

ALLIED HEALTH POLICY  
OF  
LEGACY MOUNT HOOD MEDICAL CENTER

Adopted July 22, 2021

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## DEFINITIONS

The following definitions shall apply to the AHP Policy:

**Allied Health Professional or AHP** means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. Allied health practitioners are described as licensed independent practitioners or dependent **practitioners** in the Medical Staff governing documents.

**Adverse** means a recommendation or action of the Medical Executive Committee or Board that denies, limits (*e.g.*, suspension, restriction, *etc.*) for a period in excess of fourteen (14) days or terminates a Practitioner's Medical Staff appointment and/or Privileges on the basis of clinical competency or professional conduct.

**Board** means the Board of Directors of Legacy which serves as the governing body of the Hospital with responsibility for the conduct of the Hospital including oversight of the Medical Staff. Reference to the Board shall include any Board committee or individual authorized by the Board to act on its behalf in designated matter.

**Clinical Privileges or Privileges** means the permission granted by the Board to a practitioner or AHP to provide patient care, treatment, and/or clinical services, pursuant to an applicable Delineation of Privileges, at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, and judgment.

**Credentials Committee** means the Medical Staff Credentials Committee.

**Dependent Allied Health Professional** means practitioners who are authorized to function in the Hospital only as an employee of, or under direct supervision of, a physician or physicians appointed to the Medical Staff pursuant to a defined scope of practice. Dependent AHPs currently include but are not limited to RNFAs. The following clinicians are excluded from this policy: Registered Nurse Assistants, Surgical Technical Assistants and Dental Assistants as they fall under the Clinical Assistant role and associated policies.

**Ex Officio** means serving in a certain capacity by virtue of an office or position held. Individuals serving as Ex Officio Members shall not have the right to vote and shall not be counted in determining the existence of a quorum unless otherwise expressly provided.

**Federal Health Program** means Medicare, Medicaid, TRICARE, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

**Hospital** means Legacy Mount Hood Medical Center and its provider-based locations, if any.

**Independent Allied Health Professional** means a practitioner who is not a member of the medical staff but who has been authorized by the Legacy Board to provide certain health care services upon order by a member of the medical staff but without an ongoing supervisory relationship by any specified member of the medical staff, limited to orthotists and acupuncturists.

**Legacy** means Legacy Health

**Legacy Chief Executive Officer or CEO** means the individual appointed by the Legacy Board to act as the chief executive officer on its behalf in the overall management of Legacy and shall include the Legacy CEO's designee.

**Legacy Chief Medical Officer or CMO** means the individual serving as Legacy's Chief Medical Officer.

**Medical Executive Committee** means the executive committee of the Medical Staff.

**Medical Quality & Credentialing Committee** is a Legacy Board committee comprised of representatives from each Legacy Medical Staff, the Legacy Board, and Legacy administration. This committee's purpose is to assess, monitor and improve the delivery of quality care throughout Legacy Health ("Legacy) via both the credentialing and continuous quality improvement processes. The Committee is responsible for facilitating communication and consultation to and between the Legacy Medical Staffs and the Legacy Health Board of Directors. The committee is responsible for reviewing and recommending to the Legacy Health Board of Directors, recommendations from the Legacy Medical Staffs relating to credentialing and Privileges, Bylaws, clinical Policies, and rules and regulations, and oversee the conduct of credentialing activities outlined in Legacy Health's Bylaws.

**Medical Staff** means all practitioners who are appointed to the Medical Staff with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed.

**Medical Staff Bylaws** or **Bylaws** means these Medical Staff Bylaws approved by the voting Members of the Medical Staff and the Board, as such document may be amended from time to time.

**Medical Staff Department** or **Department** means a grouping or division of Medical Staff clinical services as set forth in these Bylaws or *the Medical Staff Organization Policy*. The head of each Medical Staff Department shall be designated as the **Department Chair**.

**Medical Staff Member** or **Member** means a practitioner who has been granted appointment to the Hospital's Medical Staff. A Medical Staff Member must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges, or unless otherwise provided in the Bylaws. References to Medical Staff appointment shall mean the same thing as Medical Staff Membership for purposes of the Medical Staff governing documents.

**Medical Staff Policy** or **Policies** means those Medical Staff Policies, recommended by the Medical Executive Committee and approved by the Board, that serve to implement the Medical Staff Bylaws including the Credentials Policy, Organization Policy, Fair Hearing Policy, Allied Health Professional Policy, Professional Conduct Policy, Impairment/Wellness Policy, and Professional Practice Evaluation Policy.

**Medical Staff Rules & Regulations** or **Rules & Regulations** means the rules and regulations of the Medical Staff, as recommended by the MEC and approved by the Board, that address issues related to clinical care, treatment, and services provided by Practitioners and Allied Health Professionals granted Privileges at the Hospital.

**Medical Staff Year** means a calendar year starting on January 1<sup>st</sup> and goes through December 31<sup>st</sup>.

**Notice** means notification or warning of something, especially to allow preparations to be made.

**NPDB** means the National Practitioner Data Bank

**Peer Review** means an organized effort to evaluate and analyze medical care, treatment, and/or services delivered to patients and to assure the quality and appropriateness of such care, treatment, and/or services through the generation of constructive feedback and valid reporting. It refers to activities that analyze the professional behavior, judgment, and ability of individuals; as distinguished from Quality Assessment, which evaluates the collective performance of systems and groups. Combined, Peer Review and quality assessment form the basis for total quality management and continual improvement.

**Physician** means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)

**Practitioner** means Physicians, Dentists, Podiatrists, Certified Nurse Midwives, Certified Nurse Anesthetists, Nurse Practitioners, Physician Assistants and Psychologists.

**Prerogative** means the right to participate, by virtue of Medical Staff category, granted to a Medical Staff Member and subject to the ultimate authority of the Board, and the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff Policies.

**Professional Liability Insurance** means Professional Liability Insurance coverage of such kind, in such amount, and underwritten by such insurers as required and approved by the Board.

**Special Notice** means written Notice (a) sent by certified mail, return receipt requested; or (b) by personal delivery service with signed acknowledgment of receipt.

**Supervising Physician** means a licensed physician who engages in the direct supervision of an Allied Health Professional whose duties are encompassed by the supervising physician's scope of practice and privileges.

**Use of an Authorized Designee:** Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position (*e.g.*, the CEO, Hospital President, CMO, Medical Staff President, Department Chair, *etc.*), then reference to the individual shall also include the individual's authorized designee.

Words used in the Medical Staff governing document shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the Medical Staff governing documents.

## ARTICLE 1: INTRODUCTION AND CATEGORIES

Only those classes of Allied Health Professionals that have been approved by the Legacy Board shall be eligible to apply for Clinical Privileges to practice at Hospital. Authorization for Clinical Privileges and scope of practice approval will be granted in accordance with Legacy Board approved criteria and policies.

### 1.A: CATEGORIES:

There are two categories of Allied Health Professionals (AHPs) eligible for practice at Hospital:

- (a) Independent AHP
- (b) Dependent AHP

AHPs are not eligible for membership on the medical staff or accorded any of the prerogatives of medical staff appointment.

### 1.B: SUPERVISION:

- (a) The Supervising Physician(s) shall assume full responsibility and be fully accountable for the conduct of the AHP within the Hospital. It is the responsibility of the supervising physician to orient the AHP to the appropriate policies and rules and regulations of the medical staff and the Hospital. AHPs applying for or approved for practice at Hospital shall be required to comply with all appropriate hospital policies, and Legacy Medical Staff governing documents.

## ARTICLE 2: PERMISSION TO PRACTICE

### 2.A: QUALIFICATIONS FOR AUTHORIZATION TO PRACTICE

#### 2.A.1. General Qualifications:

- (a) Authorization to practice is a courtesy which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this policy and in such policies as are adopted from time to time by the Legacy Board.
- (b) All processes described in this Article shall be subject to the confidentiality provisions described in Section 2.J of this policy.

#### 2.A.2. Specific Qualifications:

- (a) Only those categories of AHP that have been approved by the Legacy Board shall be eligible to apply for permission to practice at Hospital.
  - (1) where applicable to their practice, have a current, active, license by order of the appropriate Oregon licensing board to practice in the State of Oregon;
  - (2) where applicable to their practice, have a current Drug Enforcement Agency (DEA) certificate;
  - (3) are located (office and residence) close enough to the Hospital to fulfill their patient care responsibilities and to provide timely and continuous care to their hospitalized patients, in accordance with those specific requirements as approved by the Legacy Board;
  - (4) possess current, valid Professional Liability Insurance coverage in amounts required by the Hospital and state law and regulation;

- (5) have successfully completed an accredited training program or such other training as specifically defined by the Legacy Board for the requested practice area.
  - (i) For Acupuncturists- Graduated from an acupuncture program that satisfies the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).
  - (ii) For Orthotists-Graduation from orthotics and prosthetics school accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the National Commission on Orthotic and Prosthetic Education (NCOPE)
  - (iii) For Radiology Practitioner Assistants-Completion of a two-year RPA training program, which is accredited through the Northwest Regional Accrediting Agency for Colleges and Universities.
  - (iv) For Registered Nurse First Assistants-Completion of a program that meets AORN standards for first assistant education programs and is accepted by the Competency and Credentialing Institute (CCI).
- (6) Are board certified by the appropriate specialty board unless such requirement is waived by the Legacy Board after considering the specific education, training, experience, and competence of the individual in question.
  - (i) For Acupuncturists-Board Certification from the American Board of Medical Acupuncture or certification by the National Certification for Acupuncture and Oriental Medicine (NCCAOM).
  - (ii) For Orthotists-Board Certification through the American Board for Certification of Orthotists or Prosthetics Inc. (ABC)
  - (iii) For Radiology Practitioner Assistants-Certification from the Board of Radiology Practitioner Assistants (CBRPA)
  - (iv) For Registered Nurse First Assistants-Certification in Operating Room Nursing or as a Registered Nurse First Assistant from the Competency and Credentialing Institute (CCI).
- (7) Be eligible to participate in Federal and State Health Programs,
- (8) Successful completion of professional education
- (9) Have never been convicted of a felony crime

2.A.3. Additional Qualifications:

- (a) Allied Health Practitioners must also document their:
  - (1) background, experience, training and demonstrated competence
  - (2) adherence to the ethics of their profession,
  - (3) good reputation and character,
  - (4) ability to safely and competently exercise the Clinical Privileges requested with or without reasonable accommodation, and
  - (5) ability to work harmoniously (i.e. in a cooperative and professional manner) with others sufficiently to demonstrate to the Hospital that all patients treated by them at Hospital shall receive quality care and that the Hospital and Medical Staff shall be able to operate in an orderly manner;
  - (6) Satisfy such other qualifications as are set forth in the applicable AHP category and Privilege set.
- (b) The qualifications set forth in paragraphs (1), (2), (3), (4), (5), (6) and (7) above are deemed to be baseline criteria for application to practice at Hospital. Individuals who have an application for



licensure and professional liability insurance pending shall be deemed to have satisfied the threshold criteria for the purpose of the pre-application process.

#### 2.A.4. No Entitlement to Authorization to Practice

No individual shall be entitled to exercise Clinical Privileges at the Hospital merely that such individual:

- (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 and/or Privileges at any Hospital or health care facility.
- (d) Resides in the geographic service area of Hospital.
- (e) Is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.
- (f) Is certified by any clinical board.
- (g) Is a Member of a professional school faculty.
- (h) Had or presently has Medical Staff appointment and/or Privileges at this Hospital.
- (i) Is, or is about to become, affiliated in practice with a Practitioner who has, or with a group of Practitioners, one or more who has/have Medical Staff Appointment and/or Privileges at this Hospital.
- (j) Contracts with or is employed by the Hospital.

#### 2.A.5. Nondiscrimination Policy:

No Practitioner shall be denied authorization to practice with Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

#### 2.B: APPLICATION FOR PRIVILEGES

##### 2.B.1. Information:

- (a) Applications for authorization to practice with Clinical Privileges shall be in writing and shall be submitted on forms approved by the Legacy Board, upon recommendation of the Credentials Committee. These forms shall be obtained from the Medical Staff Office or the Legacy Credentials Verification Services Department.
- (b) The application shall contain require detailed information concerning the specific scope of practice desired by the applicant as well as the applicant's professional qualifications, including but not limited to:
  - (1) Allied Health category and the Clinical Privileges requested.
  - (2) The names and complete addresses of at least three Practitioners licensed in the same professional discipline as the applicant with recent personal knowledge of the applicant's current ability to practice. References must include knowledge of the AHP's technical/clinical skills, clinical judgement, interpersonal skills, communication skills and professionalism including ability to exercise the Privileges being requested, with or without a reasonable accomodation. These references may not all be from individuals associated or about to be associated with the applicant in professional practice. References may not be provided by individuals personally related to the applicant. At least one reference shall be from the same specialty area as the applicant.
  - (3) The names of any and all hospitals or other institutions at which the applicant has worked or trained.
  - (4) Information as to whether the applicant's Clinical Privileges have ever been voluntarily or involuntarily (while under investigation or to avoid investigation) or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, or

not renewed at any other Hospital or health care facility or if any such action is pending or under review.

- (5) Information as to whether the applicant has ever voluntarily (while under investigation or to avoid investigation) or involuntarily withdrawn his/her application for Clinical Privileges or resigned their authorization for Clinical Privileges before final decision by a Hospital's or health care facility's governing board.
- (5) Information as to whether the applicant's license to practice any profession in any state, or DEA registration is or has ever been voluntarily (while under investigation or to avoid investigation) or involuntarily suspended, modified, terminated, restricted, relinquished, revoked, subjected to probationary or other conditions or is currently being challenged. Documentation of all the applicant's current licenses to practice his/her respective profession, as well a DEA registration (if required for the Privileges requested) to include the number and in issued/expiration dates of each.
- (6) Evidence of participation in continuing education activities at the level required by the applicant's licensing board. The Hospital, in its discretion, has the right to audit and verify the applicant's participation in any such continuing education activities at any time.
- (7) Documentation of professional school/post graduate training programs completed to include the name of each institution attended, degrees granted, programs completed, dates attended, and, for postgraduate training, names of Practitioner responsible for monitoring the applicant's performance;
- (8) Documentation regarding board certification, as applicable;
- (9) Information as to whether the applicant has currently in force Professional Liability Insurance coverage, the name of the insurance company, and the amount and classification of such coverage, and whether said insurance coverage covers the Clinical Privileges the AHP seeks to exercise at the Hospital;
- (10) Information concerning the applicant's professional liability litigation experience, specifically information concerning pending matters, closed matters, final judgments, and/or settlements to include: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Hospital, may request;
- (11) A consent to the release of information from the applicant's present and past Professional Liability Insurance carriers;
- (12) Information concerning any professional misconduct proceedings involving the applicant in this state, any other state or any country, whether such proceedings are closed or still pending;
- (13) Information concerning the suspension, termination or revocation for any period of time of the right or privilege to participate in Medicare, Medicaid, any other Federal Health Program, or any private or public medical insurance program, and information as to whether the applicant has been the subject of or is currently under investigation by any of the aforementioned payors and, if so, the outcome of such investigation.
- (14) Current information regarding the applicant's ability to exercise the Privileges requested with or without reasonable accomodation.
- (15) Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime other than minor traffic violations with details about any such instance, and an authorization and consent to release of information to perform a criminal background check to verify such information;

- (16) A complete chronological listing of the applicant's work history including, but not limited to, professional and educational appointments, employment, and/or other positions.
- (17) Information required by applicable conflict of interest Policies.
- (18) Information on the citizenship and/or visa status of the applicant.
- (19) Signed the Medicare/Tricare acknowledgement statement.
- (20) The applicant's signature.
- (21) Designate a Supervising Physician with Medical Staff appointment and clinical Privileges at the Hospital or any requirement for a current, written standard care arrangement or supervision agreement.
- (22) Such other information the Hospital, may require.

#### 2.B.2. Effect of Application

- (1) The applicant must sign the application and in doing so, attests that all information furnished is correct and complete and acknowledges that any material misstatement in, or omission from, the application constitutes grounds for denial of Clinical Privileges. In the event that Clinical Privileges are granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute grounds for termination of Clinical Privileges. In either situation, there shall be no entitlement to any hearing or appeal rights.
- (2) Signifies his/her willingness to be interviewed, as requested, in connection with his/her application.
- (3) Acknowledges receiving access to the Medical Staff governing documents and agrees to abide by the terms of such Medical Staff governing documents as well as applicable Hospital Policies, if granted Clinical Privileges at the Hospital; and, to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not Privileges are granted.
- (4) Agrees to fulfill his/her responsibilities including, but not limited to, those set forth in Section 2.B.3.
- (5) Understands and agrees that if requested Privileges are denied based upon the applicant's clinical competence or conduct, the applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.
- (6) Agrees that if an Adverse recommendation or action is made/taken with respect to his/her application for Privileges or his/her current, the applicant will exhaust the administrative remedies afforded by the Medical Staff governing documents, before resorting to formal legal action.
- (7) Acknowledges and agrees to the provisions set forth in Article 2.B.5. of the Bylaws regarding authorization to obtain and release information, confidentiality of information, immunity for reviews, release of liability, and the right to secure releases for obtaining and sharing information.
- (8) Agrees to notify Medical Staff Services or System-wide Credentials Verification Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the applicant so long as they has Privileges at the Hospital.
- (9) Acknowledges that the Hospital and Affiliate Hospitals are part of a System and that information is shared within the System. As a condition of Privileges, the applicant recognizes and understands that any and all information relative to exercise of Privileges may be shared between the Hospital and Affiliate Hospitals including Peer Review that is maintained, received, and/or generated by any of them. The applicant further understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

### 2.B.3. Basic Responsibilities of Having Clinical Privileges:

Unless otherwise provided in the Medical Staff governing documents, a condition of consideration of an application for Medical Staff clinical privileges, and as a condition of continued Clinical Privileges, if granted, every AHP shall, as applicable to the Privileges granted to each such AHP:

- (a) Provide or make arrangements for provision of appropriate continuous care and supervision to/for all patients within the Hospital for whom the individual has responsibility.
- (b) Make, continuously throughout all times during which the AHP holds Clinical Privileges at the Hospital, prior arrangements with another AHP or AHP's Clinical Privileges to provide medical coverage in case of unavailability.
- (c) Abide by all Medical Staff governing documents and applicable Hospital Policies including, but not limited to, the Hospital's "HIPAA/Notice of Privacy Practices of the Organized Care Arrangement," corporate responsibility plan, and conflict of interest Policies as applicable, without regard to whether or not appointment to the Medical Staff and/or Clinical Privileges are granted.
- (d) Accept committee assignments and fulfill such other reasonable Medical Staff duties and responsibilities as may be assigned.
- (e) Provide, with or without request, new or updated information to the Medical Staff, as it occurs, that is pertinent to any question on the application form.
- (f) Maintain the confidentiality of the Peer Review processes.
- (i) Use Hospital and its facilities sufficiently to allow Hospital, through assessment by appropriate Medical Staff committees and such committee's authorized agents (*e.g.* Department chairs, etc.) to evaluate in a continuing manner the current competence of the AHP, and provide adequate supplemental information from other facilities as requested by Hospital to help evaluate current competence.
- (j) Refrain from fee splitting or other illegal inducements relating to patient referral.
- (k) Refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised, as applicable.
- (l) Refrain from deceiving patients as to the identity of an individual (*e.g.* operating surgeon, *etc.*) providing care, treatment and/or services.
- (m) Seek consultation whenever necessary.
- (n) Promptly notify the Medical Staff Office of any change in eligibility for payments by third-party payers or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a Quality Improvement Organization citation and/or quality denial letter concerning alleged quality problems in patient care.
- (o) Abide by generally recognized ethical principles applicable to the AHP's profession.
- (p) Participate in Medical Staff Peer Review, quality monitoring, performance improvement, utilization review, and professional practice evaluation activities.
- (q) Prepare and complete in a timely manner the medical record and other required documentation for all patients they provides care, treatment, and/or services to as required by the Medical Staff governing documents and other applicable Hospital [or System] Policies.

- (r) Work cooperatively and professionally with other Practitioners, Medical Staff leadership, Hospital management, allied health professionals, and other Hospital personnel (*e.g.* nurses, *etc.*).
- (s) Promptly pay any applicable Medical Staff dues, fees, and assessments, in accordance with all Medical Staff governing documents, including this policy.
- (t) Participate in continuing education programs appropriate to the Privileges requested or held or as otherwise required to maintain his/her professional license.
- (u) Incorporate into practice use of the Hospital's electronic medical record and technologic advances (including, but not limited to, computerized order entry) in the electronic medical record as they are made available to the Medical Staff.
- (v) Complete educational sessions, as required, with respect to the Hospital's electronic medical record, computerized order entry system, *etc.*
- (w) Cooperate in any relevant or required review of any AHP's (including his/her own) qualifications or compliance with the Medical Staff governing documents and refrain from directly or indirectly interfering, obstructing, or hindering any such review whether by threat of hard or liability, by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.
- (x) Assist with any Medical Staff approved education programs for students, interns, and residents, if applicable.
- (y) Comply with Hospital health screening and immunization requirements (or an exception thereto) set forth in applicable Hospital Policies.
- (z) Complete Hospital mandated education and training as directed by the Medical Executive Committee.
- (aa) Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for denial of regrant of Privileges or for corrective action pursuant to the procedure set forth in these policies.

#### 2.B.4. Burden of Providing Information:

- (a) The applicant shall have the burden of producing information deemed adequate by the Hospital for proof of identity and a proper evaluation of his/her qualifications for Privileges, and of resolving any doubts about such qualifications., and of satisfying requests for additional information or clarification made by appropriate Medical Staff or Hospital authorities.
- (b) The applicant shall have the burden of providing evidence that all the statements made, and information given on the application are true and correct.
- (c) Until the applicant has provided all information requested by Hospital, the application for Clinical Privileges shall be deemed incomplete and shall not be further processed.

#### 2.B.5. Grant of Immunity and Authorization to Obtain/Release Information:

The following statements, which shall be included on the application form and which form a part of these policies, are express conditions applicable to every individual having or seeking or granted Clinical Privileges at Hospital. By applying for Clinical Privileges, the applicant expressly accepts these conditions, whether or not Clinical Privileges are granted, during the processing and consideration of the application, during the time of they holds any Clinical Privileges, and after the expiration, resignation, relinquishment, revocation, or other termination of Clinical Privileges.

(a) Immunity:

To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, its Medical Staff, Legacy, their authorized representatives, and/or appropriate third parties, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

- (1) Applications for Clinical Privileges, including temporary Privileges
- (2) Evaluations concerning regrant of Privileges, and/or changes in Clinical Privileges
- (3) Formal corrective action proceedings for suspension or reduction of Clinical Privileges or any other disciplinary sanction;
- (4) Summary Suspension
- (5) Medical care evaluations
- (6) Utilization reviews
- (7) Other activities relating to the quality of patient care or professional conduct
- (8) Matters or inquiries concerning the applicant's or appointee's professional Qualifications for Clinical Privileges, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or
- (9) Any other matter that might directly or indirectly relate to the applicant's clinical competence or conduct, to patient care, or to the orderly operation of this or any other Hospital or health care facility.

(b) Authorization to Obtain Information:

The applicant specifically authorizes Hospital, its Medical Staff, and their authorized representatives to consult with any third party who may have information bearing on the individual's applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's or appointee's satisfaction of the criteria for initial and continued appointment to the for Clinical Privileges. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such qualifications. The individual applicant also specifically authorizes said third parties to release said information to Hospital, its Medical Staff, and their authorized representatives upon request. The applicant or appointee specifically authorizes Hospital, the Medical Staff and its their authorized representatives to perform a criminal background check and shall execute an authorization and consent to release of information to such effect.

(c) Authorization to Release Information:

The applicant signs a release of information that specifically authorizes Hospital, its Medical Staff, and it's their authorized representatives to release any information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's or appointee's professional qualifications pursuant to a request for Clinical Privileges.

## 2.C: PROCEDURE FOR INITIAL APPLICATION

### 2.C.1. Pre-Application Review Process:

- (a) An application for Clinical Privileges shall be processed only for those individuals who:
  - (1) Meet the baseline criteria for Clinical Privileges set forth in Section 2.A.
  - (2) Any Policies, plans, and objectives formulated by the Board concerning the Hospital's current and projected patient care needs and the availability of adequate physical, personnel, and financial resources may also be considered by the applicable Medical Staff and Board authorities in making recommendations or taking action on new application for Clinical Privileges and requests for additional Clinical Privileges during a current appointment/Privilege period.

- (3) Are not seeking Clinical Privileges that are currently subject to an exclusive contract, unless the individual (or the group with whom the individual is employed or contracted) has been or is to be awarded such contract.
- (b) An individual requesting Clinical Privileges shall be notified of the baseline criteria for Privileges and shall be required to attest that they meets the such baseline criteria at the time of the request.
- (c) Those individuals who attest that they can meet the baseline criteria for Clinical Privileges shall be given an application. Individuals who fail to meet the baseline criteria shall not be given an application and shall be so notified. If, during processing of the application, information is obtained that establishes that the individual does not meet the baseline criteria, processing shall be discontinued, and the individual shall be notified of such action.
- (d) An individual who does not meet the baseline criteria for Clinical Privileges and who has not been granted a waiver by the Legacy Board shall not be given an application and shall not be entitled to a hearing as provided in these Bylaws.

#### 2.C.2. Submission of Application:

- (a) A completed application form for Clinical Privileges with copies of all required documents must be returned within two weeks after provision receipt by Hospital of same if the individual desires further consideration. The application must be accompanied by payment of the processing fee in order to be considered complete.
- (b) The Medical Staff Office shall review the application to determine that all questions have been answered, all references and other required information or materials deemed pertinent have been received, and that all pertinent information, including, but not limited to, applicant's current licensure, applicant's specific relevant training, and applicant's current competence, has been verified with primary sources.
- (c) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting required documentation has been supplied, all information has been verified, and the processing fee has been received. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the processing of the application.  
  
Failure, without good cause, by an applicant to respond to a request for additional information regarding his/her pending application within thirty (30) days following a written request therefore will be deemed a voluntary withdrawal of the application.
- (d) A National Practitioner Data Bank (NPDB) query shall be conducted by the Medical Staff Office on all applicants at the time of initial request for Privileges and/or regrant of Privileges, and when an AHP requests additional Privileges during a current Privilege period. The Medical Staff Office shall also conduct an NPDB query each time an AHP applies for temporary Privileges. The Medical Staff Office shall also query the Office of Inspector General's Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the applicant has been convicted of a health care related offense, or debarred, excluded, or otherwise made ineligible for participation in a Federal Health Program.
- (e) As part of the process of reviewing the application, the Medical Staff Office shall determine whether the application shall be processed in accordance with Section 2.C.5. When the application is complete and collection and verification is accomplished, the Medical Staff Office shall transmit the complete application and all supporting accompanying information to the appropriate Department and Section Chairs.

### 2.C.3. Verification of Identity:

- (a) The credentialing process for initial grant of Privileges includes the following mechanism to ensure that the individual requesting to exercise Privileges is the same individual identified in the credentialing documents.
  - (1) Applicants for Clinical Privileges, including those granted temporary Privileges, shall obtain a Legacy Photo Identification Badge prior to entering a clinical area or seeing providing care, treatment, and/or services to a patient. Before issuing a Photo Identification Badge, the Legacy employee or representative shall view a valid, government-issued photo identification (*e.g.*, driver's license, passport, *etc.*) to confirm that the individual is the applicant. Confirmation of the verification shall be documented and forwarded to the Medical Staff Office.
    - (i) If the photo identification equipment is unavailable for any reason, a Temporary Identification Badge shall be obtained.
    - (ii) A permanent Legacy Photo Identification Badge shall be obtained prior to the expiration of the Temporary Identification Badge.
  - (2) Applicants for locum tenens Privileges, or for temporary Privileges who are not also applicants for Medical Staff appointment, shall obtain a Temporary Identification Badge prior to entering a clinical area or seeing providing care, treatment, and/or services to a patient. Before issuing a Temporary Identification Badge, the Legacy employee or representative shall view a valid, government-issued photo identification (*e.g.*, driver's license, passport, *etc.*) to confirm that the individual is the applicant. Confirmation of the verification shall be documented and forwarded to the Medical Staff Office.
- (1) Electronic copies of photos obtained for Legacy Photo Identification Badges shall be forwarded to the Medical Staff Office and made available for access by Legacy staff on the Legacy Intranet and for other appropriate purposes.

### 2.C.4. Section and Department Chair Procedure

- (a) The chair of each Section and Department in which the applicant seeks Clinical Privileges shall provide the Credentials Committee (or the chair of the Credentials Committee if the application qualifies for processing pursuant to Section 2.C.5.) with a written report concerning the applicant's qualifications for appointment and/or requested Clinical Privileges. The applicable Section and Department Chairs have the right to meet with/ interview the applicant to discuss any aspect of the application, and his/her qualifications, for the requested Clinical Privileges.
- (b) The applicable Section Chair and Department Chair, or the individual within the section or department to which the chair has assigned this responsibility, shall evaluate the applicant's education, training, and experience, qualifications for Clinical Privileges and may make inquiries with respect to the same to the applicant's past or current department chair(s), professional education program director, and others who may have knowledge about the applicant's qualifications (*e.g.*, education, training, experience, clinical competence, and ability to work with others).
- (c) The Section and Department Chair shall be available to the Credentials Committee (or the chair of the Credentials Committee if the application qualified for processing pursuant to Section 2.C.5.) to answer any questions that may be raised with respect to that chair's report and findings.

### 2.C.5. Processing Clean Applications When No Questions Are Raised and All Information is Appropriate and in Order

- (a) Clean Applications, which are deemed complete, may be processed in an expedited manner as set forth in this section. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
  - (1) The applicant has a current challenge or a previously successful challenge to licensure or registration.
  - (2) Hospital has determined that there has been either an unusual pattern of, or an excessive number of,



- professional liability actions resulting in a final judgment against the applicant.
- (3) The applicant has had involuntary limitation, reduction, denial or loss of Clinical Privileges or involuntary termination of Membership at another organization.
  - (4) Questions have been raised about the applicant by the Section or Department Chair.
  - (b) The chair of the Credentials Committee, acting on behalf of the Credentials Committee, shall, after receiving the a favorable report from each appropriate Section and Department Chair and information contained in references given by the applicant and from other available sources, examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall review the application and accompanying materials and determine whether the applicant has established and satisfied all of the necessary qualifications for Medical Staff appointment and/or for the Clinical Privileges requested.
  - (c) As part of the process of making a report, the Credentials Committee chair may conduct an interview with the applicant.
  - (d) The Credentials Committee shall provide a report and forward this information to the Medical Executive Committee. All recommendations to appoint, shall specify the Medical Staff category and specifically recommend the Clinical Privileges, if any, to be requested.
  - (e) If the chair of the Credentials Committee has any questions about the applicant's qualifications (including, but not limited to, or current clinical competence), the chair shall refer the matter to the entire Credentials Committee and the routine credentialing appointment and privileging process, as set forth below, shall be followed.
  - (f) The Medical Executive Committee shall review the reports from the applicable Department/Section Chairs and recommendation made by the chair of the Credentials Committee. If the Medical Executive Committee concurs with the favorable recommendation reports from the applicable Department/Section Chairs and the Credentials Committee chair, the favorable recommendation of the MEC shall be forwarded to the Medical Quality & Credentialing Committee for action. If the Medical Executive Committee has any questions about the applicant, the questions shall be noted, and the matter shall be referred to the entire Credentials Committee for further processing pursuant to the routine appointment and privileging process.
  - (g) The Medical Quality & Credentialing Committee shall review the reports from the applicable Department/Section Chairs, the Credentials Committee chair, and the MECs and evaluates the qualifications and competence of the applicant and along with the Medical Staff application and accompanying material prior to renderings its decision. If it concurs with the favorable recommendations from the applicable Department/Section Chairs, the Credentials Committee chair, and the MEC, the status or Medical Staff appointment and/or Privileges requested are granted. If the Medical Quality & Credentialing Committee's decision is does not concur with the favorable recommendations of the applicable Department/Section chairs, the Credentials Committee chair, and the MEC, to the applicant, the matter is referred back to the Medical Executive Committee for further evaluation/processing pursuant to the routine appointment and privileging process.
  - (h) A report regarding all applicants who are granted an appointment and Clinical Privileges pursuant to the expedited appointment and privileging process set forth in this Section 2.C.5. shall be forwarded to the Legacy Board for information.

#### 2.C.6. Credentials Committee Procedure:

- (a) Except as expressly provided in Section 2.C.5., all other applications for Clinical Privileges shall be processed as set forth in Sections 2.C.6. - 2.C.8.
- (b) Upon receipt of the report from the applicable Department/Section Chairs, the Credentials Committee shall review such report and the application and accompanying materials to determine, whether the applicant has satisfied the qualifications for the Clinical Privileges requested.
- (c) As part of the process of making its report, the Credentials Committee may, at its discretion, conduct an interview with the applicant (or designate one (1) or more of its Members to do so) to discuss the applicant's application and, qualifications for the Clinical Privileges requested.
- (d) The Credentials Committee may use the expertise of the Section or Department Chair, or any Member of the Department, if additional information is required regarding the applicant's qualifications.

- (e) If the report of the Credentials Committee is delayed longer than ninety (90) days after receipt of the Section and/or Department Chair's report, the chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee, explaining the reasons for the delay.

#### 2.C.7. Meeting with the Affected Individual

If, during the processing of an individual's application, it becomes apparent to the Credentials Committee or its chair that the committee is considering a recommendation that would deny Privileges, the chair of the Credentials Committee may notify the applicant of the general tenor of the possible recommendation and ask if the applicant desires to meet with the committee prior to a recommendation by the committee. At such meeting, if any, the affected applicant may be informed of the general nature of the evidence supporting the action contemplated and invited to discuss, explain or refute it. The individual shall not be permitted to bring an attorney. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings and appeals shall apply. The Credentials Committee shall indicate as part of its report to the Medical Executive Committee and the Legacy Board whether such a meeting occurred, and, if so, shall include a summary of the meeting.

#### 2.C.8. Credentials Committee Report:

- (a) The Credentials Committee shall send its written recommendation and findings in support thereof (which may be set forth in Credentials Committee minutes) to the Medical Executive Committee. The Credentials Committee shall recommend to the MEC:
  - (1) that the applicant be appointed to the granted the Clinical Privileges requested to include any conditions related thereto;
  - (2) that the applicant's application be deferred for further consideration; or
  - (3) that the applicant be denied Clinical Privileges.
- (b) The chair of the Credentials Committee shall be available to the Medical Executive Committee and to the Legacy Board to answer any questions that may be raised with respect to the Credentials Committee's report.

#### 2.C.9. Medical Executive Committee Procedure:

- (a) The Medical Executive Committee (MEC) shall, at its next regular meeting, consider the reports from the Department/Section Chairs and the Credentials Committee and such other documentation as the MEC deems appropriate.
- (b) The MEC may, at its discretion, conduct an interview with the applicant or designate one (1) or more of its Members to do so.
- (c) Upon completion of its review, the MEC may take any of the following actions (which may be set forth in the MEC's meeting minutes):
  - (1) Deferral: The MEC may refer the application back to the Credentials Committee for additional information and/or table transmitting its recommendation to the Board and note in the MEC minutes the deferral and the grounds, therefore. A decision by the MEC to defer (*i.e.*, to table) the application for further consideration must be revisited at the next regularly scheduled meeting, except for good cause, at which point the MEC shall issue its recommendation as to approval or denial of Privileges.
  - (2) Favorable Recommended Action: An MEC recommendation to grant the requested Privileges is forwarded to the Board for action.
  - (3) Adverse Recommended Action: When the recommendation of the MEC is to deny the requested Privileges, the Medical Staff President shall promptly provide the applicant Special Notice of the Adverse recommendation and the applicant shall be entitled, if applicable, to the procedural due process rights set forth in the Medical Staff Bylaws upon proper and timely

request therefore. No such Adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her right to a hearing, if any, as provided for in the Medical Staff Bylaws.

2.C.10. Board Action:

- (a) The Board shall, at its next regular meeting, consider the recommendation of the MEC and such other documentation as the Board deems appropriate.
- (b) Upon completion of its review, the Board may take any of the following actions:
  - (1) Following a Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, an MEC recommendation to grant the requested Medical Staff appointment and/or Privileges or refer the application back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent MEC recommendation must be made to the Board.
    - If the Board's decision is favorable to the applicant, the action shall be effective as its final decision.
    - If the Board's decision is Adverse to the applicant, the Hospital President/CEO shall so notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Medical Staff Bylaws upon proper and timely request therefore. Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Medical Staff Bylaws. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.
  - (2) Without Benefit of Medical Executive Committee Recommendation: If the Board, in its determination, does not receive a recommendation from the MEC within an appropriate time frame, the Board may, after notifying the MEC of the Board's intent and providing a reasonable period of time for response by the MEC, take action on its own initiative employing the same type of information usually considered by the Medical Staff authorities.
    - If the Board's decision is favorable to the applicant, the Board action shall be effective as its final decision.
    - If the Board's decision is Adverse to the applicant, the Hospital President/CEO shall inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Medical Staff Bylaws. Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Medical Staff Bylaws. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges where none existed before.
  - (3) Adverse MEC Recommendation: If the Board is to receive an Adverse MEC recommendation, the Medical Staff President shall withhold the recommendation and not forward it to the Board until after the applicant either exercises or waives his/her right, if any, to the procedural due process rights set forth in the Medical Staff Bylaws. The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.
  - (4) Joint Conference Committee Review: Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee. This committee shall, after due consideration, make its written recommendation to the Board within fifteen (15) days after referral to the committee. Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

### 2.C. 11. Notice of Board Decision

Written Notice of the Board's final decision shall be provided to the applicant. Appropriate Hospital and Medical Staff leaders shall also be notified.

A decision and Notice to Privileges includes, as applicable (1) the Medical Staff category to which the applicant is appointed; (2) the Department(s) and/or Section(s) to which they is assigned; (3) the Clinical Privileges they may exercise; and (4) any special conditions attached to the Privileges.

### 2.D: SCOPE OF PRACTICE

#### 2.D.1. General:

- (a) Each individual who has been authorized to practice as an AHP shall be entitled to exercise only the functions of the scope of practice or job description specifically granted by the Legacy Board.
- (b) The scope of practice or job description recommended to the Legacy Board shall be based upon consideration of the following:
  - (1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the functions requested;
  - (2) the applicant's ability to meet all current criteria for the requested scope of practice;
  - (3) availability of qualified physician members of the medical staff to provide the required supervision or backup for the applicant;
  - (4) adequate levels of professional liability insurance coverage with respect to the scope of practice requested;
  - (5) the Hospital's available resources and personnel;
  - (6) any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;
  - (7) any information concerning professional review actions, voluntary or involuntary termination of authorization to practice, or voluntary or involuntary limitation, reduction, or loss of authorization to practice at another hospital; and
  - (8) other relevant information, including a written report and findings by the chair of each of the clinical services in which such authorization to practice is sought.
- (f) The applicant shall have the burden of establishing qualifications for and competence to exercise the scope of practice requested.
- (g) The reports of the chair of the clinical service in which authorization to practice is sought shall be forwarded to the Credentials Committee or Chairperson of the Credentials Committee, depending upon whether any questions are raised, and processed as a part of the initial application for Clinical Privileges.

#### 2.D.2. Authorization to Practice New Procedures:

Whenever an AHP requests authorization to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

- (a) Recognition of New Service/Procedure
  - 1) Considerations.

The Board shall determine the Hospital's scope of patient care services based upon recommendations from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

- The Hospital's available resources and staff.
- The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).
- The availability of other qualified Practitioners with Privileges at the Hospital to provide coverage for the service or procedure when needed.
- The quality and availability of training programs.
- Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.
- Whether there is a community need for the service or procedure.

(b) Privilege Requests for a New Service or Procedure. Requests for Privileges to perform a new service or procedure at the Hospital (or to use a new technique to perform an existing procedure) that has not yet been recognized by the Board shall be processed as follows:

- The AHP must submit a written Privilege request for a new service or procedure to the Medical Staff Office. The request should include a description of the Privileges being requested, the reason why the AHP believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance in evaluating the request.
- The Medical Staff Services Office will notify the applicable Department Chair/Section Chair of such request.
- If the Department Chair/Section Chair determines that the service or procedure should not be recognized at the Hospital, the Department Chair/Section Chair will provide the basis for his/her recommendation to the Medical Executive Committee.
- If the Department Chair/Section Chair determines that the service or procedure should be included in an existing Privilege set, the Department Chair/Section Chair will provide the basis for his/her recommendation to the Medical Executive Committee.
- If the Department Chair/Section Chair determines that the new Privileges should be recognized at the Hospital and that a new Privilege set is required, the applicable Department/Section shall develop or work with System-wide Privilege Workgroup to develop such Privileges and submit to the Medical Executive Committee a new Privilege set based upon:
  - A determination as to what specialties are likely to request the Privileges.
    - The positions of specialty societies, certifying boards, *etc.*
    - The available training programs.
    - Recommended standards to be met with respect to the following: education; training;
    - board certification; experience; focused professional practice evaluation
    - requirements to establish current competency; ongoing professional practice
    - evaluation criteria, *etc.*
    - Criteria required by other hospitals with similar resources and staffing.

Upon receipt of a recommendation from the Department Chair/Section Chair, the Credentials Committee shall review the matter and forward its recommendation to the MEC. Upon receipt of a recommendation from the Credentials Committee, the MEC shall review the matter and forward its recommendation to the Board.

The recommendation of the MEC, whether favorable or not favorable, will be reviewed and acted upon by the Board:

- 1) If the Board approves the new Privilege set, the requesting AHP(s) may apply for such Privilege(s) consistent with the applicable process set forth in Article 2 of this Policy.

- 2) If the Board does not approve the new Privilege set, the requesting AHP(s) shall be so notified. A decision by the Board not to recognize a new service or procedure does not give rise to the procedural due process rights provided Article 2.C.2 of these Policies.
- 3) Confirmation that the applicant has no current or previously successful challenges to his/her licensure or registration.
- 4) Confirmation that the applicant has not been subject to the involuntary termination of his/her Medical Staff appointment at another organization.

(c) Once the foregoing steps are accomplished, specific requests from AHP's who wish to perform the procedure in question shall be handled in accordance with Section 3.B of this policy ("Procedures for Requesting Increase in Scope of Practice").

2. D.3. Appointment Period

Appointments to the Medical Staff and granting of Clinical Privileges are for a period of up to two (2) years.

An appointment or grant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of Article Article 14 of the Bylaws.

2.E: TIME PERIODS FOR PROCESSING

The time periods set forth below are guidelines only and are not directives such as to create any right for an applicant to have an application processed within these precise periods

All individuals and groups required to act on an application for Medical Staff appointment and/or Privileges should do so in a timely and good faith manner and, except for obtaining additional information or for other good cause, within:

<u>INDIVIDUAL/GROUP</u>	<u>TIME</u>
Department/Section Chair Credentials Committee	Within 90 days after receipt of a complete application. Next regular meeting after receiving a report from the Department/Section Chair.
Medical Executive	Next regular meeting after receiving a report from the Credentials Committee.
Board (aka MQ&CC)	Next regular meeting after receiving a recommendation from the MEC.

If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time period guideline.

If the provisions set forth in Article 2.E. are activated, the time requirements provided therein govern the continued processing of the application.

ARTICLE 3: CLINICAL PRIVILEGES

3.A: CLINICAL PRIVILEGES

3.A.1. General:

- (a) Medical Staff appointment or reappointment shall not confer any Clinical Privileges to provide care, treatment, and/or services at the Hospital.
- (b) Each AHP shall be entitled to exercise only those Clinical Privileges specifically granted by the Legacy Board.

- (c) A grant of Clinical Privileges shall carry with it acceptance of the obligations of such Privileges, including as applicable, emergency service and other rotational obligations to fulfill Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.
- (d) Clinical Privileges shall be voluntarily relinquished in a manner that provides for the orderly transfer of such obligations.
- (e) The Clinical Privileges recommended to the Legacy Board shall be based upon consideration of the qualifications set forth in Article 2 of this Policy.

### 3.B: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Temporary Privileges may be granted only in the circumstances and under the conditions described in Sections 3.B.1 or 3.B.2. Under all circumstances, the Practitioner requesting temporary Privileges shall agree, in writing, to abide by the Medical Staff governing documents and applicable Hospital Policies in all matters relating to his/her exercise of temporary Privileges at the Hospital.

Temporary Privileges may be granted on a case-by-case basis in the following circumstances:

#### 3.B.1. Temporary Clinical Privileges for Applicants with a Pending Application:

- (a) Temporary Privileges shall not routinely be granted to applicants. Only those applicants who meet the conditions outlined in Section 2.C.5. for review of a pending application through the expedited appointment and privileging procedure are eligible to receive temporary Privileges while their application is pending.
- (b) Temporary Clinical Privileges may only be granted by the Legacy CEO to applicants for new Privileges awaiting review and action on his/her application by the MEC and Board upon satisfaction of the following:
  - Receipt of a written request from the applicant for the temporary Privileges desired.
  - Receipt of a complete application that raises no concerns.
  - Verification of current licensure, relevant training/experience, current competence, ability to perform the Privileges requested, and such other qualifications as set forth in Article 2.
  - Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by 2.C.2. of these Bylaws.
  - Confirmation that the applicant has no current or previously successful challenges to his/her licensure or registration.
  - Confirmation that the applicant has not been subject to the involuntary termination of his/her Medical Staff appointment at another organization.
  - Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of his/her Clinical Privileges.
  - A favorable recommendation from the President of the Medical Staff (or from the applicable Department Chair or the Chair of the Credentials Committee as designees of the President of the Medical Staff) regarding the applicant's pending application for Medical Staff appointment and Clinical Privileges.
- (c) Temporary Privileges for new applicants may be granted in this circumstance for a limited period of time, not to exceed the pendency of the application (*i.e.*, completion of review and recommendation/action on the application by the MEC and Board) or 120 days, whichever is less.
- (d) Under no circumstances may temporary Privileges be granted if the application is pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

### 3.B.2. Temporary Clinical Privileges for an Important Patient Care Treatment, or Service Need

- (a) Temporary Privileges may be granted to fulfill an important patient care, treatment or service need. A request for temporary Privileges for an important patient care, treatment or service need must be accompanied by payment of any processing fee.
- (b) An AHP must meet all the qualifications set forth in Section 2.A.2. in order to be granted temporary Privileges.
- (c) Temporary Privileges may be granted by the Legacy CEO to meet an important patient care, treatment or service need upon satisfaction of the following:
  - Receipt of a written request from the applicant for the specific temporary Privileges desired.
  - Documentation of an important patient care treatment and/or service need necessitating temporary Privileges.
  - Verification of the AHP's:
    - (1) Current Licensure
    - (2) DEA registration, if applicable to the temporary Privileges requested.
    - (3) Current clinical competence relative to the temporary Privileges being requested (*e.g.* a fully positive written or documented oral reference specific to the Practitioner's current competence with respect to the temporary Privileges being requested from a responsible Medical Staff authority (*e.g.* department/section leader, etc.) at the AHP's current principal Hospital affiliation).
    - (4) Professional Liability Insurance coverage.
    - (5) A query and evaluation of the reports from the NPDB and OIG List of Excluded Individuals/Entities.
  - A favorable recommendation from the President of the Medical Staff (or from the applicable Department Chair or the Chair of the Credentials Committee as designees of the President of the Medical Staff).
  - Temporary Privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the grant of temporary Privileges be for a period exceeding 120 days.

### 3.B.3. Special Requirements:

In exercising temporary Privileges, the AHP shall act under the supervision of the appropriate Section/Department Chair.

Special requirements of consultation and reporting may be imposed by the Section/Department chair concerned on any Practitioner granted temporary Clinical Privileges.

## 3.C: TERMINATION OF TEMPORARY PRIVILEGES

### 3.C.1. Termination

The CEO, CMO, Hospital President or Medical Staff President may, at any time, terminate any or all of a AHP's temporary Privileges. Where the life or well-being of a patient is determined to be endangered, the AHP's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

### 3.C.2. Procedural Due Process Rights

A Practitioner who has been granted temporary privileges, is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members. A Practitioner shall not be entitled to the procedural due process rights set forth in Article 4 because the Practitioner's request for temporary Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

### 3.C.3 Patient Care

In the event a Practitioner's temporary, disaster, or Telemedicine Privileges are terminated, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner with appropriate Privileges by the applicable



Department Chair/Section Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

### 3.D: PROFESSIONAL PRACTICE EVALUATION

#### 3. D.1 Focused Professional Practice Evaluation (FPPE)

The Medical Staff's focused professional practice evaluation ("FPPE") process is set forth in detail in the Medical Staff Professional Practice Evaluation (PPE) Policy. FPPE shall be implemented for all: (a) AHP's requesting initial Privileges; (b) existing AHP's requesting new Privileges during the course of an appointment/Privilege period; and, (c) in response to concerns regarding an AHP's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the AHP's current clinical competence and ability to perform the requested Privileges.

#### 3.D.2. Ongoing Professional Practice Evaluation (OPPE)

Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all AHP's with Privileges at the Hospital. The Medical Staff's OPPE process is set forth, in detail, in the Medical Staff Professional Practice Evaluation (PPE) Policy and requires the Hospital/Medical Staff to gather, maintain, and review data on the performance of all AHP's with Privileges on an ongoing basis.

## ARTICLE 4: REGRANT OF CLINICAL PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS WHO HAVE BEEN AUTHORIZED TO PRACTICE

### 4.A: PROCEDURE FOR REGRANTING OF CLINICAL PRIVILEGES

All terms, conditions, and procedures relating to initial authorization to practice shall apply to continued authorization to practice and scope of practice or Clinical Privilege approval.

#### 4.A.1. Qualifications:

- (a) To be eligible to apply for the regranting of Clinical Privileges, an individual must have, during the previous authorization to practice term:
  - (1) completed all medical records;
  - (2) provided information regarding participation in continuing education related to the scope of practice to be exercised by the individual, if so required;
  - (3) continued to meet all qualifications and criteria applicable to practice and the scope of practice requested as outlined in the applicable Medical Staff governing documents, the Hospital and Legacy, including the qualifications outlined in Section 2.A.2 of this policy.
- (b) To be eligible to apply for the regranting of Clinical Privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous authorization to practice term to enable the appropriate Section or Department Chair and the Credentials Committee to assess the applicant's current clinical competence. Any AHP seeking a regrant of Clinical Privileges whose level of clinical activity at the Hospital is not sufficient to permit an informed judgement as to his/her current competence in exercising the Privileges requested shall cause to be submitted supplemental documentation of his/her clinical performance (*e.g.* professional practice evaluation data, *etc.*) from his/her primary practice location, in such form as may be requested, before the AHP's application shall be considered complete and processed further. Upon regrant of Privileges, the Medical Staff obtains and evaluates peer recommendations as set forth in Article 2.

#### 4.A.2. Application:

- (a) An application for regranting of Privileges shall be provided (or made available) to each eligible AHP's by the Medical Staff Office prior to the expiration of each such AHP's current appointment/Privilege period. Each Practitioner who is eligible to be regranted Privileges shall be responsible for completing an application and for paying a processing fee in an amount determined by the Medical Executive Committee

and approved by the Legacy Board. The AHP must sign the application for Medical Staff regrant of Privileges and in doing so accepts the same conditions as set forth in Section 2.B.2.

- (b) An application for Medical Staff regrant of Privileges shall be considered incomplete and shall not be processed unless the appointee is current with respect to the payment of Medical Staff dues, fees, and assessments.
- (c) The AHP has the burden of producing adequate information for a proper evaluation of his/her qualifications for regrant of Privileges, of resolving and doubts about such qualifications, and satisfying requests for additional information or clarification made by authorized Medical Staff or Hospital representatives.
  - (1) Failure to return the application for Medical Staff regrant of Privileges by the expiration date of the AHP's current Medical Staff Privilege period is deemed a voluntary resignation and results in automatic termination of the AHP's Medical Staff Privileges at the expiration of the AHP's Privilege term. For any future consideration for appointment and/or Privileges, the AHP must submit a new complete application for Privileges, including the application fee.
  - (2) If an application for regranting of Privileges has not been fully processed by the expiration date of the AHP's current Privilege period, the AHP's Privileges shall terminate on the last date of his/her current Privilege period.
  - (3) If the AHP qualifies, they may be granted temporary Privileges to meet an important patient care need pursuant to Section 3.B.2 of these Bylaws.
- (d) Regrant of Privileges, if granted by the Legacy Board, shall be for a period of not more than two years. The specific staggering of regranting of Privilege periods shall be in a manner established by the Medical Staff Office.

#### 4.A.3. Factors to be Considered at the Time of Regranting of Privileges:

Each recommendation concerning the regranting of Privileges shall include, as applicable, consideration of such AHP's:

- (a) Ethical behavior, clinical competence, and clinical judgment in the treatment of patients.
- (b) Compliance with the Medical Staff governing documents and applicable Hospital Policies.
- (c) Behavior at the Hospital, including cooperation with other Practitioners and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital and its personnel.
- (d) Patterns of care as demonstrated by quality review, utilization review, and Peer Review activities.
- (e) Current information regarding the AHP's ability to competently exercise the Privileges requested, with or without reasonable accommodation, and to perform the duties and responsibilities of Medical Staff appointment.
- (f) Capacity to satisfactorily treat patients as indicated by the results of the Medical Staff's quality improvement, professional practice evaluation (*i.e.* FPPE/OPPE), and Peer Review activities.
- (g) Satisfactory completion of such continuing education requirements as may be imposed by law in order to maintain licensure, the Hospital, or applicable accreditation agencies
- (h) Current Professional Liability Insurance status and pending malpractice claims, lawsuits, judgments, and settlements.

- (i) Status of licensure, including currently pending challenges to any license, certification or registration.
- (j) Voluntary (while under investigation or to avoid investigation) or involuntary limitation, reduction, suspension, or termination/resignation/loss of Medical Staff appointment and/or Clinical Privileges at another Hospital.
- (k) Any sanctions imposed or pending.
- (l) Other reasonable indicators of continuing satisfaction of the qualifications and responsibilities set forth in these Bylaws.

#### 4.A.4. Verification:

- (a) The Medical Staff office verifies the information provided on the application for the regranting of Privileges working with the same authorities and generally in the same manner, to the extent applicable, as provided for in the initial application process set forth in Section 2.C.2.
- (b) When the application is complete and collection and verification is accomplished, the Medical Staff Office shall notify the applicable Department/Section Chair that the AHP's file for regranting of Privileges is available for review.
- (c) All individuals and groups required to act on an application for Medical Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.

#### 4.A.5. Department Chair Procedure:

- (a) Applications for regranting of Privileges shall be reviewed and acted upon by the applicable Department Chair/Section Chair in accordance with the procedure set forth in Section 2.C.4. For the purposes of regranting of Privileges, the terms "applicant" and "Privileges" as used in Section 2.C.4 shall be read as "AHP" and "regrant of Privileges" respectively.

#### 4.A.6. Processing Clean Applications When No Questions Are Raised and All Information is Appropriate and in Order:

- (a) Clean Applications for the regranting of Privileges which are deemed complete may be processed in an expedited manner as set forth in Section 2.C.5. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
  - (1) Since the time of his/her last grant/regrant of Privileges, the AHP has a current challenge or previously successful challenge to licensure or registration.
  - (2) Since the time of his/her last grant/regrant of Privileges, Hospital has determined that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the AHP.
  - (3) Since the time of his/her last grant/regrant of Privileges, the AHP has had an involuntary limitation, reduction, suspension, denial or termination/loss of Clinical Privileges or Membership at another organization.
  - (4) Questions have been raised about the AHP by the applicable Section or Department chair.
- (b) For the purposes of the regranting of Privileges, the terms "applicant" and "Privileges" used in Section 2.C.5.

#### 4.A.7. Credentials Committee Procedure:

- (a) Except as expressly provided in Section 3.A.5., all other applications for the regranting of Clinical Privileges shall be processed as set forth in Sections 3.A.6. - 3.A.8.

- (b) Applications for regranting Privileges shall be reviewed and acted upon by the Credentials Committee in accordance with the procedure set forth in Section 3.A.7. For purposes of regranting Privileges, the terms “applicant” and “Privileges” as used in Section 2.C.6. shall be read as “AHP” and “regrant of Privileges,” respectively.

#### 4.A.8. Medical Executive Committee Recommendation:

- (a) Applications for regranting Privileges shall be reviewed and acted upon by the Medical Executive Committee in accordance with the procedure set forth in Section 2.C.9. For purposes of regranting Privileges, the terms “applicant” and “Privileges” as used in Section 2.C.9. shall be read as “AHP” and “regrant of Privileges,” respectively.

#### 4.A.9. Board Action

- (a) Applications for regranting Privileges shall be reviewed and acted upon by the Board in accordance with the procedure set forth in Section 2.C.10. For purposes of regranting Privileges, the terms “applicant” and “Privileges” as used in Section 2.C.10. shall be read as “AHP” and “regrant of Privileges,” respectively.

### 4.B: PROCEDURES FOR REQUESTING INCREASE IN SCOPE OF PRACTICE

#### 4.B.1. Application for Additional Scope of Practice:

- (a) Whenever, during the term of authorization to practice, additional scope of practice is desired, the AHP requesting the increase shall apply in writing to the Medical Staff Office. The application shall state in detail the specific additional functions desired and the AHP’s relevant recent training and experience which justify the addition. If the applicant meets the relevant threshold criteria for the change in question, this application shall be transmitted by the Medical Staff Office to the appropriate Section or Department Chair. Thereafter, it shall be processed in the same manner as an application for initial scope of practice.
- (b) Whenever an AHP requests authorization to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the process set forth in Section 2.D.2. of this policy shall be followed.

#### 4.B.2. Factors to be Considered:

- (a) Recommendations for additional scope of practice shall be based upon:
  - (1) relevant recent training;
  - (2) observation of patient care provided;
  - (3) review of the records of patients treated in this or other hospitals;
  - (4) results of the Hospital’s quality improvement activities;
  - (5) applicant’s ability to meet the qualifications and criteria for the requested change; and
  - (6) other reasonable indicators of the individual’s continuing qualifications for practice in question.
- (b) The recommendation for such increased scope of practice may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

### 4.C: PROCEDURE FOR QUESTIONS INVOLVING AHP’S

#### 4.C.1 Automatic termination:

The authorization to practice within the Hospital shall automatically terminate if:

- (a) the employment or supervisory relationship between the AHP and the physician is terminated or if the Legacy employment of the Independent AHP is terminated.

- (b) the medical staff appointment of the supervising physician is terminated for any reason or if the supervising physician's clinical privileges are curtailed to the extent that the professional services of the AHP within the Hospital are no longer necessary or permissible to assist the employer.

#### 4.C.2. Initial Procedure for review of concerns or questions:

- (a) Whenever a concern or question has been raised regarding:
  - (1) the clinical competence or clinical practice of any AHP;
  - (2) the care or treatment of a patient or patients or management of a case by any AHP;
  - (3) the known or suspected violation by any AHP of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital, Legacy or the Medical Staff, including, but not limited to the Hospital's quality improvement, risk management, and utilization review programs; and/or
  - (4) behavior or conduct on the part of any AHP that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the AHP to work harmoniously with others; the President of the Medical Staff, Physician Advisor, Chair of the Credentials Committee, or Legacy CEO shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible, after which it shall be submitted in writing to the Medical Executive Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Hospital and the AHP concerned, they may, but are not required to, discuss the matter with the affected AHP.

#### 4.C.3. Procedure Thereafter:

- (a) In acting after the review, the Medical Executive Committee may:
  - (1) determine that no action is justified;
  - (2) issue a written warning;
  - (3) issue a letter of reprimand;
  - (4) impose terms of probation;
  - (5) impose a requirement for additional supervision;
  - (6) recommend reduction of clinical privileges or scope of practice;
  - (7) recommend suspension of scope of practice for a term;
  - (8) recommend revocation of authorization to practice; or
  - (9) make such other recommendations as it deems necessary or appropriate.

#### 4.D: OTHER ACTIONS

The following events shall result in an automatic suspension of Privileges without recourse to the procedural rights set forth the Fair Hearing Policy.

- (a) **Licensure Suspension or Expiration.** Whenever an AHP's license is suspended by the applicable licensing entity or expires, the AHP's Privileges shall be automatically suspended.
- (b) **Licensure Restriction.** Whenever an AHP's license is limited/restricted by the applicable licensing entity, the AHP's Privileges will be likewise automatically limited/restricted.
- (c) **Probation.** Whenever an AHP's license is made subject to probation by the applicable licensing entity, the Practitioner's Privileges shall automatically become subject to the same terms of such probation.
- (d) **Controlled Substance Authorization Suspension.** Whenever an AHP's DEA registration (or other authorization to prescribe controlled substances) is suspended by the DEA or other applicable federal or state authority, his/her Privileges shall be automatically suspended.

- (e) **Professional Liability Insurance.** If an AHP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the AHP's Privileges shall be automatically suspended until Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to the below.

The CVO or Medical Staff Office must be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the AHP's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitations on the new policy, and a summary of relevant activities during the period of non-compliance.

For purposes of this section, the failure of an AHP to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

- (f) **Federal Health Program.** Whenever an AHP is suspended from participating in a Federal Health Program, the Practitioner's appointment and Privileges shall be automatically suspended.
- (g) **Failure to Complete Medical Records.** Whenever an AHP fails to complete medical records as provided for in Medical Staff governing documents and/or applicable Hospital (*i.e.*, Health Information Management) Policies, the AHP's Privileges shall be automatically suspended consistent with the applicable document(s).
- (h) **Plea of Guilty, etc.** If an AHP pleads guilty to, is found guilty of, or pleads no contest to a felony or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; (ii) fraud, bribery, evidence tampering, or perjury; or, (iii) a drug offense, the AHP's Privileges shall be immediately and automatically terminated.

#### 4.D.1. Procedure for Leave of Absence:

- (a) AHP's may, for good cause, be granted leaves of absence by the Legacy Board, for a stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of authorization to practice, unless an exception is made by the Legacy Board upon recommendation of the Medical Executive Committee.
- (b) Requests for leaves of absence shall be made to the President of the Medical Staff and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff shall transmit the request together with a recommendation to the for action by the Legacy Board.
- (c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement at least 30 days prior to intended return with the AHP summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at that time. All this information shall be considered by the Credentials Committee and the Medical Executive Committee in arriving at a recommendation regarding reinstatement.
- (d) If the leave of absence was for medical reasons, then the AHP must submit a report from his or her attending physician indicating that the AHP is physically and/or mentally capable of resuming a hospital practice and exercising the scope of practice requested. The AHP shall also provide such other information as may be requested by the Hospital at that time. After considering all relevant information, the Hospital, the Credentials Committee and the Medical Executive Committee shall then make a recommendation to the Legacy Board for final action.
- (e) In acting upon the request for reinstatement, the Legacy Board may approve, may limit, or modify the scope of practice to be extended to the individual upon reinstatement.

## ARTICLE 5: REMOVAL AND HEARING PROCEDURES

#### 5.A: REMOVAL PROCEDURES:

The Hospital retains the right either through the Medical Staff President or his designee, or upon recommendation of the Medical Executive Committee, Section or Department Chair or Credentials Committee Chairman to suspend or terminate any or all of the Privileges of an AHP. Allied health professionals are not entitled to any of the due process, hearings or appeal rights set forth in the Medical Staff governing documents.

#### 5.B: HEARING RIGHTS:

- (a) When an Independent AHP who is also a Legacy employee is to be or has been terminated or Clinical Privileges is or has been substantially curtailed, such termination or curtailment shall fall under the established policies, including any appeal rights, of the then current Legacy Health Human Resources Policies and Procedures.
- (b) When any other AHP covered under this policy is to be terminated or Clinical Privileges is to be or has been substantially curtailed, the supervising physician(s) and the Dependent AHP shall be notified in writing by the Medical Staff President or designee of the reasons for such action and, if the supervising physician so requests within thirty (30) days of receipt of notification, the Dependent AHP shall be entitled to have such action reviewed by the Medical Executive Committee, excluding such members who are in direct economic competition with the Dependent AHP. At any such meeting, the Dependent AHP and the supervising physician(s) shall be allowed to be present and fully participate but may not be present during final deliberation and vote by the MEC. The Medical Executive Committee can recommend to accept, reject or modify the decision to terminate or curtail, subject to review and final decision by the governing body.

#### 5.C: APPEAL RIGHTS:

- (a) Independent AHPs who are also Legacy employees: Appeal rights shall fall under the established policies of the then current Legacy Health Human Resources Policies and Procedures.
- (b) All other AHPs covered under this policy: Prior to action by the governing body, the decision of the MEC will be communicated in writing to the Supervising Physician and the Dependent AHP, and the Supervising Physician will be allowed 30 days to appeal the MEC's decision in writing. If no written appeal is received within that time frame, the MEC's recommendation will be forwarded to the governing body for final action.

### ARTICLE 6: CONFIDENTIALITY AND REPORTING

Actions taken, recommendations made, and information shared pursuant to these Policies shall be treated as confidential in accordance with applicable legal requirements, as well as such Policies regarding confidentiality as may be adopted by Hospital and the Medical Staff. In addition, reports of actions taken pursuant to these Policies shall be made by the Medical Staff President or Hospital President to such governmental agencies as may be required by law.

Hospital shall maintain all information it receives from third parties in strict confidence, and the release of any such information shall be in accordance with applicable federal and state law, including, but not limited to, ORS §41.675 or RCW 4.24.240 & 70.41.200 or the corresponding provisions of any subsequent state or federal law providing protection to Peer Review or related activities. No party shall disclose this information to any third party without the express written consent of the others.

The Medical Staff and Hospital recognize that it is vital to maintain the confidentiality of records maintained by or on behalf of the Medical Staff (collectively, "Medical Staff Records"). Medical Staff Records include, but are not limited to, Medical Staff committee records and minutes and credentials, quality and Peer Review files of individual practitioners. Medical Staff Members participate in Peer Review, performance improvement, quality assurance, utilization review, credentialing, education, training, supervision and discipline and privileging activities

(collectively, "Peer Review Activities") in reliance upon the confidentiality of and legal protections afforded to these activities. As such, Medical Staff Records are confidential, privileged and protected pursuant to ORS 41.675 & 41.685, RCW 4.24.240 & 70.41.200, the federal Health Care Quality Improvement Act of 1986 and other applicable law and may be disclosed only in accordance with these Bylaws or as otherwise authorized by law.

ARTICLE 7: AMENDMENTS

- (a) This policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee.
- (b) In limited circumstances outlined below, this policy may also be amended by the Legacy Board on its own motion provided that any such amendment is first submitted to the Credentials Committee and the Medical Executive Committee for review and comment at least thirty (30) days prior to any final action by the Legacy Board on such amendment. Instances where such action by the Legacy Board shall be warranted shall be limited to the following:
  - (1) action to comply with changes in federal and state laws that affect the Hospital and the Hospital corporation, including any of its entities;
  - (2) action to comply with requirements imposed by the Hospital's general and professional liability or Director's and Officer's insurance carrier; and
  - (3) action to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.

ARTICLE 8: ADOPTION

This Policy is adopted and made effective upon approval of the Legacy Board, superseding and replacing any and all other Medical Staff Bylaws, rules, regulations or Policies pertaining to the subject matter herein.

ADOPTED BY THE LEGACY BOARD AFTER RECEIPT OF A RECOMMENDATION FROM HOSPITAL'S MEDICAL EXECUTIVE COMMITTEE ON JULY 22, 2021.

Adopted by the Medical Staff:

/s/ Aaron Kabb, DO                      Date: 4/12/2021  
President of the Legacy Mount Hood Medical Staff

Approved by the Legacy Health Board:

/s/ Charles Wilhoite                      Date: 7/22/2021