medical record for each patient includes but not limited to the following:

- identification data
- history & physical
- physician orders
- operative reports
- consultation reports
- imaging reports
- laboratory reports
- pathology reports
- other ancillary reports
- provisional diagnosis
- progress notes
- final diagnosis
- condition on discharge
- discharge summary
- autopsy reports
- consent form(s)

Medical records shall be permanently filed when complete or approved for filing by the Medical Records Committee.

- (b) The attending member of the Medical Staff shall be held responsible for the preparation of the medical record, concurrent documentation and authentication of entries, and for ensuring that the discharge summary is completed within 24 hours of discharge. All records shall be completed within 30 days following the patient's discharge from the Hospital.
- (c) Residents are expected to adhere to the same policy as members of the Ochsner Clinic Foundation medical staff in regard to medical record completion. Academic credit can be withheld, at the prerogative of the Program Director, for failure to comply with the timely completion of medical records with the review and endorsement of the Graduate Medical Education Committee (GMEC). The involved resident has the right to challenge this decision through the established Ochsner Clinic Foundation GMEC Grievance Policy.
- (d) History and Physical

It shall be the responsibility of the attending physician and/or resident or allied health or mid-level provider who is licensed and credentialed to record a complete history and physical examination for each patient within twenty-four hours after admission or within 30 days before admission and before any interventional or invasive procedure is performed. When a history and physical is completed within 30 days before an admission, an updated medical record entry documenting an examination of any changes in the patient's current condition must be documented.

- The history and physical shall include chief complaint, present illness, relevant past social family history, past medical history and physical examination.
- A short stay history and physical exam performed by a qualified physician is acceptable for inpatient admission of less than forty-eight (48) hours and required for ambulatory outpatients undergoing invasive procedures or procedures requiring a history and physical.

Outpatient invasive procedures requiring a history and physical include:

- Procedures performed in the operating room
- Invasive procedures performed in cardiology and endoscopy procedure areas
- Procedures utilizing moderate sedation
- Cardiac Angiogram
- Cardiac Countershock

When a history and physical is not documented before an operation or invasive procedure, the procedure shall be cancelled or delayed unless the attending physician states in writing that the delay would be detrimental to the health of the patient.

(e) Orders

All orders for treatment shall be written clearly, legible, dated, timed, authenticated and may be written by Active Staff, Consulting Staff, Academic Staff, House Staff, those with temporary privileges, and Allied Health Professionals who are licensed and credentialed to do so.

(f) Verbal orders

- i. Verbal orders shall be used only when the practitioner is not physically present to document in the record or when the practitioner is involved in urgent care matters that prevent their direct entry.
- ii. An order dictated over the telephone shall be signed, dated and timed by the person to whom dictated. The order must be under the name of the practitioner issuing the order.
- iii. Verbal orders shall be only accepted by licensed (graduate) nurse, dietician, pharmacist, respiratory therapist, physical, occupational, or speech therapist.
- iv. Verbal orders shall be signed within 10 days by the prescribing practitioner and/or fellow physician caring for the patient.
- v. All verbal orders shall be read back for validation.

(g) Progress Notes

Active participation in the treatment of the patient should be evidenced by daily legible, dated, timed and authenticated progress notes by a physician, resident, nurse practitioner or physician assistant participating in the care of the patient.

(h) Operative/ Procedure Reports

All operations shall be fully described in writing or dictation by the attending surgeon or his assistant immediately following the operation or procedure. Operative reports must contain a description of the findings, the technique used, the tissue or specimen removed or altered and the postoperative diagnosis. In the event of a transcription delay, an operative or procedure postoperative note must be entered in the medical record to facilitate continuity of care. All tissues or specimens removed at the operation must be examined by a pathologist, unless the specimen is one for which the obligation has been exempted. The Staff Executive Committee in consultation with the Surgical Services Council and the Department of Pathology may determine types of specimens which may be exempted. The pathologist's findings shall be reported in writing and the report signed by the pathologist.

(i) Consultation Reports

A consultation report shall include findings, opinions and recommendations and shall be signed and documented in the medical record.

(j) Discharge Summary

discharge summary report shall be written or dictated for all hospitalized patients within 24 hours of discharge. A short stay discharge plan documented by a qualified physician and authenticated by the medical staff responsible for the care of the patient is acceptable for patients hospitalized less than forty-eight hours and for ambulatory outpatients undergoing invasive procedures. All discharge summaries shall be dated and authenticated by the responsible provider. The report shall include the following:

- Primary and secondary diagnosis
- Brief history
- Pertinent physical and laboratory, imaging and other relevant findings
- Course of treatment
- Condition on discharge
- Follow-up care
- Discharge medications

(k) Time Out – Verification of correct site, correct procedure, correct person shall be documented per policy.

(k) Symbols and abbreviations are only used in accordance with policy.

(l) The medical record shall be completed in accordance with the Health Information Management Policy.

- (m) All records are the property of the Ochsner Clinic Foundation and shall not be taken from Ochsner Clinic Foundation or Ochsner Clinics except in accordance with a court order, subpoena or statute. Medical records may be released from the institution in accordance with release of information policies of Ochsner Clinic Foundation.
- 3. It shall be the responsibility of each staff member to attempt to obtain permission for autopsies on all unexplained and unexpected patient deaths, and all deaths in patients receiving experimental therapy while under his/her care. No autopsy shall be performed without written consent of a relative or legally authorized agent.
- 5. The member shall also bring to the attention of the Credentials Committee, through its secretary, any pending challenges to the member's licensure or registration, any pending Drug Enforcement Agency (DEA) investigation involving the staff member, or of any pending loss of Medical Staff membership or clinical privileges at any medical institution.

Failure to timely report, enforcement actions, licensure or privileges revocations as provided herein may result in disciplinary action against the member as provided in the Credentials Policy.

- 6. On-Call Rotation Responsibilities.
 - (a) The chairperson of each department/section, on behalf of the Hospital, shall be responsible for developing an on-call rotation schedule that includes the name and pager number of each physician in the department who is required to fulfill on-call duties. On-call rotation schedules shall be maintained in the Emergency Department.
 - (b) Members of the Active Staff with admitting privileges have an obligation, but not a right, to share on-call duties.
 - (c) Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility, if it reduces the level of service to the Emergency Department.
 - (d) When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must do so within a reasonable time period. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be controlling in this regard.
 - (e) An on-call physician or his designee is responsible for the care of a patient through the episode that created the emergency medical condition until the time of hospital discharge or transfer to another service.
 - (f) A refusal or failure to timely respond shall be reported immediately to the Medical Director and/or designee, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Staff Executive Committee for further investigation and appropriate disciplinary action.

- (g) All designated attending staff on-call for hospital service shall be available by beeper or telephone on a 24-hour per day basis for the duration of the on-call schedule unless unavailable as defined by EMTALA regulations.
- 7. The Foundation's Academic Division through its Graduate Medical Education Committee (GMEC) delegates to the appropriate Medical Staff full responsibility for the supervision of residents appointed by and assigned to the Ochsner Clinic Foundation, as outlined in Graduate Medical Education Institutional Policy.

AMENDMENTS

These Medical Staff Rules and Regulations may be amended by a majority vote of the members of the SEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be posted in advance of the SEC meeting and any member of the Medical Staff may submit written comments to the SEC. No amendment shall be effective unless and until it has been approved by the Board.

Amended by the Staff Executive Committee:

June 14, 2005

July, 2008

Approved by the Board of Directors of Ochsner Clinic Foundation:

July 18, 2005

July, 2008

ADOPTION

These Medical Staff Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Rules and Regulations pertaining to the subject matter thereof.

Adopted by the Medical Staff of Ochsner Clinic Foundation

June 19, 2002

Approved by the Board of Directors of Ochsner Clinic Foundation

July 17, 2002



OCHSNER CLINIC FOUNDATION CREDENTIALS POLICY

CREREDENTIALS POLICY

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ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (a) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than medical staff members who are authorized by law to provide patient care services, whose scope of practice is defined in the Allied Health Professionals Policy.
- (b) “BOARD” means the Board of Directors of the Foundation, which has the overall responsibility for the Foundation, or its designated committee.
- (c) “BOARD CERTIFICATION” is the designation received by a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process including passing an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that medical specialty. This certification may be conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, and the physician, dentist or podiatrist has received notification, in writing, that he/she is “board certified”.
- (d) “Chief Executive Officer” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the Foundation.
- (e) “CLINICAL PRIVILEGES” means the authorization granted by the Board to render specific patient care services.
- (f) “DAYS” means calendar days.
- (g) “SEC” means the Staff Executive Committee.
- (h) “FOUNDATION” means Ochsner Clinic Foundation.
- (i) “HOUSE STAFF” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (j) “MEDICAL STAFF” means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.
- (k) “MEMBER” means any physician, dentist, and/or podiatrist who has been granted medical staff appointment and clinical privileges by the Board to practice at the Foundation.
- (l) “SPECIAL NOTICE” means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

ARTICLE 2
QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

- (a) be an employee of Ochsner Clinic Foundation or any successor organization ;or
- (b) be affiliated, or who is an employee, shareholder, or partner in a professional corporation or partnership that is affiliated, under a written agreement with Ochsner Clinic Foundation.
- (c) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;
- (d) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;
- (e) be located (office and residence) within the geographic service area of the Foundation, as defined by the Board, close enough to fulfill their medical staff responsibilities and to provide timely and continuous care for their patients;
- (f) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Foundation;
- (g) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (h) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (i) have never had medical staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (j) have never been convicted of any felony, or of any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse or violence;
- (k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in a specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (l) be certified by the appropriate specialty board of the ABMS, the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency training within the last five (5) years shall be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification within five (5) years from the date of completion of their residency training. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of

adoption of this Policy. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments).

2.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, SEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Foundation and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a “denial” of appointment or clinical privileges.

2.A.3. Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, demonstrated current competence and judgment;
- (b) adherence to the ethics of their profession;
- (c) good reputation and character;
- (d) ability to perform, safely and competently, the clinical privileges requested; and
- (e) ability to work harmoniously with others sufficiently to convince the Foundation that all patients treated by them will receive quality care and that the Foundation and its Medical Staff will be able to operate in an orderly manner;
- (f) challenges to any licensure or registration;
- (g) voluntary and involuntary relinquishment of any license or registration;
- (h) voluntary and involuntary termination of medical staff membership;
- (i) voluntary and involuntary limitation, reduction, or loss of clinical privileges;
- (j) any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant;
- (k) documentation as to the applicant’s health status
- (l) relevant practitioner-specific data are compared to aggregate data, when available;

(m)morbidity and mortality data, when available

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, medical staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Foundation; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, race, creed, religion, age, disability, sexual orientation, marital status, military reserve status or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and member specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Foundation and Medical Staff in force during the time the individual is appointed;
- (c) to accept committee assignments, emergency service call obligations, and such other reasonable duties and responsibilities as assigned;
- (d) to provide, with or without request, new or updated information to the Medical Staff Office as it occurs, pertinent to any question on the application form;
- (e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Rules and Regulations and agrees to be bound by them;
- (f) to appear for personal interviews in regard to an application for initial appointment or reappointment;
- (g) to use the Foundation's facilities sufficiently to allow continuing assessment of current competence;
- (h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (i) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (j) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (k) to seek consultation whenever necessary;
- (l) to participate in monitoring and evaluation activities;
- (m) to complete in a timely manner all medical and other required records, containing all information required by the Foundation;
- (n) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (o) to satisfy continuing medical education requirements; and
- (p) that, if there is any misstatement in, or omission from, the application, the Foundation may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

2.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete within timeframe requested after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications.
- (b) In addition to other information, the applications shall seek the following:
 - i. information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;
 - ii. information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - iii. information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the SEC, or the Board may request; and
 - iv. current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts the following conditions during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, the Foundation, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Foundation, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Foundation, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Foundation and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Foundation representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Foundation.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Foundation and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information among Components:

The individual specifically authorizes the Foundation and its components to share credentialing and peer review information within the system and with other entities that delegate credentialing to OCF pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment.

2.D. Leave of Absence

- (a) Voluntary Leave - A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting written notice to the President of the Medical Staff, Medical Director or Associate Medical Director or the request may come directly from the regional Medical Director's office on behalf of the Medical Staff member upon collaboration with the Medical Staff member. The request is presented to the Credentials Committee stating the period of time of the leave, which may not exceed six months or the remaining term of the practitioner's appointment to the Medical Staff. The Credentials Committee shall approve or deny the request for the leave of absence subsequently informing the Board at their next regularly scheduled meeting. If the Credentials Committee declines the request, the practitioner shall continue to fulfill all qualifications and responsibilities of Medical Staff appointment, unless he/she permanently resigns from the Medical Staff or terminates his/her affiliation with Ochsner Clinic Foundation. The Medical Staff member shall not exercise any of the privileges or requirements of medical staff membership during the leave of absence.
- (b) Termination of Leave – At least twenty days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member or the regional Medical Director's office after collaboration with the Medical Staff member may request reinstatement of privileges by submitting a written notice to the Credentials Committee, accompanied by a summary of relevant activities during the leave and a statement that the practitioner continues to meet all of the qualifications for Medical Staff appointment and Clinical Privileges. The Credentials Committee shall approve or deny the reinstatement and will forward their decision to the Board.
- (c) New Privileges – If a practitioner requesting reinstatement also requests additional Clinical Privileges, the request for additional Clinical Privileges shall be processed separately.
- (d) Failure to Request Reinstatement – Failure to make a timely request for reinstatement or to provide a summary of activities and statement of continued qualification shall result in automatic termination of membership, privileges, and prerogatives without any further procedural rights. A request for Medical Staff Membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for Initial Appointment to the Medical Staff.

- (e) Medical Leave of Absence – The Credentials Committee shall determine the circumstances under which a particular Medical Staff Member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. Medical Leave of absence for practitioners employed by Ochsner Clinic Foundation will be processed through the appropriate Regional Medical Director’s office.
- (f) Military Leave of Absence – Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Credentials Committee. Reactivation of membership to the Medical Staff and Clinical Privileges previously held shall be granted, as outlined in the “Military Leave Medical Staff Policy” Policy No. 4.23 approved by the Credentials Committee and Board of Directors.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT TO THE MEDICAL STAFF

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be in writing and shall be on a uniform form designed by the Medical Staff Office.
- (b) An individual seeking initial appointment shall be sent a letter that outlines the eligibility criteria for appointment, the applicable criteria for clinical privileges and the application form.
- (c) A completed application form with copies of all required documents must be returned to the Medical Staff Office.

3.A.2. Initial Review of Application:

- (a) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will be withdrawn.
- (b) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

3.A.4. Department Chair Procedure:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. Each chair shall verify that the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The department chair shall be available to the Credentials Committee, SEC or the Board to answer any questions that may be raised with respect to that chair's report and findings.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.
- (b) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the applicant's Confirmation of Ability to Perform Privileges Requested to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.
- (c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

3.A.6. SEC/Credentials Committee Procedure:

- (a) The Credentials Committee is composed of the members of the SEC. The Credentials Committee reviews and makes recommendations on all applications for appointment to all categories of the Medical Staff, except the house staff, and on all recommendations that specific appointments not be renewed on behalf of the SEC directly to the Board.
- (b) If the recommendation of the Credentials Committee would entitle the applicant to request a hearing, the Credentials Committee shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and there is no evidence of any of the following:
 - i. a current or previously successful challenge to any license or registration;
 - ii. an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - iii. a final adverse judgment in a professional liability action.
 - iv. Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.
- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - i. appoint the applicant and grant clinical privileges as recommended; or
 - ii. refer the matter back to the Credentials Committee or to another source inside or outside the Foundation for additional research or information; or
 - iii. reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairpersons of the Credentials Committee. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. In the event that necessary information cannot be verified within that time frame, the matter will be discussed at the next regularly scheduled meeting of the Credentials Committee. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. PROVISIONAL STATUS

3.B.1. Duration of Provisional Period:

- (a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial clinical privileges shall be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee.
- (b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period will be recommended by the Credentials Committee, after consulting with the department chair, and approved by the Board.
- (c) During the provisional period, the individual shall be evaluated by the chair of the department in which the individual has clinical privileges and by the relevant committees as to the individual's clinical competence and general behavior and conduct.

ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges.
- (b) ~~Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.~~
- (c) The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Foundation's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
- (d) Clinical privileges may be voluntarily relinquished only in a manner that provides for the orderly transfer of applicable obligations.
- (e) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.
- (f) The clinical privileges recommended to the Board shall be based upon consideration of the following:
 - i. the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;
 - ii. availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;
 - iii. professional liability insurance coverage in a form and in amounts satisfactory to the Foundation, for the clinical privileges requested;
 - iv. the Foundation's available resources and personnel;
 - v. any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - vi. any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and
 - vii. other relevant information, which may include a written report and findings by the chair of each of the clinical departments in which privileges are sought.
- (g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
- (h) During the term of appointment, a member may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria.

4.A.2. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform a new procedure or service not currently being performed at the Foundation will be reviewed by the Credentials Committee for determination if added privileging is required.
- (b) The Credentials Committee will approve (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee shall review the matter and forward its recommendations to the Board for final action.

4.A.3 Clinical Privileges That Cross Specialty Lines:

- a) Requests for clinical privileges that traditionally at Ochsner Clinic Foundation have not been included in a specialty's delineation of privileges and/or have been exercised by individuals from another specialty will be processed after a determination has been made regarding the individual's eligibility to perform the clinical privileges in question.
- b) The Credentials Committee shall develop recommendations regarding the (1) minimum education, training, and experience necessary to perform the clinical privileges in question and (2) the extent of monitoring and supervision that should occur. The Credentials Committee shall consult with experts who may include those on the Medical Staff (e.g. department chairs, individuals with special interest and/or expertise) and may conduct research inside and/or outside the Ochsner Clinic Foundation (e.g. specialty societies, residency training programs, other hospitals).
- c) The Credentials Committee shall review the matter and forward its recommendations to the Board for action. Final approval will reside with the Foundation Board.

4.A.4. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chair of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the medical staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the medical staff Rules and Regulations and in compliance with the Foundation and Medical Staff Bylaws and this Policy.

4.A.5. Clinical Privileges for Podiatrists:

- (a) The scope and extent of surgical procedures that a podiatrist may perform shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by podiatrists shall be under the general supervision of the Chair of Podiatry. A medical history and physical examination of each patient shall be made and recorded before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Foundation and Medical Staff Bylaws and this Policy.

4.A.6. House Staff:

House Staff shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty and/or attending staff members shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the CEO or designee only to meet an important patient care need that requires immediate authorization for the care of a specific patient.
- (b) The Medical Staff Office shall verify appropriate information regarding the individual's licensure, DEA registration, current clinical competence and judgment, character, ethical standing, behavior, ability to safely and competently exercise the privileges requested, lack of Medicare/Medicaid/other government health care program exclusion/sanctions and professional liability insurance coverage and shall query the National Practitioner Data Bank, before making a final decision to grant temporary privileges.
- (c) Temporary privileges may be granted only after the CEO or his designee has consulted with the department chair and the President of the Medical Staff or Vice President of Medical Affairs..
- (d) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Foundation.
- (e) Temporary privileges shall be granted for a specific period of time or a specific patient as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding three months.
 - 1. in the case of a well newborn, the Department Chairperson of Pediatrics may designate a physician who for this purpose need not have formal affiliation with the Medical Staff. Such privileges will be granted on a biennial basis. The physician shall assume the responsibility for the well baby medical care.
- (f) Temporary privileges shall expire at the end of the time period for which they are granted.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chair or designee. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

- (a) The CEO or his designee may, at any time after consulting with the President of the Medical Staff, Vice President of Medical Affairs or the department chair, terminate temporary privileges.
- (b) The granting of temporary privileges is a courtesy and may be terminated for any reason.
- (c) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.
- (3) For emergent situations involving a disaster situation, the Disaster Privileges Operational Policy will be followed.
- (4) When the emergency situation no longer exists, the patient shall be assigned by the department chair, Vice President of Medical Affairs or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

ARTICLE 5
PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested; and
- (e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Foundation must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice and/or a quality profile from a managed care organization), before the application will be considered complete and processed further.

5.A.2. Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

- (a) current clinical competence, judgment and technical skill in the treatment of patients;
- (b) challenges to any licensure or registration;
- (c) voluntary and involuntary relinquishment of any license or registration;
- (d) voluntary and involuntary termination of medical staff membership;
- (e) voluntary and involuntary limitation, reduction, or loss of clinical privileges;
- (f) involvement in a professional liability action, as defined in the medical staff bylaws or policies and procedures , including final judgments and settlements involving a practitioner;
- (g) relevant practitioner-specific data are compared to aggregate data if such data are available for that practitioner;
- (h) morbidity and mortality data if such data are available for that practitioner
- (i) peer recommendations
- (j) compliance with medical staff policies regarding continuing medical education;
- (k) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Foundation;
- (l) participation in medical staff duties, including committee assignments and emergency call;
- (m) appropriate professional conduct and behavior, including cooperation with Medical Staff and personnel, as it relates to patient care, the orderly operation of the Foundation, and ability to work with others;
- (n) documentation as to applicant's health status and current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;
- (o) capacity to satisfactorily treat patients as indicated by the results of the Foundation's performance improvement and professional and peer review activities;
- (p) appropriate resolution of any verified complaints received from patients and/or staff; and
- (q) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term
- (b) Reappointment, if granted, shall be for a period of not more than two years.
- (c) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.
- (d) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

- (a) The Medical Staff Office shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) If it becomes apparent to the Credentials Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6
QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages collegial and educational efforts by Medical Staff leaders and Foundation administration, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.
- (3) The President of the Medical Staff in conjunction with the Chief Medical Officer or Vice President of Medical Affairs shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Physician Health or the OCF Due Process Policy, or to direct it to the SEC for further determination.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:
 - i. the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - ii. the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Foundation or the Medical Staff; and/or
 - iii. conduct by any member of the Medical Staff that is considered lower than the standards of the Foundation or disruptive to the orderly operation of the Foundation or its Medical Staff, including the inability of the member to work harmoniously with others, the matter may be referred to the President of the Medical Staff, Medical Director, Vice President of Medical Affairs, the CEO, or the Chairperson of the Board.
- (b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Credentials Committee.
- (c) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Reporting of Infractions and Preliminary Investigations:

- (a) Every member of the Medical Staff is obliged to report to the CEO or his designee, the Vice President of Medical Affairs, or the President of the Medical Staff or their representatives: professional conduct thought to be at variance with the standards or aims of Ochsner Clinic Foundation; known or suspected violations of the Medical Staff Bylaws, Rules and Regulations or any professional ethical code; questions regarding a physician's or health care provider's clinical competence, management or treatment of a patient; suspected substance abuse or impairment; or, disruptive or abusive conduct. Any report of such concern, incident or behavior may be accompanied by a request for corrective action. A report of a suspected violation or request for corrective action may also be initiated by the CEO or his designee or a Medical Staff officer.

- (b) A report of a suspected violation or a request for corrective action shall be in writing and delivered to the CEO or his designee, the Vice President of Medical Affairs, or the President of the Medical Staff. The report should detail the specific activities or conduct in question. Upon receipt of a report or request for corrective action against a Medical Staff member, the CEO or his designee shall consult with the Vice President of Medical Affairs and the President of the Medical Staff, or in the President's absence, with the Vice-President or Secretary, and if in their opinion the matter warrants additional investigation, the CEO or his designee and the President shall appoint a subcommittee of the Credentials Committee, which will be charged with investigating the allegations of misconduct.

6.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the SEC President shall appoint an ad hoc committee to conduct the investigation. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, or podiatrist).
- (b) The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Foundation, as well as the authority to use outside consultants, if needed
- (c) The investigating committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The results of such examination shall be made available for consideration by the investigating committee.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review, and within a total of 90-120 days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of

the Foundation, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation.

6.B.4. Recommendation:

- (a) The ad hoc committee or subcommittee may recommend:
 - i. that no action is justified;
 - ii. that the medical staff member submit to informal counseling;
 - iii. that the medical staff member submit to formal counseling;
 - iv. issue a letter of guidance, warning, or reprimand;
 - v. impose conditions for continued appointment;
 - vi. impose a requirement for monitoring or consultation;
 - vii. recommend additional training or education;
 - viii. recommend reduction of clinical privileges;
 - ix. recommend suspension of clinical privileges for a term;
 - x. recommend revocation of appointment and/or clinical privileges; or
 - xi. make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation that would entitle the individual to request a hearing shall be forwarded to the CEO or designee, who shall promptly inform the individual by special notice. The CEO or designee shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the recommendation does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation that would entitle the individual to request a hearing, the CEO or designee shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Foundation's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension:

- (a) Any two of the following: the President of the Medical Staff, the Vice President of Medical Affairs, the Medical Director, the Chief Operating Officer, the CEO or the Board Chairperson shall have the authority to suspend all or any portion of an individual's clinical privileges whenever failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Foundation. Notification with reasons for suspension will be provided to the staff member at that time. The individual may be given an opportunity to refrain voluntarily from exercising privileges prior to an investigation.
- (b) Precautionary suspension is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.
- (c) A precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff and the Vice President of Medical Affairs, and shall remain in effect unless it is resolved.

6.C.2. Credentials Committee Procedure:

The Credentials Committee shall review the matter resulting in a precautionary suspension within a reasonable period and determine whether there is sufficient information to warrant a recommendation, or proceed under the investigative procedure.

6.C.3. Care of Suspended Individual's Patients:

- (a) *Immediately upon the imposition of a precautionary suspension, the President of the Medical Staff shall inform the Department Chairperson or Section Head who shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.*
- (b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chair, the SEC/Credentials Committee, the Vice President of Medical Affairs and the CEO in enforcing suspensions.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Action by Government Agency or Insurer:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the CEO or designee, the Vice President of Medical Affairs, the Medical Director and legal counsel.
- (b) An individual's clinical privileges shall be automatically relinquished (or restricted as appropriate) if any of the following occur:
 - i. Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.
 - ii. Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.
 - iii. Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Foundation or cease to be in effect, in whole or in part.
 - iv. Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
 - v. Criminal Activity: Indictment, conviction, or a plea of guilty or *nolo contendere* pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance fraud or abuse; or (iv) violence against another.
- (c) Situations involving the expiration of a medical license, controlled substance authorization (DEA or state) or a conviction or plea of guilty pertaining to any misdemeanor involving the use of alcohol will be evaluated on a case-by-case basis.
- (d) Automatic relinquishment or restriction shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of privileges has been acted upon by the Credentials Committee and the Board.

6.D.2. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the CEO, or any committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

6.D.3. Failure to Attend Special Conference:

- (a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chair, Vice President of Medical Affairs or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this conference shall be given by special notice at least 24 hours prior to the conference and shall inform the individual that attendance at the conference is mandatory, and a mutually agreed upon time shall be arranged.

6.D.4. TERMINATION OF AFFILIATION

A medical or professional staff membership shall automatically terminate on the earliest date on which:

- (a) The member's employment with Ochsner Clinic Foundation is terminated;
- (b) The member's affiliation with Ochsner Clinic Foundation is terminated;
- (c) The member's employment, shareholder status or partnership with a professional corporation or a partnership that is affiliated with Ochsner Clinic Foundation is terminated;
- (d) The affiliation between Ochsner Clinic Foundation and the Professional corporation or partnership through which the member obtained privileges is terminated.

ARTICLE 7
HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever one the following recommendations are made:
 - i. denial of initial appointment to the Medical Staff;
 - ii. denial of reappointment to the Medical Staff;
 - iii. revocation of appointment to the Medical Staff;
 - iv. denial of requested clinical privileges;
 - v. revocation of clinical privileges;
 - vi. suspension of clinical privileges for more than 30 days; or
 - vii. mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) The hearing shall be conducted in as informal a manner as possible.
- (d) The individual may request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior Credentials Committee recommendation. In this instance all references in this Article to the Credentials Committee shall mean the Board.

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) issuance of a letter of guidance, warning, or reprimand;
- (b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) determination that an application is incomplete;
- (h) determination that an application will not be processed due to a misstatement or omission; or
- (i) determination of ineligibility based on a failure to meet threshold criteria or a lack of need or resources.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO or designee shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the CEO or designee and shall include the name, address and telephone number of the individual's counsel, if any. Failure to request a hearing within 30 days shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The CEO or designee shall schedule the hearing and provide, by special notice, the following:
 - i. the time, place, and date of the hearing;
 - ii. the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - iii. a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Witness List:

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall exchange written lists with the hearing presiding officer including the names of witnesses expected to offer testimony on his or her behalf.

- (b) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.B.5. Hearing Panel and Presiding Officer:

(a) Hearing Panel:

The CEO, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chairperson. The Hearing Panel shall be composed of members of the Medical Staff who did not actively participate in the matter at any previous level, physicians or laypersons not connected with the Foundation or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Foundation or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(b) Presiding Officer:

- (1) In lieu of a Hearing Panel Chairperson, the CEO may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing. , and, may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- (2) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.
- (3) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence;
 - (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (4) The Presiding Officer may be advised by legal counsel to the Foundation with regard to the hearing procedure.

(c) Objections:

Any objection to any member of the Hearing Panel or Presiding Officer, shall be made in writing within 10 days of receipt of notice to the CEO or designee, who shall resolve the objection.

7.C. PRE-HEARING AND HEARING PROCEDURE

7.C.1. Provision of Relevant Information:

- (a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:
- i. one copy of, or reasonable access to, all patient medical records referred to in the statement of reasons;
 - ii. reports of experts relied upon by the Credentials Committee or subcommittee;
 - iii. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - iv. copies of any other documents relied upon by the Credentials Committee or subcommittee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.
- (c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Foundation employees appearing on the Credentials Committee witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

7.C.2. Pre-Hearing Conference:

The Presiding Officer shall require a representative (who may be counsel) for both parties to participate in a pre-hearing conference. At the pre-hearing conference the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

7.C.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.C.4. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Foundation. One copy of the transcript shall be available. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - i. to call and examine witnesses, to the extent they are available and willing to testify;
 - ii. to introduce exhibits;
 - iii. to cross-examine any witness on any matter relevant to the issues;
 - iv. to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case; and
 - v. to submit a written statement at the close of the hearing.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.7. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.C.8. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the President of the Medical Staff.

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CEO or his designee on a showing of good cause.

7.C.10. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:

The Credentials Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Credentials Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CEO or his designee. The CEO or designee shall send by special notice a copy of the report to the individual who requested the hearing. The CEO or designee shall also provide a copy of the report to the Credentials Committee.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure to comply with this Policy and/or the Bylaws of the Foundation or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

- (a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Foundation, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).
- (d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Credentials Committee for its information.

7.E.6. Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:

No applicant or member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8
CONFIDENTIALITY AND PEER REVIEW PROTECTION

8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

- (a) when the disclosures are to another authorized member of the Medical Staff or authorized Foundation employee and are for the purpose of conducting legitimate peer review activities; or
- (b) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Foundation.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

8.B. PEER REVIEW COMMITTEES

- (a) All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in accordance with applicable state law. Peer review committees include, but are not limited to:
 - i. all committees;
 - ii. all departments and sections;
 - iii. the Board and its committees; and
 - iv. any individual acting for or on behalf of any such entity, including but not limited to department chairs, section chairs, committee chairpersons and members, officers of the Medical Staff, the Vice President of Medical Affairs, the Chief Medical Officer and experts or consultants retained to assist in peer review activities.
- (b) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable state law.
- (c) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

ARTICLE 9
AMENDMENTS

This Policy may be amended by a majority vote of the members of the SEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be posted in a designated manner at least 14 days prior to the SEC meeting and any member of the Medical Staff may submit written comments to the SEC. No amendment shall be effective unless and until it has been approved by the Board.

Amended by the SEC:

May 13, 2003

September 14, 2004

June 14, 2005

December 13, 2005

February 13, 2007

Amendment Approved by Board of Directors:

June 9, 2003

October 11, 2004

July 18, 2005 – Unanimous Consent

January 9, 2006

April 9, 2007

ARTICLE 10
ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Foundation policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:
June 19, 2002

Approved by the Board:
July 17, 2002



**MEDICAL STAFF
ORGANIZATION MANUAL**

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual, the Bylaws and related policies and manuals:

- (1) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than medical staff members who are authorized by law to provide patient care services, whose scope of practice is defined in the Allied Health Professionals Policy.
- (2) “BOARD” means the Board of Directors of the Foundation, which has the overall responsibility for the Foundation, or its designated committee.
- (3) “BOARD CERTIFICATION” is the designation received by a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process including passing an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that medical specialty. This certification may be conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable, and the physician, dentist or podiatrist has received notification, in writing, that he/she is “board certified”.
- (4) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the Foundation.
- (5) “CLINICAL PRIVILEGES” means the authorization granted by the Board to render specific patient care services.
- (6) “DAYS” means calendar days.
- (7) “SEC” means the Staff Executive Committee.
- (8) “FOUNDATION” means Ochsner Clinic Foundation.
- (9) “HOUSE STAFF” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (10) “MEDICAL STAFF” means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.
- (11) “MEMBER” means any physicians, dentists, and podiatrists who have been granted medical staff appointment and clinical privileges by the Board to practice at the Foundation.
- (12) “SPECIAL NOTICE” means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

1.B: TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C: DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

ARTICLE 2
DEPARTMENTS AND SECTIONS

2.A: LIST OF DEPARTMENTS AND SECTIONS

The following departments and sections are established:

- 1) Anesthesiology
- 2) Cardiology
 - a. Section of Heart Failure and Cardiac Transplantation
 - b. Section of Interventional Cardiology
 - c. Section of Consultative Cardiology
 - d. Section of Prevention Rehabilitation and Outreach Programs
 - e. Section of Vascular Medicine
- 3) Colon and Rectal Surgery
- 4) Communicative Disorders
- 5) Dermatology
 - a. Section of Dermatologic Surgery
- 6) Emergency Medicine
- 7) Family Medicine
- 8) Allergy and Clinical Immunology
- 9) Endocrinology and Metabolic Diseases
- 10) Gastroenterology
- 11) Community General Internal Medicine
- 12) General Internal Medicine
- 13) Hematology and Oncology
- 14) Hospital Medicine
- 15) Hypertensive Diseases
- 16) Infectious Diseases
- 17) Nephrology
- 18) Pulmonary Diseases/Critical Care
- 19) Rheumatology
- 20) Neurology
- 21) Neurosurgery

- 22) Obstetrics and Gynecology:
 - a. Section of Infertility
 - b. Section of Maternal-Fetal Medicine
 - c. Section of Gynecologic Oncology
- 23) Ophthalmology:
 - a. Section of Glaucoma
 - b. Section of Retina and Vitreous Surgery
 - c. Section of Optometry
 - d. Section of Cornea & Anterior Segment
- 24) Orthopedic Surgery:
- 25) Otorhinolaryngology
- 26) Pathology
 - a. Section of Anatomic Pathology
 - b. Section of Clinical Pathology
- 27) Pediatrics:
 - a. Section of Pediatric Allergy
 - b. Section of Pediatric Cardiology
 - c. Section of Community Pediatrics
 - d. Section of Pediatric Critical Care
 - e. Section of Child Development
 - f. Section of Pediatric Electrophysiology
 - g. Section of Pediatric Endocrinology
 - h. Section of Pediatric Gastroenterology
 - i. Section of General Pediatrics
 - j. Section of Pediatric Hematology/Oncology
 - k. Section of Pediatric Infectious Diseases
 - l. Section of Pediatric Nephrology
 - m. Section of Neonatology
 - n. Section of Pediatric Dentistry
 - o. Section of Pediatric Pulmonology
 - p. Section of Pediatric Rheumatology
- 28) Physical, Rehabilitation, and Occupational Medicine
- 29) Podiatry

30) Psychiatry:

- a. Section of Child Psychiatry
- b. Section of Psychology
- c. Section of Social Work

31) Radiation Oncology

32) Radiology:

- a. Section of Nuclear Medicine

33) Sleep Medicine

34) Surgery:

- a. Section of Breast Surgery
- b. Section of Cardiothoracic Surgery
- c. Section of General Surgery/Oncology
- d. Section of Laparoscopic Surgery
- e. Section of Oral and Maxillofacial Surgery
- f. Section of Pediatric Surgery
- g. Section of Plastic and Reconstructive Surgery
- h. Section of Transplant Surgery
- i. Section of Vascular Surgery

35) Urology

2.B: FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS & SECTIONS

The functions and responsibilities of departments, sections and chairpersons are set forth in the Medical Staff Bylaws.

ARTICLE 3
STANDING MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES

- (1) Committee chairs and physician members of the committees shall be appointed by the President of the Medical Staff in accordance with the Medical Staff Bylaws.
- (2) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the CEO or his designee. All such representatives shall serve on the committees without vote.

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet at least quarterly, or at the discretion of the chair, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the SEC and to other committees and individuals as may be indicated in this Manual.

3.C: CREDENTIALS COMMITTEE

The Credentials Committee shall:

- (1) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
- (2) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations; and
- (3) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges, as set forth in the Credentials Policy.

3.D: CANCER COMMITTEE

The Cancer Committee will be responsible to plan, initiate, stimulate, and assess the results of cancer activities in the institution. The Cancer Committee is a multi-disciplinary committee, and provides program leadership with duties and membership described in Cancer Program Standards of the American College of Surgeons, Commission on Cancer.

3.E: PERFORMANCE IMPROVEMENT COMMITTEE

The Performance Improvement Committee is a multidisciplinary committee charged with measuring, assessing, and evaluating the quality and safety of care rendered to all patients. It shall be composed of members of the Active Medical Staff, the Director of Clinical Performance Improvement, a representative from: Ochsner Clinic Foundation administration, nursing (ambulatory/inpatient), infection control, and other ad-hoc members as the committee deems appropriate.

The committee will develop standards for the utilization of services provided within the organization. The committee, with the assistance of the Clinical Performance Improvement Department and Medical Informatics Department, will be responsible for maintaining the data needed to measure and evaluate utilization of services, including the development and review of data mandated by regulatory agencies.

The committee will measure, assess, evaluate and improve the quality of care and patient safety by complementing and supporting projects and activities to promote continued improvement in the quality and safety of care and services delivered. Quality issues requiring peer review and medical service specific action or follow-up will be forwarded to the appropriate Department/Section Head as outlined in the Performance Improvement Plan.

In carrying out its duties, the Performance Improvement Committee shall be assisted by subcommittees that will be responsible for quality and utilization evaluation and improvement in the areas of Rehab and Skilled Nursing Facilities.

3.F: THERAPEUTICS COMMITTEE

The Therapeutics Committee shall be responsible for insuring continued improvement in the quality of care through the following functions:

- (1) reviewing policies and procedures related to administering, ordering, distributing, handling, and use of drugs to promote safe, effective, timely and accurate administration;
- (2) maintaining a drug formulary;
- (3) insuring safe and accurate use of drugs;
- (4) monitoring the use of investigational drugs with the Clinical Investigations Committee;
- (5) defining “significant untoward drug reactions” and reviewing all such reactions;
- (6) monitoring and evaluating drug utilization by specific drug or clinical population to promote safety and effectiveness in selection, dosage and regimen;
- (7) reviewing, formulating and implementing policies and procedures related to nutritional care;
- (8) in coordination with the Infection Control Program and the Hospital Operations Specialty Practice Group, reviewing, developing and supporting the implementation of policies and programs to control infection within the Hospital, including antibiotic monitoring and evaluation of the infection potential of the related environment.

3.G: CRITICAL CARE COMMITTEE

- (a) The Critical Care Committee will serve as a multi-disciplinary oversight committee responsible for evaluating the quality and continued improvement of care provided in the adult critical care units, inclusive of the Emergency Department. The committee will also be responsible for:
- 1) formulation and application of policy and procedures governing the operation of the critical care units;
 - 2) formulation and application of policies and procedures related to emergency cardiopulmonary resuscitation within the Ochsner Foundation Hospital, Ochsner Clinic, adjacent structure and campus grounds.
 - 3) ***oversight of performance improvement activities in critical care***
- (b) Membership shall include representatives of clinical and administrative disciplines having significant involvement in the care of patients in these units.

3.H: MATERNAL/CHILD HEALTH COMMITTEE

The Maternal/Child Health Committee will serve as a multi-disciplinary oversight committee responsible for the evaluation and continued improvement of care provided to obstetric and pediatric patients. The committee will also be responsible for:

- (1) formulation and application of policies and procedures governing the operation of the units providing this care;
- (2) assist the Medical Staff in the evaluation and management of suspected cases of child abuse or neglect;
- (3) formulation and application of policies and procedures for the maternal and neonatal transport system and the delivery of obstetric, neonatal and pediatric care involving the integration of the specialties.
- (4) Performance Improvement

3.I: MEDICAL RECORDS COMMITTEE

The Medical Records Committee shall:

- (1) Establish standards for the format and content of the medical record and assure maintenance and retention in compliance with state and federal regulations.
- (2) Assure compliance with JCAHO standards, Medicare conditions of participation and state and federal laws governing all health information issues including HIPAA regulations governing security and privacy of health information.
- (3) Establish policies to lead Ochsner Clinic Foundation toward a fully electronic patient record.
- (4) Quarterly, review the findings of the multidisciplinary Medical Record Review Committee to assure quality documentation, clinical pertinence and timely completion of medical records.
- (5) Report quarterly to the Staff Executive Committee.

- (6) Shall be composed of members of the Active Medical Staff and representatives from the following departments:
 - (a) Health Information Management Department.
 - (b) Nursing –
 - i. Director of Nursing*
 - ii. Representatives from ambulatory nursing and hospital nursing departments.
 - (c) Performance Improvement
 - (d) Information Services*
 - (e) Compliance
- (7) Be chaired by a member of the Active Medical Staff.

3.J: BIOETHICS COMMITTEE

The Bioethics Committee will serve upon request in an advisory capacity to physicians, staff, and family/patients in bioethical situations, be available for an official consult at the request of a physician, staff or family, will organize educational sessions, and will advise the staff of relevant legislation.

3.K: BYLAWS COMMITTEE

The Bylaws Committee shall be responsible for periodic review of the Medical Staff Bylaws and make proposals to the Medical Staff for appropriate changes, which would be in accordance with national standards, the Joint Commission on Accreditation of Healthcare Organizations and other applicable regulatory bodies. The Bylaws Committee shall be composed of the staff officers and the COO, or designee.

3.L: FORMS COMMITTEE

The Forms Committee shall:

- (1) Establish standards for the format of all forms to be included in the medical record.
- (2) Review and approve forms submitted for inclusion in the medical record.
- (3) Assure that all forms comply with JCAHO standards, Medicare conditions of participation and state and federal laws.
- (4) Participate in and support Ochsner Clinic Foundation's transition from the paper documentation to an electronic patient record.
- (5) Report quarterly to the Staff Executive Committee.
- (6) Be composed of members of the Active Medical Staff and representatives from the following departments:
 - a. Health Information Management*
 - b. Ambulatory nursing and hospital nursing departments
 - c. Compliance
 - d. Purchasing
 - e. Management and Engineering
- (7) Be chaired by a member of the Active Medical Staff

3.M: RADIATION CONTROL COMMITTEE

The Radiation Control Committee shall consist of qualified members of the administrative and Medical Staff. It shall maintain and administer Ochsner Clinic Foundation's Radioactive Material License and shall establish policies and regulations governing the use of ionizing radiation, including radioisotopes and radiation-producing equipment. These policies shall be carried out to promote compliance with all applicable state and federal regulations regarding the use of ionizing radiation.

3.N: SURGICAL SERVICES COUNCIL

The Surgical Services Council is a multi-disciplinary council whose purpose is to provide balanced leadership of the surgery program in order to provide safe, efficient, state-of-the-art perioperative care to patients. The scope of the council is:

- (1) to coordinate medical and hospital activity within Surgical Services;
- (2) to bridge the relationship between nursing, surgeons, anesthesiologists and the hospital as it relates to Surgical Services operations;
- (3) to serve as a forum to facilitate multidisciplinary communications and a means to resolve interdisciplinary issues;
- (4) to guide the future direction of the surgical program to improve patient care and services;
- (5) to develop and facilitate innovative surgical care.
- (6) to identify targeted outcomes for process performance evaluating efficacy, appropriateness, effectiveness, availability, timeliness, and efficiency.

3.O: TRANSPLANT COUNCIL

The Transplant Council is a multi-disciplinary council whose purpose is to provide balanced leadership to the transplant programs in order to provide safe, efficient, state of the art transplantation care to patients. Membership includes the United Network for Organ Sharing (UNOS) medical and surgical directors of the heart, kidney, liver, lung and pancreas transplant programs and other representatives of clinical and administrative disciplines having significant involvement in transplant activities. The scope of the council is:

- (1) To plan, initiate, stimulate, and assess the results of transplant activities in the institution.
- (2) To provide for continuous improvement in the quality of care and service delivered.
- (3) To provide for compliance improvement in the quality of care and service delivered.
- (4) To provide for compliance with regulations governing transplant activities.

3.P: SEDATION COMMITTEE

The Sedation Committee is a medical staff multidisciplinary committee responsible for oversight of the practice of sedation provided to patients in accordance with established standards of practice, quality of care, and compliance with regulatory and accreditation bodies. The committee will promote continued improvement in the quality of care through the following functions:

- (1) Define the four levels of sedation and anesthesia and determine qualified personnel within OCF to administer the different levels of sedation,
- (2) Develop/revise privileging criteria and processes including recertification for personnel providing the different levels of sedation,
- (3) Monitor deep/moderate sedation processes throughout the organization,
- (4) Collect and analyze data to determine outcomes and opportunities for improvement and develop action plans when appropriate.

ARTICLE 4
AMENDMENTS

This Manual may be amended by a majority vote of the members of the SEC present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of any committee whose composition or duties are proposed to be revised shall have first been received and reviewed by the SEC. Notice of all proposed amendments shall be communicated to the medical staff. No amendment shall be effective unless and until it has been approved by the Board.

Amended

12/10/2002
7/19/2004
6/14/05
2/13/07

Amendment Approved by Board of Directors

1/13/2003
9/13/2004
7/18/05
4/9/07

ARTICLE 5
ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all section and committee activities of the Medical Staff and of each individual serving as a member of a section or staff committee shall be undertaken pursuant to the requirements of this Manual.

Adopted by the Ochsner Clinic Foundation Medical Staff:

June 19, 2002

Approved by the Ochsner Clinic Foundation Board of Directors:

July 17, 2002