

MEDICAL STAFF BYLAWS  
OF  
LEGACY GOOD SAMARITAN MEDICAL CENTER

Adopted January 19, 2022

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## DEFINITIONS

The following definitions shall apply to the Medical Staff governing documents:

**Advance Practice Providers (APP)** are a group of professionals who provide direct care in collaboration with physicians and the healthcare team. This group includes Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, Nurse Practitioners and Physician Assistants., all licensed to diagnose, prescribe and treat patients.

**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.

**Certified Nurse Midwives (CNM)** are RN's who are masters and doctorate prepared in the field of midwifery. They are board certified and licensed as nurse practitioners to practice in the specialty of women's health including, pregnancy, labor, and delivery. In Oregon and Washington, there is no physician supervision requirement under state law.

**Certified Registered Nurse Anesthetists (CRNA)** are RN's who are masters and doctorate prepared advanced practice nurses, providing anesthesia services to patients across the lifespan in a range of practice settings. In Oregon and Washington, there is no physician supervision required, under state law.

**Clinical Nurse Specialists (CNS)** are RN's who are masters and doctorate prepared advanced practice nurses and are certified in their specialty to practice at an advanced level to manage patient populations, nurse practice and healthcare systems, in collaboration with healthcare teams. CNS' may have prescriptive authority based on clinical preparation. Full independent practice without physician supervision, is permitted in Oregon and Washington, under state law.

**Clinical Privileges or Privileges** means the permission granted by the Board to a Practitioner 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.

**Dentist** means a Doctor of Dental Surgery (D.D.S.) or a Doctor of Dental Medicine (D.M.D.).

**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.

**Good Standing** means that no adverse professional review action as defined in the Health Care Quality Improvement Act has been taken regarding this practitioner. That means that there has been no reduction, restriction, suspension, revocation, denial, or non-renewal of the practitioner's staff membership or clinical privileges.

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

**Joint Conference Committee** means a committee of three (3) representatives from each of the Medical Quality and Credentialing Committee and the Medical Executive Committee, as selected by those committees, to resolve conflicting recommendations and/or findings.

**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 President** means the qualified Medical Staff Member who is elected to serve as the president of the Medical Staff.

**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 to inform someone of something.

**NPDB** means the National Practitioner Data Bank.

**Nurse Practitioners (NP)** are RNs who are masters and doctorate prepared advanced practice nurses with board certification and licensure to practice in primary, acute, and specialty practice across the continuum based on participation. Full practice is permitted in Oregon and Washington, under state law.

**Oral Surgeon** means a licensed Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation of the American Dental Association.

**Patient Contact** means any admission, inpatient consultation, evaluation, procedure (inpatient or outpatient) or diagnostic test involving direct patient interaction (except in imaging and pathology) performed at the Hospital. Patient Contacts do not include referrals to the Hospital for diagnostic studies or for procedures performed by another practitioner.

**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.)

**Physician Assistant (PA)** are medical professionals with master's level education with board certification and licensure to practice in primary, acute and specialty practice across the age continuum under physician supervision.

**Podiatrist** means a Doctor of Podiatric Medicine (D.P.M)

**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.

**Psychologist** means a Psy.D or a Ph.D.

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

**Telemedicine** means those who prescribe, render a diagnosis, or otherwise provide or direct clinical treatment to a patient at Hospital utilizing electronic or other communication technologies that provide or support clinical care from a distance.

**Use of an Authorized Designee:** Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of their 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: PURPOSE

The purpose of this organization is to bring the professionals who practice at Hospital together into a cohesive body to promote high quality patient care, provide oversight in activities related to patient safety and improve patient satisfaction. To this end, among other activities, it shall screen applicants for Medical Staff Membership, review Privileges of Medical Staff Members, evaluate and assist in improving the work done by the Medical Staff, provide education, and offer advice to the Legacy Board.

## ARTICLE 2: MEDICAL STAFF MEMBERSHIP

### 2.A. MEDICAL STAFF MEMBERSHIP:

Qualifications and conditions for appointment to the Medical Staff are outlined in these Bylaws. Medical Staff Members must conform to and follow all Hospital and Medical Staff Bylaws, rules, regulations, and Policies including, but not limited to, those regarding impairment, harassment, and conduct.

### 2.B. MEDICAL STAFF DUES:

- (a) The Medical Executive Committee shall have the power to determine the amount of annual dues or assessments, if any, for each category of Medical Staff Membership, and to determine the manner of expenditure of such funds received.
- (b) Annual dues for Membership shall be due and payable at an amount and timeframe set by the Medical Executive Committee. An individual who joins the Medical Staff during the last quarter of the calendar year shall not be assessed dues until the ensuing year.
- (c) Failure to render payment within three months of initial billing shall constitute a voluntary resignation from the Medical Staff.
- (d) Honorary staff shall not be required to pay dues.

## ARTICLE 3: CATEGORIES OF THE MEDICAL STAFF

### 3.A. ACTIVE MEDICAL STAFF

#### 3.A.1. Qualifications:

- (a) Meet the qualifications outlined in Section 11.A.
- (b) Have sufficient Patient Contacts at the Hospital during the most recent appointment period (at least thirty-eight (38) during a three-year period twenty-five (25) during a two-period or thirteen (13) during a one-year period).
- (c) Actively contribute to the activities of the Hospital and Medical Staff through committee assignments, leadership roles, and participation in Medical Staff activities.

#### 3.A.2. Prerogatives:

Members to this category may:

- (a) Exercise Clinical Privileges granted.
- (b) Attend Medical Staff meetings; vote on Medical Staff matters.

- (c) Attend meetings of the Medical Staff Department/Section of which they are a member; vote on Department/Section matters.
- (d) Serve as a member or chair of Medical Staff committees, subject to satisfaction of applicable qualifications, with the right to vote on committee.
- (e) Hold Medical Staff Office subject to satisfaction of the applicable qualifications.
- (f) Serve as Medical Staff Department Chair or Section Chair subject to satisfaction of the applicable qualifications.
- (g) Serve as a MEC at-large Member subject to satisfaction of the applicable qualifications.
- (h) Attend Medical Staff and Hospital education programs.

### 3.A.3. Responsibilities:

Members to this category must:

- (a) Meet the responsibilities and requirements outlined in Section 11.B.3.
- (b) Actively participate in quality assessment and other performance improvement activities and discharge such other Medical Staff functions as may from time to time be required.
- (c) For Medical Staff Members with attending Privileges, be within a thirty (30) minute response time of Hospital when on call.
- (d) Participate in emergency service and other rotational obligations if asked to do so by the Medical Executive Committee.
- (e) Timely pay Medical Staff dues, fees, and assessments.

### 3.A.4. Automatic Transfers/Terminations:

After three (3) consecutive years in which a Member to the active Medical Staff fails to have at least thirty-eight (38) Patient Contacts at the Hospital during a three-year appointment period (or any consecutive three-year period for Members whose appointment period is less than three years), the Member shall be automatically transferred to another appropriate Medical Staff category, if any, for which the Member is qualified. If the Member fails to qualify for another Medical Staff category, they will be considered ineligible for appointment and Privileges. An automatic transfer to another Medical Staff category or failure to be reappointed based upon this section shall not entitle a Practitioner to the procedural due process rights as set forth in these Medical Staff Bylaws or the Fair Hearing Policy.

Hospital occasionally needs practitioners in certain medical specialties who primarily maintain office practices and do not have sufficient Patient Contacts in Hospital (e.g., allergists, dermatologists, rheumatologists, pediatricians, family practitioners, and other specialties as approved by the Medical Staff) to see and treat patients in Hospital. These practitioners are eligible for active status if they provide information deemed adequate by the Medical Executive Committee to properly evaluate their education, training, experience, competence, and other qualifications to practice in Hospital.

## 3.B. COURTESY MEDICAL STAFF

### 3.B.1. Qualifications:

Members to this category must:

- (a) Meet all criteria and qualifications outlined in Section 11.A.
- (b) Be an appointee in good standing of the active Medical Staff of another Hospital or health care facility that has a formal quality improvement and patient safety program with Clinical Privileges and sufficient Patient Contacts during their most recent reappointment period (at least thirty-eight (38) during a three-year period, twenty-five (25) during a two-year period or thirteen (13) during a one-year period) and provide documentation of Patient Contacts, if requested.
- (c) Meet one (1) of the following qualifications:
  - (1) Have not more than thirty-seven (37) Patient Contacts at the Hospital during a three-year period or twenty-four (24) Patient Contacts at the Hospital during a two-year period, or twelve (12) patient contacts at the hospital during a one-year period; OR
  - (2) Members who are granted appointment to this category and exceed the maximum number of Patient Contacts at the Hospital during their most recent appointment period shall be transferred to the active Medical Staff at the time of reappointment unless Member meets one of the following conditions:
    - (i) Member presents an explanation, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur again in the next appointment period, unless such Member otherwise qualifies for continued appointment to the courtesy Medical Staff pursuant to one of the remaining options set forth below:
    - (ii) Member requests Medical Staff appointment and Privileges for the sole purpose of providing periodic back-up coverage for another Medical Staff Member with comparable Privileges; **OR,**
    - (iii) Member requests Medical Staff appointment and Privileges for the sole purpose of providing Hospital-approved temporary staffing for an extended period of time; **OR,**
    - (iv) Member requesting appointment and Privileges for the sole purpose of providing Hospital-based contracted exclusive professional medical services (*e.g.*, radiology, emergency medicine, anesthesia, pathology, *etc.*) unless such Appointee otherwise qualifies for appointment to the active Medical Staff.

### 3.B.2. Prerogatives:

Members to this category may:

- (a) Exercise Clinical Privileges granted.
- (b) Attend Medical Staff meetings.
- (c) Attend meetings of the Medical Staff Department/Section of which they are a Member.
- (d) Serve as a Member of Medical Staff Committees subject to satisfaction of applicable qualifications, with the right to vote on committee matters.
- (e) Serve as a Section Chair subject to satisfaction of applicable qualifications.
- (f) Attend Medical Staff and Hospital education programs.

### 3.B.3. Responsibilities:

Members to this category must:

- (a) Meet all responsibilities and requirements outlined in Section 11.B.3.
- (b) Participate in emergency service and other rotational obligations if asked to do so by the Medical Executive Committee.
- (c) Be within a thirty (30) minute response time of Hospital when on call.
- (d) Timely pay Medical Staff dues, fees, and assessments.

### 3.C. AFFILIATE MEDICAL STAFF

#### 3.C.1. Qualifications:

Members to this category must:

- (a) Meet the qualifications outlined in Section 11.A. to the extent such qualifications are applicable to a request for Medical Staff appointment without Privileges.
- (b) Contribute to the Hospital or Medical Staff through one or more of the following activities:
  - refer patients to Members of the active Medical Staff.
  - order diagnostic or therapeutic services at Hospital.
  - serve as an officer of the Medical Staff.
  - serve on Hospital or Medical Staff Committee(s).
  - accept and provide office-based care to patients referred from Hospital's Emergency Department.
  - participate in Hospital or Medical Staff quality improvement activities, including case review; or
  - conduct clinical research at Hospital.

#### 3.C.2. Prerogatives:

Members to this category may:

- (a) Attend Medical Staff meetings, vote on Medical Staff matters.
- (b) Attend meetings of the Department/Section of which they are a Member; vote on Department and/or Section matters.
- (c) Hold Medical Staff office subject to satisfaction of applicable qualifications.
- (d) Serve as a Department Chair or Section Chair subject to satisfaction of applicable qualifications.
- (e) Serve as a MEC at-large Member subject to satisfaction of the applicable qualifications.
- (f) Serve as a member or chair any Medical Staff committee, subject to satisfaction of applicable qualifications, with the right to vote on committee matters.
- (g) Attend Medical Staff and Hospital education programs.
- (h) Visit their patients who are in the Hospital and view their patient's medical records in accordance with Applicable Hospital Policies regarding access to medical records and HIPAA confidentiality/privacy requirements; and subject to training, as required, with respect to view only access to the electronic medical record. An Affiliate Member may not document in a patient's Hospital medical record.

3.C.3. Responsibilities:

Members to this category must:

- (a) Meet all responsibilities and requirements outlined in Section 11.B.3. to the extent such responsibilities are applicable to a request for Medical Staff appointment without Privileges.
- (b) Have an arrangement with a Member of the Medical Staff with appropriate Privileges to admit and manage the care of the affiliate Member's hospitalized patients.
- (c) Timely pay Medical Staff dues, fees, and assessments.

3.C.4. Restrictions:

- (a) Members to this Category may not be granted Clinical Privileges (*e.g.*, to admit patients, perform consults, or otherwise provide care, treatment, and/or services) at the Hospital.

3.D. HONORARY MEDICAL STAFF

3.D.1. Qualifications:

To be designated as an Honorary Medical Staff Member, an individual must:

- (a) Be recommended for Honorary appointment by the Medical Executive Committee.
- (b) Possess an outstanding reputation.
- (c) Have made noteworthy contributions to the health and medical sciences or have previous longstanding service as an active Member in good standing of the Medical Staff for a minimum of five (5) continuous years.
- (d) Continue to adhere to high professional and ethical standards.

Honorary Medical Staff Members are not required to meet criteria and the qualifications outlined in Section 11.A.

3.D.2. Prerogatives:

Honorary Medical Staff Members may:

- (a) Attend Medical Staff meetings but may not vote on Medical Staff matters.
- (b) Attend Medical Staff and Hospital education programs.

3.D.3. Restrictions:

Members to this category:

- (a) May not hold Medical Staff office.
- (b) May not serve as a Medical Staff Department Chair or Section Chair or MEC Member-at Large Member.
- (c) Are not required to Pay Medical Staff dues, fees, or assessments.
- (d) Are not required to meet the responsibilities outlined in Section 11.B.3

## ARTICLE 4: OFFICERS

### 4.A. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

- (a) President.
- (b) President-elect.
- (c) Immediate Past President.

#### 4.A.1. Qualifications of Officers:

Except as otherwise provided, only those Members of the Medical Staff who satisfy the following criteria shall be eligible to serve as Medical Staff officers:

- (a) Are a Doctor of Medicine or Osteopathy, a Doctor of Dental Surgery or Dental Medicine, or a Doctor of Podiatric Medicine<sup>1</sup>;
- (b) have served on the Medical Staff for at least three years.
- (c) are in Good Standing and continue to be in Good Standing during their term of office.
- (d) have no pending Adverse recommendations concerning Medical Staff appointment or Clinical Privileges.
- (e) are not presently serving as a Medical Staff officer, corporate officer, department chair, Medical Staff leader or employee at any other non-Legacy Hospital or Medical Staff and shall not so serve during their term of office.
- (f) are willing to faithfully discharge the duties and responsibilities of the position to which they are elected or appointed.
- (g) have had prior Medical Staff leadership or committee experience.
- (h) possess and have demonstrated an ability for harmonious interpersonal relationships.
- (i) have constructively participated in Medical Staff affairs, including Peer Review activities.
- (j) are knowledgeable concerning the duties of the office.
- (k) possess written and oral communication skills; and
- (l) agree to participate in Medical Staff education.

#### 4.A.2. Election of Officers:

- (a) Officers shall be elected by the voting Members of the Medical Staff and shall be confirmed by the Legacy Board.
- (b) A nominating committee shall be appointed by the Medical Executive Committee and may include members of the Medical Executive Committee. This committee shall offer one or more nominees for each office. Nominations shall be announced, and the names of the nominees distributed to all Members of the Medical Staff at least thirty (30) days prior to the vote.
- (c) Nominations may also be made by a petition signed by at least five percent (5%) of the voting Members of the Medical Staff. All such nominees shall meet all the criteria outlined in this section and shall have agreed to be nominated. Such petition shall be submitted to the Medical Staff Office at least twenty (20) days prior to the vote.
- (d) The candidate who receives a majority vote of the Medical Staff shall be elected. If no candidate receives a majority vote, then the Medical Staff shall hold a run-off election, to be held as soon as practicable, between the two candidates with the most votes.

#### 4.A.3. Term of Office:

All officers shall take office on the first day of the calendar year and shall serve a term of two years. Medical Staff officers succeed themselves and once they have completed the succession from President-Elect, President and Past-President; they are eligible to be re-nominated by the Medical Staff as an Officer.

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<sup>1</sup> Medicare Hospital Condition of Participation 42 CFR 482.22 (b)(3)



#### 4.A.4. Vacancies in Office:

Vacancies in office, except the office of President of the Medical Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President of the Medical Staff, the President-elect shall serve the remainder of the term.

#### 4.A.5. Duties of Officers:

- (a) President of the Medical Staff: The President of the Medical Staff shall:
- (1) act in coordination and cooperation with administration, nursing services and other patient care services.
  - (2) communicate and represent the views, needs and concerns of the Medical Staff and report on the medical activities of the Medical Staff to the Legacy Board, Legacy CEO, and other appropriate individuals.
  - (3) enforce Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies.
  - (4) call, preside at and be responsible for the agenda of the annual and special meetings of the Medical Staff.
  - (5) make recommendations to the Medical Executive Committee for appointment of committee chairs and Members to all standing and special Medical Staff committees, except the Medical Executive Committee, in accordance with the provisions of these Bylaws.
  - (6) serve as Chair of the Medical Executive Committee.
  - (7) serve as Ex Officio Member on all Medical Staff committees other than the Medical Executive Committee.
  - (8) serve as day-to-day liaison on medical matters with the Legacy CEO, the Legacy CMO and the Legacy Board.
  - (9) consult with the Chief Medical Officer or Vice President of Medical Affairs, if applicable, on matters of special concern to staff appointees and/or to assist in settling Medical Staff grievances and problems; and
  - (10) receive and interpret the Policies of the Legacy Board to the Medical Staff and report to the Legacy Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care.
- (b) President-elect: The President-elect of the Medical Staff shall:
- (1) in the absence of the President of the Medical Staff, assume all the duties and have the authority of the President of the Medical Staff.
  - (2) perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time-to-time request.
  - (3) be a member of the Credentials Committee.
  - (4) see to the safeguarding of Medical Staff funds, the administration of Medical Staff expenditures and the collection of dues, and make periodic reports of the status of same to the Medical Staff; and
  - (5) represent the Medical Staff as the At-Large Member of the Legacy Board Medical Quality and Credentialing Committee.
- (c) Past-President: The Past-President of the Medical Staff shall:
- (1) serve as a member of the Medical Executive Committee,
  - (2) serve as a member of the Credentials Committee,
  - (3) perform other duties to assist the President of the Medical Staff as may be requested.

#### 4.A.6. Removal from Office:

The Legacy Board may remove any officer, but only after a special meeting with Joint Conference Committee. The affected individual shall be invited to attend the joint conference to speak on their own behalf but shall be excused prior to the deliberations and decision. The Medical Staff may remove any officer by petition of ten percent (10%)

of the eligible voting Members of the Medical Staff and a subsequent majority vote by at least fifty percent (50%) of the eligible voting Members of the Medical Staff at a special meeting called for such a purpose by the Medical Executive Committee.

Permissible grounds for removal of a Medical Staff officer include, without limitation:

- Conduct detrimental to the interests of the Medical Staff or the Hospital.
- Inability to fulfill the duties of the office.
- Failure to perform the duties of the office in an appropriate manner.
- Failure to continuously satisfy the qualifications for the position.
- Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or a corrective action resulting in a final Adverse decision.

Automatic termination of Medical Staff appointment and/or Privileges shall result in an automatic removal of the Member from their office.

## ARTICLE 5: DEPARTMENTS

### 5.A.1. Departments:

A department shall be organized as a clinical unit and shall have a chair who is selected and has the authority, duties, and responsibilities as set forth in these Bylaws. The following departments are established:

- (a) Medicine
- (b) Surgery
- (c) OB/GYN/Pediatrics
- (d) Emergency Medicine

Additional departments, as required from time to time, may be established or dissolved by the Legacy Board after considering recommendations from the Medical Executive Committee. Any requests for a new department will require a minimum of five Members of the Medical Staff.

### 5.A.2. Optional Sections:

- (a) Any Medical Staff Members who practice in the same or similar areas and who wish to have a forum for discussion of those clinical areas may organize into a section. Any section, if organized, shall not be required to hold any number of regularly scheduled meetings.
- (b) Additional sections of departments may be established or dissolved by the department after considering recommendations from the Medical Executive Committee. Any requests for a new section will require a minimum of five Medical Staff Members.
- (c) Sections may perform any of the following activities:
  - (1) Continuing education.
  - (2) Discussion of policy.
  - (3) Discussion of equipment needs.
  - (4) Development of recommendations for the department chair or Medical Executive Committee.
  - (5) Participation in the development of criteria for Clinical Privileges (when requested by the Department Chair); and
  - (6) Discussion of a specific issue at the special request of a department chair or the Medical Executive Committee.

### 5.A.3. Qualifications, Selection, and Term of Department Chairs, Department Vice-Chairs and Section Chairs:

Each Department Chair, Department Vice-Chair and Section Chair shall meet all qualifications outlined below and shall be willing and able to discharge the functions of their position.

(1) Qualifications of Chairs and Vice-Chairs:

Except as otherwise provided, only those Members of the Medical Staff who satisfy the following criteria shall be eligible to serve as a Medical Staff Department Chair, Section Chair or Vice-Chair:

- (a) are a Doctor of Medicine or Osteopathy, a Doctor of Dental Surgery or Dental Medicine, or a Doctor of Podiatric Medicine if requesting to be a Department Chair. Section Chairs may include Advanced Practice Professionals if the chair can adequately assess the qualifications of section members.
  - (b) are a current Medical Staff Member for whom their category's prerogatives allow the Member to act as a Medical Staff Department or Section Chair.
  - (c) are either board certified or have been determined to possess equivalent qualifications by the Medical Executive Committee. Exceptions to the board certification requirements can be made by the Legacy Board upon recommendation by the Medical Executive Committee.
  - (d) have been a Member of the Medical Staff for at least three years.
  - (e) are in good standing and continue to be in good standing during their term of office.
  - (f) have no pending Adverse recommendations concerning Medical Staff appointment or Clinical Privileges.
  - (g) are not presently serving as a Medical Staff officer, corporate officer, department chair, Medical Staff leader or employee at any other non-Legacy Hospital or Medical Staff and shall not so serve during their term of office.
  - (h) are willing to faithfully discharge the duties and responsibilities of the position to which they are elected or appointed.
  - (i) possess and have demonstrated an ability for harmonious interpersonal relationships.
  - (j) have constructively participated in Medical Staff affairs, including Peer Review activities.
  - (k) are knowledgeable concerning the duties of the office.
  - (l) possess written and oral communication skills.
  - (m) agree to participate in Medical Staff education.
  - (n) is free from any conflict of interest that would affect their ability to carry out a substantial portion of the position's duties.
- (2) Department Chairs shall be elected by the Members in the applicable department who are eligible to vote. Vote will occur via ballot and approved by the Medical Executive Committee and the Legacy Board. Department Vice-Chairs shall be appointed by the Department Chairs and approved by the Medical Executive Committee and the Legacy Board.
- (3) Department Chairs may be removed from their position by the Legacy Board after a majority vote of the Medical Executive Committee acting on its own initiative, but only after a meeting of the Joint Conference Committee. The vote will occur at a Medical Executive Committee meeting at which a quorum is present, and the Department Chair will be entitled to speak on their behalf prior to any removal vote occurs.
- (4) Department Chairs may also be removed from office by the Legacy Board after a majority vote of at least fifty percent (50%) of the eligible voting Members of the Department. The vote will occur at a special Department meeting at which a quorum is present, and at which the Department Chair will be entitled to speak on their behalf prior to any removal vote.
- (5) Permissible grounds for removal of a Medical Staff Department Chair or Section Chair include, without limitation:

- Conduct detrimental to the interests of the Medical Staff or the Hospital.
- Inability to fulfill the duties of the position.
- Failure to perform the duties of the position in an appropriate manner.
- Failure to continuously satisfy the qualifications for the position.
- Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or a corrective action resulting in a final Adverse decision.

Automatic termination of Medical Staff appointment and/or Privileges shall result in an automatic removal of the Member from their position.

- (6) A Department Chair may resign from their position by submitting their resignation in writing to Medical Staff Officers.
- (7) Department Chairs, Department Vice-Chairs and Section Chairs shall serve two-year terms and may succeed themselves. There is no limitation on the number of terms a Department or Section Chair may serve. All Chairs shall take office on the first day of the calendar year unless a chair position becomes vacant during a term.
- (8) Section Chairs shall be elected by the Members of the section by the majority vote of the Members who are eligible to vote. Vote will occur via ballot and will be approved by the Medical Executive Committee and the Legacy Board.

5.A.4. Vacancies of Department Chairs, Section Chairs or Vice-Chairs:

Vacancies in Chair roles shall be filled by Members appointed by the Medical Executive Committee during the term.

5.A.5. Functions of Departments:

- (a) Each Department shall:
  - Recommend criteria for the granting of Clinical Privileges.
  - Be responsible to the Medical Executive Committee for the quality of care provided at the Hospital in areas of professional practice subject to the Department's authority, by reviewing the professional performance of Members assigned to it and participating in the quality-of-care program approved by the Medical Executive Committee and the Hospital under the direction of the Hospital Department Chairs.
  - Establish such rules governing clinical care as may be desirable to maintain an appropriate standard of care.
  - Conduct or make recommendations regarding the need for continuing education programs.
  - Monitor on a continuing and concurrent basis for adherence to the Policies, Hospital Rules and Regulations, and sound principles of clinical practice; and
  - Perform other activities as appropriate or as assigned by the Medical Executive Committee
- (b) Departments shall hold meetings which shall be scheduled as determined to be necessary by the Department Chair, to conduct Medical Staff business.

5.A.6. Roles and Responsibilities of Department Chairs:

Each Department chair shall:

- (a) be responsible for the clinically related activities within the Department.
- (b) be a voting Member of the Medical Executive Committee.
- (c) continually monitor the ongoing professional performance of all Members in the Department who have delineated Clinical Privileges and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated.
- (d) recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department.
- (e) recommend a sufficient number of qualified and competent individuals to provide patient care, treatment, and services.
- (f) be responsible for the integration of the Department into the primary functions of Hospital.
- (g) be responsible for the coordination and integration of interdepartmental and intradepartmental services.
- (h) be responsible for the implementation and adherence of Policies and procedures that guide and support the provision of patient care, treatment, and services.
- (i) maintain quality control programs and appoint ad hoc committees or working groups as necessary to carry out quality improvement activities.
- (j) recommend to the Credentials Committee Clinical Privileges for each Member of the Department.
- (k) be responsible for the focused professional practice evaluation for new Members and report thereon to the Credentials Committee.
- (l) make recommendations to the Credentials Committee regarding the qualifications and competence of department or service personnel who are not Members and who provide patient care, treatment, and services in the Department.
- (m) assist Hospital, in accordance with the provisions of these Bylaws, the evaluation of requests for temporary Privileges.
- (n) be responsible within the Department for the enforcement of Hospital and Medical Staff Bylaws, Policies, Rules and Regulations.
- (o) be responsible for implementation within the Department of actions taken by the Legacy Board and the Medical Executive Committee.
- (p) report and recommend to Hospital management, when necessary, with respect to matters affecting patient care, treatment, and services in the Department, including personnel, space and other resources, supplies, special regulations, standing orders and techniques.
- (r) assist Hospital management in the preparation of annual reports and such budget planning pertaining to the Department as may be required by the Legacy CEO, the Legacy CMO or the Legacy Board.
- (s) assess and recommend to Hospital management off-site sources for needed patient care, treatment and services not provided by the department or Hospital.
- (t) be responsible for the orientation and continuing education of all Members in the Department; and
- (u) delegate to a Vice Chair of the Department such duties as appropriate.

#### 5.A.7. Roles and Responsibilities of Section Chairs:

Each Section Chair shall:

- (a) coordinate Section activities.
- (b) report to the Department Chair, Hospital management, and nursing services for issues pertaining to or affecting the Section.
- (c) make recommendations to the Department Chair regarding Clinical Privileges for each Member of the Section.
- (d) make recommendations to the Department Chair regarding the qualifications and competence of Department Members and who provide patient care, treatment, and services in the section.
- (e) participate in the orientation and continuing education of all Members in the Section under the guidance of the Department Chair.
- (f) participate in Department meetings, provide input on medical Policies of the Hospital, and make specific recommendations regarding the Section.
- (g) assist the Department Chair in enforcing Hospital and Medical Staff Bylaws, rules, regulations, and Policies within the Section, and initiate focused reviews of clinical performance when necessary.

- (h) participate in every phase of administration in the Section, such as cooperating with nursing services and administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
- (i) perform any other duties as may be requested by the Department Chair, President of the Medical Staff, or the Medical Executive Committee; and
- (j) if necessary, appoint a Vice-Chair subject to concurrence by the Department Chair and President of the Medical Staff.

5.A.8. Clinical Vice Presidents of Service Lines:

A Legacy employed or contracted Clinical Vice President of a clinical service line may not hold the position of Department Chair or Section Chair. Clinical Vice Presidents shall work collaboratively with Department Chairs and Section Chairs.

ARTICLE 6: COMMITTEES

6.A. MEDICAL STAFF COMMITTEES

6.A.1. Standing Committees:

The Medical Staff shall have four standing committees:

- (a) Medical Executive Committee
- (b) Credentials Committee
- (c) Quality Council
- (d) Peer Review Coordination Committee

6.A.2. Additional Committees:

The Medical Staff and Medical Executive Committee may designate additional committees for specific purposes on a permanent or temporary basis.

6.A.3. Committee Members and Chairs:

- (a) Unless otherwise provided in these Bylaws, Medical Staff Members appointed to the active, courtesy, or affiliate Medical Staff category may serve as a voting Member of a Medical Staff committee.
- (b) Unless otherwise provided in these Bylaws, Members of each Medical Staff committee shall be appointed annually by the President of the Medical Staff with no limitation in the number of terms the committee Member may serve.
- (c) Unless otherwise provided in these Bylaws, all appointed Members of a Medical Staff committee may be removed, and vacancies filled by the Medical Staff President at his or her discretion.
- (d) Committee members may include individuals who are not Members of the Medical Staff. The Legacy CEO, Legacy CMO and Vice President of Medical Affairs shall all be considered Ex Officio (non-voting) Members of all Medical Staff committees.
- (e) Unless otherwise provided in these Bylaws, the Medical Staff President shall annually appoint all Medical Staff committee chairs who shall be selected from among Members appointed to the active or affiliate Medical Staff category.
- (f) Unless otherwise provided in the Medical Staff Bylaws, Medical Staff committee chairs may be reappointed by the Medical Staff President for additional one-year terms with no limitation in the number of terms they may serve.

6.A.4. Legacy Committees:

The Medical Staff shall have representation and actively participate on the following Legacy system-wide committees:

- (a) Blood Transfusion Committee
- (b) Clinical Ethics Committee
- (c) Continuing Medical Education Committee
- (d) Epidemiology (Infection Control) Committee
- (e) Graduate Medical Education Committee
- (f) Medical Staff Wellness Committee
- (g) Integrated Network Cancer Committee
- (h) Pharmacy/Therapeutics Committee
- (i) Quality Strategy & Leadership
- (j) Utilization Management Committee
- (k) APP Committee

6.B. MEDICAL EXECUTIVE COMMITTEE

6.B.1. Composition:

- (a) The Medical Executive Committee (MEC) shall be comprised of the following voting members:
  - (1) President of the Medical Staff
  - (2) President-elect of the Medical Staff.
  - (3) Immediate Past President of the Medical Staff.
  - (4) Chair of the Credentials Committee.
  - (5) Chair of Quality Council.
  - (6) Chairs of each Department.
  - (7) Informatics Liaison; and
  - (8) Two Members-at-large
- (b) The non-voting *Ex Officio* Members of the Medical Executive Committee shall be the:
  - (1) Legacy CEO
  - (2) Legacy CMO
  - (3) Hospital President
  - (4) Chief Nursing Officer of the Hospital
  - (5) Vice President of Medical Affairs
- (c) Department Vice-Chairs are invited to attend the Medical Executive Committee meeting and may vote (as the Department Chair's authorized designee) if the Department Chair is not present.
- (d) The President of the Medical Staff shall serve as chair of the Medical Executive Committee.
- (e) All Members of the active and affiliate Medical Staff are eligible for MEC membership; however, the majority of voting members of the Medical Executive Committee shall, at all times, be Physician Members.

6.B.2. Qualifications, Selection and Term of Members-at-large of the Medical Executive Committee:

- (a) Qualifications of Members-at-large:

Except as otherwise provided, only those Members of the Medical Staff who satisfy the following criteria shall be eligible to serve as Member-at-large of the MEC:

- (1) active or affiliate Member of the Medical Staff who demonstrates leadership and administrative skills.

- (2) willing to serve at least a two-year term of office.
  - (3) willing to participate in educational opportunities provided by the Medical Staff in order to attain and maintain competence in the performance of the duties of this position; and
  - (4) not currently serving as a Medical Staff officer, corporate officer, department chair at any other non-Legacy Hospital or medical staff.
- (b) The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the two Members-at-large.
  - (c) Members-at-large shall serve two-year terms and may succeed themselves. There is no limitation on the number of terms a Member-at-large may serve. All Members-at-large shall take office on the first day of the calendar year unless a chair position becomes vacant mid-term. In instances where there is a vacancy mid-term, the MEC will promptly appoint a new Member-at-large.
  - (d) Members-at-large may be removed from their position by the Legacy Board after a majority vote of the Medical Executive Committee, but only after a meeting of the Joint Conference Committee. The vote will occur at an MEC meeting at which a quorum is present, and the Member-at-large will be entitled to speak on their behalf prior to any removal vote.
  - (e) Members-at-large may also be removed from their position by the Legacy Board after a majority vote of at least ten percent (10%) of the eligible voting Members of the Medical Staff. The vote will occur at a special Medical Staff meeting at which a quorum is present, and the Member-At-Large will be entitled to speak on their behalf prior to any removal vote.
  - (f) Permissible grounds for removal of a Member-at-large include, without limitation:
    - Conduct detrimental to the interests of the Medical Staff or the Hospital.
    - Inability to fulfill the duties of the position.
    - Failure to perform the duties of the position in an appropriate manner.
    - Failure to continuously satisfy the qualifications for the position.
    - Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or a corrective action resulting in a final Adverse decision.
  - (g) Automatic termination of Medical Staff appointment and/or Privileges shall result in an automatic removal of the Member from their position.
  - (8) A Member-at-large may resign from their position by submitting their resignation in writing to Medical Staff Officers.

### 6.B.3. Selection and Removal of Voting MEC Members

Voting MEC Members are selected as follows:

- Medical Staff officers attain their position in accordance with the procedure set forth in Section 4.A.3. of the Medical Staff Bylaws.
- Department Chairs attain their position in accordance with the procedure set forth in Section 5.A.3. of the Medical Staff Bylaws.
- The Credentials Committee chair attains their position in accordance with the procedure set forth in Section 6.A.3. of the Medical Staff Bylaws.
- The chair of the Quality Council attains their position in accordance with the procedure set forth in Section 6.A.3. of the Medical Staff Bylaws



- The Informatics Liaison attains their position in accordance with the procedure set forth in Section 6.B.2. of the Medical Staff Bylaws.
- The MEC at-large Members attain their positions in accordance with the procedure set forth in Section 6.B.2. of the Medical Staff Bylaws.

Voting MEC Members are removed as follows:

- Medical Staff officers may be removed from their position in accordance with the procedure set forth in Section 4.A.6. of the Medical Staff Bylaws.
- Department Chairs may be removed from their position in accordance with the procedure set forth in Section 5.A.3. of the Medical Staff Bylaws.
- The Credentials Committee chair may be removed from their position in accordance with the procedure set forth in Section 6.A.3. of the Medical Staff Bylaws.
- The chair of the Quality Council may be removed from their position in accordance with the procedure set forth in Section 6.A.3. of the Medical Staff Bylaws.
- The Informatics Liaison may be removed from their positions in accordance with the procedure set forth in Section 6.A.3. of the Medical Staff Bylaws.
- The MEC at-large Members may be removed from their positions in accordance with the procedure set forth in Section 6.B.2. of the Medical Staff Bylaws.

#### 6.B.4. Duties:

The Medical Executive Committee shall perform the following duties:

- Represent and act on behalf of the Medical Staff, between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
- Coordinate the activities and general Policies of the various Medical Staff Departments.
- Receive and act upon Medical Staff committee, department, or other assigned reports.
- Implement Policies of the Medical Staff not otherwise the responsibility of the Medical Staff Departments.
- Serve as the liaison between the Medical Staff and the Legacy CEO.
- Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of Hospital.
- Be accountable to the Legacy Board for the medical care of patients admitted to or receiving care, treatment, and/or services at the Hospital.
- Review the report of the Credentials Committee on all applicants and make recommendations for Medical Staff Membership, assignments to Departments and/or Sections, and delineation of Clinical Privileges.
- Make recommendations to terminate Medical Staff Membership and/or Clinical Privileges in accordance with these Bylaws.
- Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance for all individuals granted Clinical Privileges.
- Request evaluations of Members' or applicants' privileges when there are concerns raised about a Member or applicant's ability to perform Clinical Privileges requested.
- Report recommendations for Medical Staff Membership and Clinical Privileges to the Legacy Board.
- Make recommendations to the Legacy Board regarding the Medical Staff's structure.
- Make recommendations to the Legacy Board in accordance with these Bylaws, the process used to review credentials and to delineate Clinical Privileges.
- Report at Medical Staff meetings.
- Determine minimum continuing education requirements for Medical Staff Members, if so required.
- Perform such other functions as are necessary for the effective operation of the Medical Staff.

#### 6.B.5. Meetings:

The Medical Executive Committee shall meet as often as necessary to fulfill its responsibility and shall maintain a permanent record of its proceedings and actions. Special meetings of the Medical Executive Committee may be called at any time by the President of the Medical Staff.

### 6.C. CREDENTIALS COMMITTEE

#### 6.C.1. Composition:

The Credentials Committee shall be a standing committee and shall consist of at least five (5) Members of the Medical Staff representative of diverse disciplines/specialties. The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair and Members of the Credentials Committee and the Medical Executive Committee shall act on such recommendations. The chair shall be an active Member of the Medical Staff. The chair and committee Members shall serve a two-year renewable term.

#### 6.C.2. Duties:

The Credentials Committee shall:

- (a) evaluate the qualifications of each applicant for initial appointment, provisional review, reappointment, modification of appointment to the Medical Staff and for Clinical Privileges and prepare a written report incorporating findings and recommendations on each applicant for Medical Staff Membership and/or the exercise of Clinical Privileges.
- (b) make recommendations to the Medical Executive Committee regarding the qualifications and competence of Allied Health Practitioners who are not Members and who provide patient care services in Hospital.
- (c) assist Hospital, in accordance with the provisions of these Bylaws, with respect to requests for temporary Privileges; and appoint ad hoc work groups as necessary to carry out Committee functions.
- (d) ensure that all applicants for Medical Staff appointment, reappointment, and/or Privileges/regrant of Privileges have access to the Medical Staff governing documents and applicable Hospital Policies for review.

#### 6.C.3. Meetings:

The Credentials Committee shall meet as often as necessary to accomplish its duties at the call of the committee chair. The Credentials Committee shall report to the Medical Executive Committee. Minutes will be maintained of each Credentials Committee meeting, copies of which will be provided to the Medical Executive Committee.

### 6.D. QUALITY COUNCIL

#### 6.D.1. Composition:

The Quality Council shall be a standing committee and shall consist of at least five (5) Members the Medical Staff. The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair of the Quality Council and the Medical Executive Committee shall act on such recommendation. The chair shall be a Member of the active Medical Staff. The chair shall serve a two-year term of office. Committee Members include key practitioners and administrative leadership that are selected by the Quality Council Chair.

#### 6.D.2. Duties:

The Quality Council provides resources necessary to reach the Hospital's quality vision, regularly monitors quality indicators, and identifies and presents trends in such indicators to the Medical Executive Committee, the Legacy Board Medical Quality & Credentialing Committee, and the Legacy Board when indicators cross pre-established thresholds or otherwise warrant attention or action by those bodies. The committee also reviews Policies which impact the quality of patient care of the Hospital as well as supports and guides process improvement teams and recognizes and celebrates continuous quality improvement efforts.

### 6.D.3. Meetings:

The Quality Council shall meet as often as necessary to accomplish its duties at the call of the committee chair. The Quality Council shall report to the Medical Executive Committee. Minutes will be maintained of each Quality Council meeting, copies of which will be provided to the Medical Executive Committee.

## 6.E. PEER REVIEW COORDINATION

### 6.E.1. Composition:

- (a) The Peer Review Coordination Committee shall be comprised of Members from each Medical Staff Department. The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair and committee Members. The chair shall be a Member of the active Medical Staff. The Chair and committee Members shall serve two-year terms and may succeed themselves if reappointed by the Medical Staff President.
- (b) The Peer Review Coordination Committee shall have representation from Legacy's Quality and Patient Safety Department and administrative support from Medical Staff Services.

### 6.E.2. Duties:

The Peer Review Coordination Committee shall:

- (a) Conduct individual case reviews
- (b) Handle professional practice evaluations (*i.e.*, FPPE/OPPE).
- (c) Identify triggers for focused reviews.
- (d) Ensure the Peer Review process is standard and fair.
- (c) Create a process for consistent, educational, and compassionate throughput/output of the case review process.
- (d) Ensure Members being reviewed are involved in the Peer Review process.
- (e) Identify a communication path for committee's receipt of information.
- (f) Define critical elements of professional practice evaluation and Peer Review; and
- (g) Examine reviewable/reportable events involving Medical Staff.

### 6.E.3. Meetings:

The Peer Review Coordination Committee shall meet as often as necessary to accomplish its duties at the call of the committee chair. The Peer Review Coordination Committee shall report to the Credentials Committee. Minutes will be maintained of each Peer Review Coordination Committee meeting, copies of which will be provided to the Credentials Committee.

### 6.E.4. Scope of Issues Routed to the Peer Review Coordination Committee:

- (a) Conflict of interest
- (b) Excess delay in Peer Review being completed
- (c) Technical expertise to review the case is not available
- (d) Section, program, or Department is unsure how to proceed
- (e) Resource for all Sections doing Peer Review
- (f) Professional practice evaluation for initial Privileges
- (g) Focused review as indicated.
- (h) Ongoing professional practice evaluations

ARTICLE 7: CONFLICT OF INTEREST

- (a) In any instance where an officer, Department Chair, Section Chair, Committee Chair, or a Member of any Medical Staff committee has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another Member of the Medical Staff that comes before the individual, such individual shall first declare the conflict and shall not vote on the matter. However, the individual may be asked, and may answer, any questions concerning the matter.
- (b) The existence of a potential conflict of interest or bias on the part of any Member of a department, section, or committee may be called to the attention of the department chair, the section chair, or the committee chair by any other Member with knowledge of such.
- (c) A Department Chair and/or Section Chair shall have a duty to delegate review of applications for appointment, reappointment, Clinical Privileges, and/or questions that may arise to another Member of the department or section if the department chair and/or section chair has a conflict of interest with the individual under review or could be reasonably perceived to be biased in the review of the matter. The Medical Executive Committee shall have the authority to delegate any duties which it reasonably determines may be affected by a conflict of interest.

ARTICLE 8: MEETINGS OF THE MEDICAL STAFF, DEPARTMENTS/SECTIONS, AND MEDICAL STAFF COMMITTEES

8.A.1. Medical Staff Meetings

- (a) The Medical Staff shall meet at the annual meeting of the Medical Staff, which shall be held during the last quarter of each Medical Staff Year. Notice of the annual meeting shall be given to each Medical Staff Member by e-mail, mail, or in person at least seven (7) days in advance of such meeting. Such Notice shall state the date, time, and place of the meeting. When sent via e-mail, Notice shall be deemed delivered on the date the e-mail is sent to a Medical Staff Member at their e-mail address on file with the Medical Staff Office. When mailed, Notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to a Medical Staff Member at their address on file with the Medical Staff Office. The attendance of any individual at any meeting shall constitute a waiver of that individual's Notice of said meeting.
- (b) The primary objective of the annual meeting shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and retained.

8.A.2. Special Meetings of the Medical Staff

The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff shall call a special meeting within twenty (20) days after receipt of a written request for such a meeting signed by ten percent (10%) of the voting Members of the Medical Staff or upon request of the Medical Executive Committee. Such request shall state the purpose of the meeting. The President of the Medical Staff shall designate the date, time, and place of any special Medical Staff meeting. Notice for a special meeting shall be given to each Medical Staff Member by e-mail, mail, or in person at least seven (7) days in advance of such meeting.

8.A.3. Regular Meetings of Medical Staff Committees, Departments, and Sections

Medical Staff committees, Departments, and Sections may, by resolution, provide the time for holding regular meetings without Notice other than such resolution.

8.A.4. Special Meetings of Medical Staff Committees, Departments, and Sections

A special meeting of any Medical Staff committee, Department, or Section may be called by or at the request of the chair thereof or by the President of the Medical Staff with at least two weeks' prior Notice. Medical Staff committee, Department or Section Members are expected to attend special meetings.

#### 8.A.5. Quorum and Action at a Meeting

The quorum requirement for meetings shall be as follows:

- (a) Medical Staff Meetings: Ten percent (10%), of those eligible to vote.
- (b) Medical Executive Committee and Credentials Committee Meetings: Fifty percent (50%) of the voting Members of the respective committee.
- (c) Medical Staff Committee, Department, and Section Meetings: Ten percent (10%), but not fewer than three, of those eligible to vote.

The action of a majority of its Members present at a meeting at which a quorum is present shall be the action of the Medical Staff or a Medical Staff committee, Department, or Section, as applicable.

Unless otherwise specified in the Medical Staff governing documents, individuals may participate in and act at any meeting by conference call, video conferencing, or other forms of telecommunication through which all persons participating in the meeting can communicate with each other in real-time. Participation by such means shall constitute attendance and presence in person at the meeting.

#### 8.A.6. Attendance Requirements

- (a) Members of the Medical Staff are encouraged to attend all relevant meetings. Meeting attendance shall not be used by the Credentials Committee in evaluating Medical Staff Members at the time of their reappointment.
- (b) Members of the Medical Staff Executive Committee and Credentials Committee are expected to attend at least one-half (1/2) of the meetings held.
- (c) Special Attendance Requirements or Conferences:
  - (1) Whenever a Medical Staff or Department educational program is prompted by findings of quality assessment/improvement activities, the individual whose performance prompted the program shall be notified of the time, date, and place of the program, the subject matter to be covered, and its special applicability to the individual's practice. The individual shall be required to be present.
  - (2) Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the Legacy CMO, the President of the Medical Staff, or the applicable Department Chair may require a Member to confer with them or with a standing or *ad hoc* committee considering the matter. The Member shall be given Special Notice of the conference at least five (5) days prior to the conference including the date, time, and place, a statement of the issue involved, and a statement that the individual's appearance is mandatory. Failure of the individual to appear at any such conference, unless excused by the Medical Executive Committee upon showing good cause, constitutes the individual's suspension of all Clinical Privileges. The individual may petition the Medical Executive Committee for reinstatement of those Clinical Privileges upon showing good cause for the initial absence.

#### 8.A.7. Participation by Legacy CEO

The Legacy CEO and any representative assigned by the Legacy CEO, may attend any meeting of the Medical Staff or of a Medical Staff committee, Department, or Section in an Ex-Officio (non-voting) capacity.

#### 8.A.8. Robert's Rules of Order

Common sense, as determined by the Medical Staff President or the chair of the Department, Section, or Medical Staff committee, as applicable, shall be applied in the conduct of meetings. To the extent there is a disagreement as to procedure, the latest edition of Robert's Rules of Order may be consulted for guidance.

#### 8.A.9. Minutes

Minutes of each regular and special meetings of the Medical Staff, a Medical Staff committee, Departments, and Sections shall be prepared and shall include a record of the attendance of Members and the vote taken on each matter. The minutes shall be approved by the presiding officer and copies thereof shall be submitted to the Medical Executive Committee. Minutes of each Medical Staff, Medical Staff committee, Department, and Section meeting shall be maintained in a permanent file.

### ARTICLE 9: PRACTITIONER RIGHTS

- (a) Each Medical Staff Member has the right to an audience with the Medical Executive Committee. In the event a Medical Staff Member is unable to resolve a difficulty working with their respective Department Chair or Section Chair, that Member may, upon presentation of a written Notice, meet with the Medical Executive Committee at its next scheduled meeting or at a time and place established by the MEC to discuss the issue.
- (b) Any Medical Staff Member has the right to initiate a recall election of a Medical Staff officer and/or Department Chair. A petition for such recall shall be presented, signed by at least ten percent (10%) of the voting Members of the Medical Staff. Upon presentation of such valid petition, the Medical Executive Committee shall schedule a special Medical Staff meeting for purposes of discussing the issue and, if appropriate, entertaining a no-confidence vote.
- (c) Any Medical Staff Member may call a special meeting of the Medical Staff. Upon presentation of a petition signed by not less than ten percent (10%) of the eligible voting Members of the Medical Staff, the President of the Medical Staff shall schedule a special Medical Staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.
- (d) Any Medical Staff Member may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any Medical Staff Member may submit a petition signed by ten percent (10%) of the voting Members of the Medical Staff. When such petition has been received by the Medical Executive Committee, it shall:
  - (1) Provide the petitioners with information clarifying the intent of such rule, regulation, or policy; and/or:
  - (2) Schedule a meeting with the petitioners to discuss the issue.
- (e) Any Department or Section may request a meeting of the full staff when a majority of the Members of the Department or Section believes that the Department or Section has not acted appropriately. This provision does not pertain to issues involving disciplinary action, denial of request for appointment or Clinical Privileges, or any other matter relating to individual credentialing actions.

### ARTICLE 10: VOTING

#### 10.A.1. Manner of Voting:

Unless otherwise provided for in these Bylaws, a vote on a matter presented to the Medical Staff, or a Department, Section, or committee thereof, may be conducted by e-mail, voice, fax, mail, or other method approved by the Medical Executive Committee prior to the vote. E-mail, fax, and mail voting may be used in lieu of a vote at the annual meeting or a special meeting of the Medical Staff. Each Medical Staff Member shall provide the Medical Staff Office with a current e-mail address by which the Medical Staff may contact the Member.

#### 10.A.2. Ballots:

Ballots shall be distributed to all Members of the Medical Staff entitled to vote and shall specify the method and date by which ballots are to be cast. Such dates shall be at least twenty-one (21) days after ballots are distributed. A Member may request a written ballot in lieu of an electronic ballot. To be valid, a ballot shall be signed and dated by the Member, or submitted electronically with the Member's name, and returned by the date established by the Medical Executive Committee.

10.A.3. Approval:

Unless otherwise provided for in these Bylaws, the election of an officer, amendment to these Bylaws or approval of a matter presented to the Medical Staff requires the affirmative vote of a majority of the Medical Staff who cast ballots. Voting results shall be communicated to the Medical Staff via e-mail, fax, or mail.

ARTICLE 11: INITIAL APPOINTMENT

11.A. QUALIFICATIONS FOR APPOINTMENT & PRIVILEGES

11.A.1. General:

- (a) Medical Staff appointment and Clinical Privileges shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Medical Staff governing documents.
- (b) All processes described in this Article shall be subject to the confidentiality provisions described in Section 16.A.

11.A.2. Specific Baseline Qualifications:

- (a) Unless otherwise provided in the Medical Staff governing documents, only practitioners who satisfy the following conditions shall be eligible for appointment to the Medical Staff and Clinical Privileges:
  - (1) have a current, active, license (by order of the Oregon Medical Board or other appropriate licensing board) to practice in the State of Oregon.
  - (2) where applicable to their practice, have a current unrestricted Drug Enforcement Administration (DEA) registration.
  - (3) are located (office and residence) close enough to Hospital to fulfill their Medical Staff 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 Hospital and state law and regulation.
- (1) have successfully completed an appropriate residency training program as set forth below unless such requirement is waived by the Legacy Board after consideration of the specific education, training, experience, and competence of the individual in question:
  - (i) for Physicians, a residency training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or Royal College of Physicians and Surgeons of Canada in the specialty in which the applicant seeks Clinical Privileges,
  - (ii) for Podiatrists, a residency training program accredited by the Council on Podiatric Medical Education.
  - (iii) for Dentists, a residency program accredited by the American Dental Association Commission on Dental Accreditation.
  - (iv) for Nurse Practitioners, appropriate graduate nursing education in a nationally accredited graduate nursing program specific to the expanded specialty in which Privileges are being requested.
  - (v) for Clinical Nurse Specialists, appropriate graduate training program accredited by the Commission on Collegiate Nursing Education or the Accreditation Commission for Education in Nursing.

- (vi) for Certified Nurse Midwives, appropriate graduate nursing education in a nationally accredited graduate nursing program specific to the expanded specialty in which Privileges are being requested.
  - (vii) for Certified Nurse Anesthetists, appropriate graduate nursing education in a nationally accredited graduate nurse anesthetist program by the Council on Accreditation of Nurse Anesthesia Educational Programs.
  - (viii) for Psychologists, accredited post-graduate training appropriate for state licensure and experience specific to the Privileges being requested.
  - (ix) for Physician Assistants, appropriate graduate training in a nationally accredited graduate Physician assistant program appropriate for state licensure and experience specific to the Privileges being requested.
- (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) A Physician, Podiatrist, or Oral Surgeon who is a qualified candidate for board certification at the time of the initial application for Medical Staff appointment and/or Privileges shall have five (5) years (or such other longer or shorter time period set by the applicable certifying board) from the date of completion of residency training to become board certified and Dentists (except general Dentists), board certification in primary specialty is required within five years of completion of a residency program in primary specialty (board certification in general Dentistry is not offered).
  - (ii) for General Dentists, board certification is not required.
  - (iii) for Nurse Practitioners, including Clinical Nurse Specialists, Certified Nurse Midwives and Certified Nurse Anesthetists, board certification in appropriate specialty is required within five years of completing specialty training.
  - (iv) for Psychologists, board certification is not required.
  - (v) for Physician Assistants, board certification by the National Commission on Certification of Physician Assistants.

Physicians, Podiatrists, Oral Surgeons, Nurse Practitioners and Physician Assistants who were granted Medical Staff appointment and Privileges at the Hospital prior to January 17, 2013, who were not board certified at the time Medical Staff Appointment and Privileges were initially granted, and have continuously held appointment and Privileges at the Hospital (without board certification) since the time such appointment and Privileges were initially granted, are not required to be board certified.

Practitioners shall maintain Board certification to be eligible for continued membership and/or continuation of privileges. Should recertification not be attained, the Practitioner shall have two years from loss of certification to re-attain board Certification or membership and/or privileges shall be automatically lost.

- (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
- (10) Have never had membership or clinical privileges revoked or involuntarily surrendered; or surrendered clinical privileges while under investigation or potential review.

### 11.A.3. Additional Requirements

Practitioners must also document the following:

- (i) background, experience, training, and demonstrated competence,
- (ii) adherence to the ethics of their profession,
- (iii) good reputation and character,
- (iv) ability to safely and competently exercise the Clinical Privileges requested with or without reasonable accommodation, and



- (v) 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.
- (w) Satisfy such other qualifications as are set forth in the applicable Medical Staff category and Privilege set.

11.A.4. Waiver of Accredited-Residency Training Program and/or Board Certification Requirements:

A written request for a waiver of a qualification for Medical Staff appointment and/or Privileges may be submitted by a Practitioner to Medical Staff Services for consideration by the Medical Staff and Board. The Practitioner who is requesting the waiver bears the burden of demonstrating that their qualifications are equivalent to, or exceed, the criterion/criteria in question; or, that there are other extraordinary circumstances that justify a waiver.

A qualification for Medical Staff appointment and/or Privileges may be waived, at the sole discretion of the Board, based upon demonstration of equivalent qualifications or extraordinary circumstances and a Board determination that such waiver will serve the best interests of patient care.

The Credentials Committee shall consider the request for waiver and shall forward its recommendations to the MEC for review. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request.

Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment/Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The Practitioner must thereafter reapply for the waiver.

No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or the Hospital's inability to process an application for failure to meet baseline qualifications; or termination of a Practitioner's appointment and Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural due process rights.

11.A.5. No Entitlement to Appointment and/or Clinical Privileges:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular Clinical Privileges at the Hospital merely by virtue of the fact 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; or
- (j) Contracts with or is employed by the Hospital

11.A.6. Nondiscrimination Policy:

No Practitioner shall be denied appointment and/or 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.

11.B: APPLICATION FOR INITIAL APPOINTMENT AND/OR CLINICAL PRIVILEGES

11.B.1. Information:

- (a) Applications for appointment to the Medical Staff and/or 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 applicant's professional qualifications including but not limited to:
  - (1) Medical Staff category and the Clinical Privileges requested, if any.
  - (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 applicant's technical/clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism including ability to exercise the Privileges being requested, with or without a reasonable accommodation. 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 Medical Staff appointment and/or 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.
  - (2) Information as to whether the applicant has ever voluntarily (while under investigation or to avoid investigation) or involuntarily withdrawn their application for appointment, reappointment, and/or Clinical Privileges, or resigned Medical Staff appointment and/or Clinical Privileges before final decision by a Hospital's or health care facility's governing board.
  - (3) 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 their respective profession, as well a DEA registration (if required for the Privileges requested) to include the number and in issued/expiration dates of each.
  - (4) 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.
  - (5) 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 Practitioners responsible for monitoring the applicant's performance.
  - (6) Documentation regarding board certification, as applicable.
  - (7) 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 applicant seeks to exercise at the Hospital.

- (8) 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.
- (9) A consent to the release of information from the applicant's present and past Professional Liability Insurance carriers.
- (10) 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.
- (11) 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.
- (12) Current information regarding the applicant's ability to exercise the Privileges requested with or without reasonable accommodation.
- (13) 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.
- (14) A complete chronological listing of the applicant's work history including, but not limited to, professional and educational appointments, employment, and/or other positions.
- (15) Information required by applicable conflict of interest Policies.
- (16) Information on the citizenship and/or visa status of the applicant.
- (17) the signed Medicare/Tricare acknowledgement statement.
- (18) The applicant's signature.
- (19) For Nurse Practitioners, Certified Nurse Midwives, Nurse Anesthetists and Physician Assistants, the requirement for designation of a collaborating or 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.
- (20) Such other information the Hospital may require.

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

The applicant must sign the application and in doing so, attests to the following:

- (a) All information furnished is correct and complete and acknowledges that any material misstatement in, or omission from, the application constitutes grounds for denial of appointment/reappointment and/or Privileges. In the event that appointment and/or Privileges are granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute grounds for termination of appointment and/or Privileges. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in these Bylaws.
- (b) Signifies their willingness to be interviewed, as requested, in connection with their application.

- (c) 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 appointment and/or 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 appointment and/or Privileges are granted.
- (d) Agrees to fulfill their Medical Staff responsibilities including, but not limited to, those set forth in Section 11.B.3.
- (e) Understands and agrees that if Medical Staff appointment and/or 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.
- (f) Agrees that if an Adverse recommendation or action is made/taken with respect to their application for Medical Staff appointment and/or Privileges or their current Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Medical Staff governing documents, before resorting to formal legal action.
- (g) Acknowledges and agrees to the provisions set forth in Article 11.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.
- (h) 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 hold Medical Staff appointment and/or has Privileges at the Hospital.
- (i) Acknowledges that the Hospital and Affiliate Hospitals are part of a System, and that information is shared within the System. As a condition of appointment and/or grant of Privileges, the applicant recognizes and understands that any and all information relative to their appointment and/or 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.

11.B.3. Basic Responsibilities of Medical Staff Appointment and/or Privileges:

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

- (a) Provide or make arrangements for provision of appropriate continuous care and supervision to/for all patients within the Hospital for whom the Practitioner has responsibility.
- (b) Make, continuously throughout all times during which the Practitioner holds Medical Staff appointment and Clinical Privileges at the Hospital, prior arrangements with another Medical Staff Member with similar Clinical Privileges to provide medical coverage in case of the Practitioner's 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 Practitioner 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 Practitioner'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 provide care, treatment, and/or services to as required by the Medical Staff governing documents and other applicable Hospital or Legacy 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 these Medical Staff Bylaws.
- (t) Participate in continuing education programs appropriate to the Privileges requested or held or as otherwise required to maintain their 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 a Practitioner's (including their 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 harm 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.

Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for denial of reappointment/regrant of Privileges or for corrective action pursuant to the procedure set forth in these Bylaws.

11.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 their qualifications for Medical Staff appointments and/or 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 appointment or reappointment and/or regrant of Clinical Privileges shall be deemed incomplete and shall not be further processed.

11.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 Bylaws, are express conditions applicable to every Medical Staff applicant for Medical Staff appointment and/or Clinical Privileges, appointee to the Medical Staff, and individuals having or seeking or granted Clinical Privileges at Hospital. By applying for appointment, reappointment, and/or Clinical Privileges, the applicant expressly accepts these conditions, whether or not appointment and/or Clinical Privileges are granted, during the processing and consideration of the application, during the time of they hold any appointment or reappointment and/or Clinical Privileges, and after the expiration, resignation, relinquishment, revocation, or other termination of Medical Staff appointment and/or 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 appointment and/or Clinical Privileges, including temporary Privileges.
- (2) Evaluations concerning reappointment, regrant of Privileges, and/or changes in Clinical Privileges.
- (3) Formal corrective action proceedings for suspension or reduction of Clinical Privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction.
- (4) Summary suspension.
- (5) Hearings and appellate reviews.
- (6) Medical care evaluations.
- (7) Utilization reviews.
- (8) Other activities relating to the quality of patient care or professional conduct.
- (9) Matters or inquiries concerning the applicant's or appointee's professional Qualifications for Medical Staff appointment and/or Clinical Privileges, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior; and/or

(10) 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 or appointee 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 Medical Staff appointment and/or 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 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 or appointee signs a release of information that specifically authorizes Hospital, its Medical Staff, and 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 appointment and/or Clinical Privileges.

11.C: PROCEDURE FOR INITIAL APPOINTMENT & PRIVILEGES

11.C.1. Pre-Application Review Process:

- (a) An application for appointment to the Medical Staff shall be processed only for those individuals who:
  - (1) Meet the baseline criteria for appointment to the Medical Staff and/or Clinical Privileges set forth in Section 11.A. (unless granted a waiver by the Legacy Board).
  - (2) 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 Medical Staff appointment and/or Clinical Privileges shall be notified of the baseline criteria for appointment and/or Privileges and shall be required to attest that they meet such baseline criteria at the time of the request.
- (c) Those individuals who attest that they can meet the baseline criteria for Medical Staff appointment and/or 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 Medical Staff appointment and/or 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.
- (e) 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 Medical Staff appointment and/or Clinical Privileges and requests for additional Clinical Privileges during a current appointment/Privilege period.

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

- (a) A completed application form for Medical Staff appointment and/or Clinical Privileges with copies of all required documents must be returned within two weeks or after provision 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 their 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 Medical Staff appointment and/or Privileges, upon reappointment and/or regrant of Privileges, and when a Practitioner requests additional Privileges during a current appointment/Privilege period. The Medical Staff Office shall also conduct an NPDB query each time a Practitioner 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 11.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.

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

- (a) The credentialing process for initial appointment and/or grant of Privileges includes the following mechanism to ensure that the individual requesting Medical Staff appointment and/or exercising Privileges is the same individual identified in the credentialing documents:
  - (1) Applicants for Medical Staff appointment and/or 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 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.

- (3) 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.

#### 11.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 11.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 their qualifications, for Medical Staff appointment and/or 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 Medical Staff appointment and/or Clinical Privileges and may make inquiries with respect to the same to the applicant's past or current department chair(s), residency training 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 11.C.5.) to answer any questions that may be raised with respect to that chair's report and findings.

#### 11.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 Board 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 Board Medical Quality & Credentialing Committee shall review the reports from the applicable Department/Section Chairs, the Credentials Committee chair, and the MECs. It will evaluate the qualifications and competence of the applicant and along with the Medical Staff application and accompanying material prior to rendering 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 does not concur with the favorable recommendations of the applicable Department/Section chairs, the Credentials Committee chair, and the MEC, 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 11.C.5. shall be forwarded to the Legacy Board for information.

11.C.6. Credentials Committee Procedure:

- (a) Except as expressly provided in Section 11.C.5., all other applications for initial appointment and/or Clinical Privileges shall be processed as set forth in Sections 11.C.6. - 11.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 Medical Staff appointment and/or 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 Medical Staff appointment and/or 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.

11.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 Medical Staff appointment and/or 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.

#### 11.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 Medical Staff appointment and/or 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 Medical Staff appointment and/or 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.

#### 11.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 Medical Staff appointment and/or Privileges.
  - (2) Favorable Recommended Action: An MEC recommendation to grant the requested Medical Staff appointment and/or Privileges is forwarded to the Board for action.
  - (3) Adverse Recommended Action: When the recommendation of the MEC is to deny the requested Medical Staff appointment and/or 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.

11.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 or 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 their 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 or 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 their 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.
  - (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 their 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.

11.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 grant an appointment and/or 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 are assigned; (3) the Clinical Privileges they may exercise; and (4) any special conditions attached to the appointment and/or Privileges.

11.C.12. 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.

11.D. 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, as follows:

<u>INDIVIDUAL/GROUP</u>	<u>TIME</u>
Department/Section Chair Credentials Committee	Within 90 days of its 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 (via 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 12.E. are activated, the time requirements provided therein govern the continued processing of the application.

ARTICLE 12: CLINICAL PRIVILEGES

12.A: CLINICAL PRIVILEGES

12.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 Practitioner appointed to the Medical Staff 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 an 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 11 of these Bylaws.

12.A.2. Clinical Privileges for Dentists and Oral Surgeons:

- (a) The scope and extent of surgical procedures that a Dentist or an Oral Surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.
- (b) Surgical procedures performed by Dentists or Oral Surgeons shall be under the overall supervision of the Chair of the Department of Surgery. Except as otherwise provided in subsection (c) a medical history and physical examination (or outpatient assessment as applicable) of the dental patient shall be performed and recorded by a consulting Physician who holds an appointment to the Medical Staff with appropriate Privileges before dental surgery is performed. A consulting Physician with appropriate Privileges shall be responsible for the care and treatment of any medical condition that is present at the time of the dental patient's Hospital admission/registration or that may arise throughout the period of hospitalization that is outside the scope of practice of the Dentist or Oral Surgeon.
- (c) Oral Surgeons who admit patients to the Hospital without underlying health problems may perform and document a complete admission history and physical examination and assess the medical risks of the procedure on the patient if such Oral Surgeons are granted the Privileges to do so.
- (d) The Dentist or Oral Surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders consistent with the Privileges granted, within the scope of their license and in accordance with the Medical Staff governing documents, and in compliance with Hospital Policies, applicable laws, rules, regulations, and accreditation standards.

12.A.3. Clinical Privileges for Podiatrists:

- (a) The scope and extent of surgical procedures that a Podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other Clinical Privileges.
- (b) Surgical procedures performed by Podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. A medical history and physical examination for each podiatric inpatient shall be performed on and been recorded in the medical record by a Physician who holds an appointment to the Medical Staff with appropriate Privileges before podiatric surgery is performed.
- (c) Podiatrists may be granted the privilege to complete the history and physical (or outpatient assessment, as applicable) for all podiatric outpatients, provided that appropriate medical consultation is obtained whenever necessary, to assure optimum standards of patient care and anesthesia safety. Discharge of the podiatric patient shall be on written order of the Podiatrist.
- (d) The Podiatrist shall arrange for a consulting Physician with appropriate Privileges to be responsible for the care and treatment of any medical condition that is present at the time of a podiatric patient's Hospital admission/registration or that may arise throughout the period of hospitalization that is outside the scope of practice of the Podiatrist.
- (e) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders consistent with the Privileges granted, within the scope of their license, and in accordance with the Medical Staff governing documents, Hospital Policies, and applicable laws, rules, regulations, and accreditation standards.

#### 12.A.4. Adoption & Amendment of Delineation of Privileges:

Delineation of Privileges may be adopted and amended following review by the applicable Department/Section Chairs and recommendation of the MEC, and approval by the Board.

#### 12.A.5. Clinical Privileges for New Procedures:

##### (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.

2. 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 Practitioner 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 Practitioner 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 their 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 their 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 the applicable Legacy System-wide privilege workgroup to develop such Privileges and submit to the Medical Executive Committee a new Privilege set based upon the following information:
  - List of specialties which 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.

3. 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.

4. The recommendation of the MEC, whether favorable or not favorable, will be reviewed and acted upon by the Board as follows:
  - If the Board approves the new Privilege set, the requesting Practitioner(s) may apply for such Privilege(s) consistent with the applicable process set forth in Article 11 of this Policy.
  - If the Board does not approve the new Privilege set, the requesting Practitioner(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 11.C.2 of these Medical Staff Bylaws.
5. Applicants for new Privileges include a Practitioner applying for Privileges at the Hospital for the first time; a Practitioner currently holding Privileges who is requesting one or more additional Privileges during their current appointment/Privilege period; and a Practitioner who is in the reappointment/regrant process and is requesting one or more additional Privileges.

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

Temporary Privileges may be granted only in the circumstances and under the conditions described in Sections 12.B.1 or 12.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 their exercise of temporary Privileges at the Hospital.

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

- (a) Confirmation that the applicant has no current or previously successful challenges to their licensure or registration.
- (b) Confirmation that the applicant has not been subject to the involuntary termination of their Medical Staff appointment at another organization.
- (c) Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of their Clinical Privileges.
- (d) A favorable recommendation made by the applicable Department/Section Chair and the Medical Staff President or their authorized designee regarding the applicant's pending application for Medical Staff appointment and Clinical Privileges

##### 12.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 11.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 their application by the MEC and Board upon satisfaction of the following:
  - (1) Receipt of a written request from the applicant for the temporary Privileges desired
  - (2) Receipt of a complete application that raises no concerns.
  - (3) Verification of current licensure, relevant training/experience, current competence, ability to perform the Privileges requested, and such other qualifications as set forth in Article 11.
  - (4) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by 11.C.2. of these Bylaws.
  - (5) Confirmation that the applicant has no current or previously successful challenges to their licensure or registration.
  - (6) Confirmation that the applicant has not been subject to the involuntary termination of their Medical Staff appointment at another organization.
  - (7) Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of their Clinical Privileges.
  - (8) 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.

#### 12.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.
- (c) A Practitioner must meet all the qualifications set forth in Section 11.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 any required fees or assessments.
    - (1) Receipt of a written request from the applicant for the specific temporary Privileges desired.
    - (2) Documentation of an important patient care treatment and/or service need necessitating temporary Privileges.
    - (3) Verification of the following Practitioner information:
      - (i) Current Licensure
      - (ii) DEA registration, if applicable to the temporary Privileges requested.
      - (iii) 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 Practitioner's current principal Hospital affiliation).
      - (iv) Professional Liability Insurance coverage.
      - (v) A query and evaluation of the reports from the NPDB and OIG List of Excluded Individuals/Entities.
    - (4) 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).
    - (5) 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.

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

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

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

12.C: PROCEDURES FOR REQUESTING CHANGE IN MEDICAL STAFF APPOINTMENT AND/OR CLINICAL PRIVILEGES

12.C.1. Request for Change in Medical Staff Appointment and/or Clinical Privileges

- (a) A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request a change in their Medical Staff category or Clinical Privileges by submitting a written request to the Medical Staff Office.
- (b) Whenever, during the term of a current appointment/Privilege term, new/additional Clinical Privileges are desired, the Practitioner requesting the additional Privileges shall detail in writing, the specific additional Clinical Privileges desired and the appointee's relevant recent education, training, and experience which justify the additional Privileges. If the Practitioner meets the relevant threshold criteria for the additional Clinical Privileges requested, the information shall be processed in the same manner as an application for initial Clinical Privileges pursuant to Article 11.
- (c) Whenever a Practitioner requests Clinical Privileges to perform a new procedure or service not currently being performed at Hospital (or to use a significant new technique to perform an existing procedure), the process set forth in Section 12.A.5 shall be followed.
- (d) Requests for new/additional Privileges during a current appointment/Privilege period will be subject to a focused professional practice evaluation and ongoing professional practice evaluation if granted.

12.C.2. Leave of Absence:

- (a) Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence, for a stated period, not to exceed one year. It is expected that all individuals appointed to the Medical Staff request a leave any time they are away from patient care responsibilities for longer than thirty (30) days due to circumstances which affect, or have the potential to affect, their ability to care for patients safely and competently.
- (b) Absences for longer than one year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Legacy Board upon recommendation of the Medical Executive Committee.
- (c) Requests for leaves of absence shall be made in writing to the Medical Staff Services Department and shall state the beginning and ending dates of the requested leave.
- (d) During the period of the leave, the provider shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff. If the provider is under investigation, the investigation shall be completed before the provider is granted a leave of absence, unless the leave is for an emergency.
- (e) If a provider's current membership and/or clinical privileges are due to expire during the leave, the Medical Staff Member must, during the leave, apply for and meet the requirements for reappointment or else membership and clinical privileges shall lapse and the member deemed to have voluntarily resigned at the end of the current appointment period. If the member subsequently wishes to rejoin the Medical Staff, he/she shall be required to reapply in accordance with the process specified in Article 11 of the bylaws, Procedure for initial appointment & privileges.
- (f) At least thirty (30) days prior to termination of the leave of absence, or at any earlier time, the provider may request reinstatement of his or her privileges by submitting a written request to the to the Medical Staff Services Department summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information that may be requested by 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.

- (g) If the leave of absence was for medical reasons, then the provider may be asked to submit a report from his/her attending physician indicating that the appointee is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The provider shall also provide such other information as may be requested by Hospital at that time. After considering all relevant information, the Credentials Committee, and the Medical Executive Committee shall then make a recommendation to the Legacy Board for final action.
- (h) In acting upon the request for reinstatement, the Legacy Board may approve reinstatement either to the same or a different staff category and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.
- (i) Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. Failure to achieve a requested reinstatement does not give rise to procedural rights, as stated in the Fair Hearing Policy, unless the reason for non-reinstatement is a medical disciplinary cause or reason.

#### 12.D EMERGENCY CLINICAL PRIVILEGES

- (a) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that harm or danger.
- (b) In such an emergency, any Practitioner who is currently appointed to the Medical Staff with Privileges is permitted by Hospital to provide any type of patient care, treatment, and/or services necessary as a life-saving measure or to prevent serious harm (regardless of that Practitioner’s appointment or Privileges) provided that the care, treatment, and services provided are within the scope of the Practitioner’s license.
- (d) Emergency Privileges automatically terminate upon alleviation of the emergency situation. When the emergency situation no longer exists, the patient shall be assigned by the appropriate department chair or the President of the Medical Staff to an appointee with appropriate Clinical Privileges. The wishes of the patient shall be considered in the selection of a substitute treating Physician.
- (e) A Practitioner who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in Article 14 of these Bylaws.

#### 12.E DISASTER PRIVILEGES

- (a) Volunteer Practitioners without Medical Staff Membership and Clinical Privileges at the Hospital may (subject to applicable state licensure laws, rules, and regulations) be granted disaster Privileges by the Legacy CEO, the Legacy CMO, Hospital President, Medical Staff President, or HEICS Medical Staff Director to practice only when (1) the Hospital Emergency Incident Command System (HEICS) has been activated and (2) the Hospital is unable to meet immediate patient needs without additional assistance.
- (b) Disaster Privileges may not exceed the limits of the Practitioner’s licensure and should be specific to the Practitioner’s specialty and for the primary function of stabilizing and triaging patients. Whenever possible, a Practitioner with disaster Privileges should act under the supervision of a current Medical Staff Member with Privileges in the same specialty.
- (d) Disaster Privileges are time-limited and automatically terminate at the time that HEICS Medical Director determines that an emergency situation no longer exists, or sooner if there is no longer a need for the additional assistance.

- (e) A volunteer Practitioner who is not a Member of the Medical Staff who seeks disaster Privileges shall:
- (1) Be a Licensed Independent Practitioner
  - (2) Complete an application for disaster Privileges.
  - (3) Provide two forms of identification:
    - (i) a valid government-issued photo identification issued by a state or federal agency (*e.g.*, driver's license or passport), and
    - (ii) at least one of the following:
      - (iii) A current Hospital picture ID card that clearly identifies professional designation.
      - (iv) A current license to practice.
      - (v) Primary source verification of the license.
      - (vi) Identification certifying that the volunteer Practitioner is a Member of the Medical Reserve Corps (MRC), a Disaster Medical Assistance Team (DMAT), Emergency System for Advance Registration of Volunteer Health Professionals (ESR-VHP) or other recognized state or federal response organization or group.
      - (vii) Identification certifying that the volunteer Practitioner has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal government entity).
      - (viii) Identification by a current Hospital employee(s) or Medical Staff Member(s) who possess(es) personal knowledge regarding the volunteer's ability to act as a Practitioner during a disaster. If possible, the ID document should be photocopied and attached to the "Application for Disaster Privileges."
- (f) A photocopy of the "Application for Disaster Privileges" shall be maintained in Hospital's Emergency Operations Center for the duration of the incident. The original application and any attachments shall be forwarded as quickly as practical to the Medical Staff Office.
- (g) Medical Staff Office personnel or designees shall proceed with credentials verification as soon as the immediate situation is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to Hospital. If, due to extraordinary circumstances, primary source verification does not occur within seventy-two (72) hours, the Medical Staff Office shall document the following: (a) the reason primary source verification could not be performed in the recorded time period, (b) evidence of the volunteer Physician's demonstrated ability to provide adequate care, treatment and/or services, and (c) evidence of the Medical Staff Office's attempt to perform primary source verification of licensure (or certification/registration, as applicable) as soon as possible. Primary source verification of licensure is not required if the volunteer Physician has not provided care, treatment and/or services under the disaster Privileges.
- (h) The Medical Staff President or their designee shall make a decision (based on information obtained regarding the professional practice of the volunteer Practitioner) within seventy-two (72) hours after the Practitioner's arrival at the Hospital, whether the disaster Privileges initially granted should continue.
- (i) If any concerns are identified during the verification process, the Medical Staff Office personnel shall communicate that information immediately to the HEICS Incident Commander or the Legacy CEO or Legacy CMO, or the Medical Staff President. Disaster Privileges may be terminated at any time in accordance with Section 12.G.
- (j) The appropriate individual shall notify the Medical Staff Office of the date and reason for termination of any disaster Privileges prior to the end of the emergency situation, including those terminated because there is no longer a need for assistance.
- (k) The Medical Staff shall oversee the professional practice of a volunteer Practitioner who receives disaster Privileges by means of direct observation, mentoring, and/or medical record review – as determined by the applicable Department/Section Chair.

- (l) All volunteer Practitioners who receive Disaster Privileges must, at all times while in the Hospital, wear a photo identification badge from the facility at which they otherwise hold Privileges. If a volunteer Practitioner does not have such identification, they will be issued a temporary badge by the Hospital Security Department identifying themselves and designating the Practitioner as a volunteer Practitioner disaster care provider.
- (m) The Medical Staff Office will maintain a file for each volunteer Practitioner granted disaster Privileges.

12.F: TELEMEDICINE

- (a) Distant-site Practitioners who do not practice on-site at the Hospital but who provide care, treatment, and services to patients located at the Hospital via a Telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with these Bylaws, accreditation standards, and applicable laws, rules, and regulations. If the Hospital has a pressing clinical need and the distant-site Practitioner can supply that service through a Telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in Section 12.C.2.
- (b) Practitioners providing distant-site Telemedicine care, treatment, and/or services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:
  1. The distant-site Practitioner is credentialed and privileged by the Hospital in accordance with the routine credentialing and privileging procedure set forth in Article 11, as applicable. **OR**
  2. Credentialing information and/or privileging decisions from the distant-site may be relied upon by the Hospital Medical Staff and Board in making its Telemedicine privileging recommendations/decision regarding each distant-site Practitioner provided that the Hospital has entered into a written agreement with the distant-site and all of the following requirements are met:
    - (i) The distant-site is a Medicare-participating Hospital; **OR** a facility that qualifies as a “Distant-site Telemedicine entity.” A “distant-site Telemedicine entity” is defined as an entity that (1) provides Telemedicine services, (2) is not a Medicare-participating Hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing Telemedicine services to the patients of the Hospital.
    - (ii) When the distant-site is a Medicare-participating Hospital, the written agreement shall specify that it is the responsibility of the distant-site Hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1) -(a)(7), as that provision may be amended from time to time, with regard to the distant-site Hospital Practitioners providing Telemedicine services.
    - (iii) When the distant site is a “distant-site Telemedicine entity” the written agreement shall specify that the distant-site Telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1) -(a)(7) with regard to the distant-site Telemedicine entity Practitioners providing Telemedicine services. The written agreement shall further specify that the distant-site Telemedicine entity’s Medical Staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1) -(a)(7) and at 42 C.F.R. 482.22 (a)(1) -(a)(2), as those provisions may be amended from time to time.
    - (iv) The distant site is The Joint Commission accredited.

(v) Each distant-site Practitioner is privileged at the distant-site for those services to be provided to Hospital patients via Telemedicine link; and the Hospital is provided with a current list of each such Practitioner's Privileges at the distant-site.

(vi) Each distant-site Practitioner holds a license issued/recognized (or meet other applicable standards as required) by the appropriate licensing entity in the State in which the Hospital whose patients are receiving the Telemedicine services is located in addition to the State in which the Practitioner is located.

(vii) The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant-site such performance information for use in the distant site's periodic appraisal of each such distant-site Practitioner. At a minimum, this information must include:

- All Adverse events that result from the Telemedicine services provided by a distant-site Practitioner to Hospital patients.
- All complaints the Hospital receives about a distant-site Practitioner.

(c) Telemedicine Practitioners may be assessed required Medical Staff dues, fees, and assessments.

## 12.G: TERMINATION OF TEMPORARY, DISASTER, AND TELEMEDICINE PRIVILEGES

### 12.G.1. Termination

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

### 12.G.2. Procedural Due Process Rights

A Practitioner who has been granted temporary, disaster, or Telemedicine 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 14 because the Practitioner's request for temporary, disaster, or Telemedicine 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.

### 12.G.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.

## 12. H. PROFESSIONAL PRACTICE EVALUATION

### 12. H.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) Practitioners requesting initial Privileges; (b) existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and (c) in response to concerns regarding a Practitioner's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges.

### 12.H.2. Ongoing Professional Practice Evaluation (OPPE)

Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners 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 Practitioners with Privileges on an ongoing basis.

ARTICLE 13: REAPPOINTMENT & REGRANT OF CLINICAL PRIVILEGES

13.A: PROCEDURE FOR REAPPOINTMENT & REGRANT OF CLINICAL PRIVILEGES

13.A.1. Qualifications:

- (a) To be eligible to apply for reappointment and/or regrant of Clinical Privileges, a Practitioner must:
- (i) Provide information as set forth in Article 11 of these Bylaws to bring their file current and to demonstrate continued satisfaction of the qualifications for Medical Staff appointment and/or Clinical Privileges set forth in the Medical Staff Bylaws and applicable Privilege set.
  - (ii) Specify the Medical Staff category and Clinical Privileges requested.
  - (iii) Have, during the last appointment/Privilege term:
    - Completed all medical records.
    - Satisfied all applicable Medical Staff responsibilities and fulfilled all duties assigned by the Medical Staff officer, Department Chair/Section Chair, or Medical Staff committee, and:
    - Satisfied the qualifications for the Medical Staff category to which the appointee is seeking reappointment; and
    - Provide information regarding participation in continuing education related to the Clinical Privileges to be exercised by the Practitioner.
- (b) To be eligible to apply for regrant of Clinical Privileges, an individual Practitioner must have performed sufficient procedures, treatments, or therapies in the previous appointment/Privilege term to enable the appropriate Section Chair, Department Chair, and the Credentials Committee to assess the Practitioner's current clinical competence for the Privileges requested. Any Practitioner seeking a regrant of Clinical Privileges whose level of clinical activity at the Hospital is not sufficient to permit an informed judgement as to their current competence in exercising the Privileges requested shall cause to be submitted supplemental documentation of their clinical performance (*e.g.* professional practice evaluation data, *etc.*) from their primary practice location, in such form as may be requested, before the Practitioner'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 11.

13.A.2. Application:

- (a) An application for Medical Staff appointment and/or regrant of Privileges shall be provided (or made available) to each eligible Practitioner by the Medical Staff Office prior to the expiration of each such Practitioner's current appointment/Privilege period. Each Practitioner who is eligible to be reappointed to the Medical Staff and/or 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 Practitioner must sign the application for Medical Staff reappointment/regrant of Privileges and in doing so accepts the same conditions as set forth in Section 11.B.2.
- (b) An application for Medical Staff reappointment and/or 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.
- (d) The Practitioner has the burden of producing adequate information for a proper evaluation of their qualifications for Medical Staff reappointment and/or 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 reappointment and/or regrant of Privileges by the expiration date of the Practitioner's current Medical Staff appointment and Privilege period is deemed a voluntary resignation and results in automatic termination of the Practitioner's Medical

Staff appointment and Privileges at the expiration of the Practitioner's current appointment/ Privilege term. For any future consideration for appointment and/or Privileges, the Practitioner Must submit a new complete application for Medical Staff appointment and/or Privileges, including the application fee.

- (2) If an application for reappointment/regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's appointment and Privileges shall terminate on the last date of their current appointment/ Privilege period.
  - (3) If the Practitioner qualifies, they may be granted temporary Privileges to meet an important patient care need pursuant to Section 12.B.2 of these Bylaws.
- (f) Reappointment and/or regrant of Privileges, if granted by the Legacy Board, shall be for a period of not more than two years. The specific staggering of reappointments/regranting of Privilege periods shall be in a manner established by the Medical Staff Office.

13.A.3. Factors to be Considered at Time of Reappointment/Regrant of Privileges:

Each recommendation concerning Medical Staff reappointment and/or regrant of Privileges shall include, as applicable, consideration of such Practitioner's:

- (a) Ethical behavior, clinical competence, and clinical judgment in the treatment of patients.
- (b) Attendance at Medical Staff, Department/Section meetings and Medical Staff committee meetings and participation in Medical Staff duties, as required.
- (c) Compliance with the Medical Staff governing documents and applicable Hospital Policies.
- (d) 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.
- (e) Patterns of care as demonstrated by quality review, utilization review, and Peer Review activities.
- (f) Current information regarding the Practitioner's ability to competently exercise the Privileges requested, with or without reasonable accommodation, and to perform the duties and responsibilities of Medical Staff appointment.
- (g) 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.
- (h) Satisfactory completion of such continuing education requirements as may be imposed by law in order to maintain licensure, the Hospital, or applicable accreditation agencies
- (i) Current Professional Liability Insurance status and pending malpractice claims, lawsuits, judgments, and settlements.
- (j) Status of licensure, including currently pending challenges to any license, certification, or registration.
- (k) 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.
- (l) Any sanctions imposed or pending.



- (m) Other reasonable indicators of continuing satisfaction of the qualifications and responsibilities set forth in these Bylaws.

13.A.4. Verification:

- (a) The Medical Staff Office verifies the information provided on the application for reappointment/regrant 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 11.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 Practitioner's file for reappointment/regrant 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.

13.A.5. Department Chair Procedure:

Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon by the applicable Department Chair/Section Chair in accordance with the procedure set forth in Section 11.C.4. For the purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment/ Membership" and "Privileges" as used in Section 11.C.4 shall be read as "Practitioner" and "reappointment" and "regrant of Privileges" respectively.

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

- (a) Clean Applications for reappointment and/or regrant of Privileges which are deemed complete may be processed in an expedited manner as set forth in Section 11.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 their last appointment/ reappointment and/or grant/regrant of Privileges, the Practitioner has a current challenge or previously successful challenge to licensure or registration.
  - (2) Since the time of their last appointment/ reappointment and/or 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 Practitioner.
  - (3) Since the time of their last appointment/ reappointment and/or grant/regrant of Privileges, the Practitioner 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 Practitioner by the applicable Section or Department Chair.
- (b) For the purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment/ Membership" and "Privileges" used in Section 11.A.5.

13.A.7. Credentials Committee Procedure:

- (a) Except as expressly provided in Section 13.A.6, all other applications for reappointment and /or regrant of Clinical Privileges shall be processed as set forth in Sections 13.A.7 - 13.A.9.
- (b) Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon by the Credentials Committee in accordance with the procedure set forth in Section 11.C.6. For purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment/Membership" and "Privileges" as used in Section 11.C.6. shall be read as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

13.A.8. Medical Executive Committee Recommendation:

Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon by the Medical Executive Committee in accordance with the procedure set forth in Section 11.C.9. For purposes of reappointment and/or regrant of Privileges, the terms “applicant” and "appointment/ Membership" and “Privileges” as used in Section 11.C.9. shall be read as “Practitioner” and "reappointment” and “regrant of Privileges," respectively.

#### 13.A.9. Board Action

Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon by the Board in accordance with the procedure set forth in Section 11.C.10. For purposes of reappointment and/or regrant of Privileges, the terms “applicant” and "appointment/Membership" and “Privileges” as used in Section 11.C.10. shall be read as “Practitioner” and "reappointment” and “regrant of Privileges," respectively.

### ARTICLE 14: OTHER ACTIONS AFFECTING MEDICAL STAFF MEMBERS

#### 14.A: PROCEDURES FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

##### 14.A.1.Collegial Intervention & Informal Remediation

- (a) Prior to initiating formal corrective action against a Medical Staff Member for professional conduct or clinical competency concerns, the Medical Staff leadership or Board (through the Hospital President or CMO, as its administrative agent) may elect to attempt to resolve the concerns informally in a manner that it determines.
- (b) The Medical Staff President, or their designee, may undertake informal interventions with a Medical Staff Member, consistent with the Medical Staff’s Peer Review, conduct, and professional practice evaluation Policies, as applicable, to resolve potential clinical competency or conduct issues.
- (c) Nothing in this Section 14.A. shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or informal remediation prior to implementing formal corrective action on the basis of a single incident.
- (d) A written record of any collegial intervention and/or informal remediation efforts will be prepared and maintained in the Medical Staff Member’s confidential file.

#### 14. B: FORMAL CORRECTIVE ACTION

##### 14.B.1. Grounds

- (a) Formal corrective action may be taken whenever a Medical Staff Member engages in activities or conduct, within or outside of the Hospital, that is or is reasonably likely to be:
  - (1) Contrary to the Medical Staff governing documents or applicable Hospital Policies or procedures.
  - (2) Detrimental to patient safety or to the quality or efficiency of patient care at the Hospital.
  - (3) Disruptive to Hospital operations.
  - (4) Damaging to the Medical Staff’s or the Hospital’s reputation.
  - (5) Below the applicable standard of care.

##### 14.B.2. Request for Initiation of Formal Corrective Action

- (a) Any of the following may request that corrective action be initiated:
  - (1) Chief Medical Officer
  - (2) Medical Staff President
  - (3) Department Chair
  - (4) Any standing committee or subcommittee of the Medical Staff (including the MEC) or chair thereof
  - (5) Hospital President
  - (6) Board or Board chair
- (b) All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. Such request must be supported by reference to the specific activities or conduct that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis therefore in its minutes.
- (c) The chair of the MEC shall promptly notify the Hospital President in writing of all requests for corrective action and shall continue to keep them fully informed of all action taken in conjunction therewith.

#### 14.B.3. MEC Options Upon Request for Initiation of Formal Corrective Action

- (a) Upon receipt of a request for corrective action, the MEC shall act on the request. The MEC may:
  - (1) Determine that no corrective action is warranted and close the matter.
  - (2) Determine that no corrective action is warranted but remand the matter for collegial intervention or informal remediation consistent with the applicable Medical Staff policy.
  - (3) Initiate a formal corrective action investigation.

#### 14.B.4. Commencement of Formal Corrective Action

- (a) A matter shall be deemed to be under formal investigation upon either of the following events, whichever occurs first:
  - (1) The Medical Staff Member is notified by the Medical Staff President (either verbally or upon proof of receipt of Special Notice) that a request for formal corrective action has been submitted to the MEC.
  - (2) The start of an MEC meeting at which a request for formal corrective action is being presented.
- (b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under formal corrective action until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.
- (c) The affected Medical Staff Member shall be provided with written Notice of a determination by the MEC to initiate a formal corrective action investigation.

#### 14.B.5. Formal Corrective Action Investigation

- (a) The MEC may conduct such investigation itself; assign this task to the Medical Staff President or Department Chair, or a standing or *ad hoc* Medical Staff committee; or may refer the matter to the Board for investigation and resolution.

- (b) This investigation process is not a “hearing” as that term is used in the Fair Hearing Policy and does not entitle the Medical Staff Member to the procedural rights provided in the Fair Hearing Policy.
- (c) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the Medical Staff Member involved, who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of, or information relevant to, the events involved.
- (d) If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the MEC as soon as is practicable after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).
- (e) The MEC may at any time in its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

#### 14.B.6. MEC ACTION

- (a) As soon as is practicable following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action.
- (b) The MEC’s actions may include, without limitation, the following:
  - (1) A determination that no corrective action be taken.
  - (2) Issuance of a verbal or written warning or a letter of reprimand.
  - (3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practice or conduct but without requirement of prior or concurrent consultation or direct supervision.
  - (4) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member’s ability to exercise previously exercised Privileges for a period of up to fourteen (14) days.
  - (5) Imposition of a suspension of all, or any part, of the Medical Staff Member’s Privileges for a period up to fourteen (14) days.
  - (6) Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member’s Privileges for a period up to fourteen (14) days.
  - (7) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Member’s ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.
  - (8) Recommendation of a suspension of all, or any part, of a Medical Staff Member’s Privileges for a period in excess of fourteen (14) days.
  - (9) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Member’s Privileges for a period in excess of fourteen (14) days.
  - (10) Recommendation of revocation of all, or any part, of the Member’s Privileges.

#### 14.B.7. Effect of MEC Action

- (a) Adverse. When the MEC’s recommendation is Adverse (as defined in these Bylaws and the Fair Hearing Policy) to the Medical Staff Member, the Medical Staff President shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural rights contained in the Fair Hearing Policy. The Medical Staff President shall then hold the Adverse recommendation in abeyance until the Medical Staff Member has exercised or waived the right to a hearing

and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

- (b) Failure to Act. If the MEC (1) refers the matter to the Board; or (2) fails to act on a request for corrective action within an appropriate time, as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (2), the Board shall make such determination after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.
  - (1) If the Board's decision is not averse to the Medical Staff Member, the action shall be effective as its final decision and the Hospital President shall inform the Member of the Board's decision by Special Notice.
  - (2) If the Board's action is averse to the Medical Staff Member, the Hospital President shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural rights in the Fair Hearing Policy.

#### 14.B.8. Exceptions to Corrective Action Procedures

The commencement of corrective action procedures against a Medical Staff Member shall not preclude the summary suspension or automatic suspension or automatic termination of the Medical Staff appointment and/or all, or any portion, of the Member's Privileges in accordance with the applicable procedures set forth in this Article.

#### 14.C. SUMMARY SUSPENSION

- (a) Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of imminent danger to the health or safety of any patient, employee, or other person present at the Hospital, or to the orderly operations of the Hospital, any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion of, the Clinical Privileges of such Practitioner:
  - (1) MEC
  - (2) Medical Staff President
  - (3) Chief Medical Officer
  - (4) Hospital President
  - (5) Board or chair thereof
- (b) A summary suspension is effective immediately. The person(s) or group imposing the summary suspension shall immediately inform the Hospital President and CMO of the summary suspension and the Medical Staff President shall promptly give Special Notice thereof to the Practitioner.
- (c) The Medical Staff President or applicable Department Chair shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner with appropriate Privileges considering the wishes of the patient, where feasible.
- (d) As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review, and consider the need, if any, for a professional review action (i.e., formal corrective action) pursuant to Section 14.B. Such a meeting of the MEC shall not be considered a "hearing" as contemplated in the Medical Staff Fair Hearing Policy (even if the involved Practitioner attends the meeting), and no procedural requirements shall apply.
- (e) The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the Hospital President.
- (f) In the case of a summary suspension imposed by the Board or the Hospital President, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated.

- (g) The Board may accept, modify, or reject the MEC's recommendation.
- (h) Not later than fourteen (14) days following the original imposition of the summary suspension, the Medical Staff President shall notify the Practitioner, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board or the Hospital President, of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or continued.
- (i) If a summary suspension remains in place for more than fourteen (14) days, the Practitioner shall be advised, by Special Notice, of the Practitioner's rights, if any, pursuant to the Medical Staff Bylaws and Fair Hearing Policy.

#### 14.D: AUTOMATIC SUSPENSION

##### 14.D.1. Grounds for Automatic Suspension/Limitation

The following events shall result in an automatic suspension of Medical Staff appointment and/or Privileges without recourse to the procedural rights set forth the Fair Hearing Policy.

- (a) **Licensure Suspension or Expiration.** Whenever a Practitioner's license is suspended by the applicable licensing entity or expires, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended.
- (b) **Licensure Restriction.** Whenever a Practitioner's license is limited/restricted by the applicable licensing entity, the Practitioner's Medical Staff appointment and Privileges will be likewise automatically limited/restricted.
- (c) **Probation.** Whenever a Practitioner's license is made subject to probation by the applicable licensing entity, the Practitioner's Medical Staff appointment and Privileges shall automatically become subject to the same terms of such probation.
- (d) **Controlled Substance Authorization Suspension.** Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is suspended by the DEA or other applicable federal or state authority, their Medical Staff appointment and Privileges shall be automatically suspended.
- (e) **Professional Liability Insurance.** If a Practitioner'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 Practitioner's Medical Staff appointment and 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 Practitioner'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 a Practitioner to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

- (f) **Federal Health Program.** Whenever a Practitioner 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 a Practitioner fails to complete medical records as provided for in Medical Staff governing documents and/or applicable Hospital (*i.e.*, Health Information Management) Policies, the Practitioner's Medical Staff appointment and/or Privileges shall be automatically suspended consistent with the applicable document(s).

- (h) **Plea of Guilty, etc.** If a Practitioner 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 Practitioner's Medical Staff appointment and Privileges shall be immediately and automatically terminated.

#### 14.D.2. Action Following Imposition of Automatic Suspension/Limitation

At the next regularly scheduled meeting or sooner as necessary after the imposition of the automatic suspension, the MEC shall convene to determine if initiation of formal corrective action is necessary in accordance with Section 14.B. of these Bylaws.

The lifting of the action or inaction on the part of the Practitioner that gave rise to an automatic suspension of Medical Staff appointment and/or Privileges shall result in the automatic reinstatement of the Practitioner's appointment and/or Privileges. The Practitioner shall be obligated to provide such information as the Medical Staff Office shall reasonably request to assure that all information in the Practitioner's credentials file is current upon reinstatement.

#### 14.D.3. Impact of Automatic Suspension

During such period of time when a Practitioner's Medical Staff appointment and/or Privileges are automatically suspended pursuant to Section 14.D., they may not, as applicable, exercise any Prerogatives of appointment or exercise any Privileges at the Hospital.

A Practitioner whose Privileges are automatically suspended pursuant to Section 14.D., (*i.e.*, for delinquent medical records), is subject to the same limitations except that such Practitioner may:

- Conclude the management of any patient under their care in the Hospital at the time of the effective date of the automatic suspension.
- Attend an obstetrical patient who has been under their care and management and who comes to term and is admitted to the Hospital in labor.
- Attend to the management of any patient under their care whose outpatient procedure was scheduled prior to the effective date of the automatic suspension.
- Attend to the management of any patient under their care requiring emergency care and intervention.

#### 14.E: CONTINUITY OF PATIENT CARE

Upon the imposition of an automatic suspension or automatic termination of Medical Staff appointment and/or Privileges, the Medical Staff President or applicable Department Chair shall provide for alternative coverage for the affected Practitioner's Hospital patients.

The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The affected Practitioner shall confer with the substitute Practitioner(s) to the extent necessary to safeguard the patients.

#### 14.F: CONSISTENCY OF ACTIONS BETWEEN HOSPITAL & AFFILIATE HOSPITALS

So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of Medical Staff appointment and Privileges considering that the Hospital and the Affiliate Hospitals are part of the same Health System, and that the Hospital and the Affiliate Hospitals have agreed to share information regarding appointment and/or Privileges, the following automatic actions shall occur:

- (a) With the exception of an automatic suspension for delinquent medical records, if a Practitioner's appointment and/or Privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.

- (b) If a Practitioner's appointment and/or Privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise Privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise Privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.
- (c) If a Practitioner's appointment and/or Privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy unless otherwise provided in the final decision at the Affiliate Hospital(s).
- (d) If a Practitioner resigns their Medical Staff appointment and/or Privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.
- (e) If a Practitioner withdraws an application, in whole or in part, for initial appointment and/or Privileges at an Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural rights set forth in these Bylaws and the Fair Hearing Policy.

## ARTICLE 15: MEDICAL HISTORY AND PHYSICAL EXAMINATIONS

### 15.A: MEDICAL HISTORY & PHYSICAL EXAMINATION; OUTPATIENT ASSESSMENTS

Patients shall, as applicable, receive a medical history and physical examination (H&P) no more than thirty (30) days prior to, or within twenty-four (24) hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For an H&P that was completed within thirty (30) days prior to registration or inpatient admission, an update documenting any changes in the patient's condition shall be completed within twenty-four hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. In lieu of the H&P requirements, an assessment for designated outpatients may be completed and documented after registration but prior to surgery or a procedure requiring anesthesia services provided that the conditions set forth in the Medical Staff Rules & Regulations are met.

The H&P or outpatient assessment, as applicable, shall be completed and documented by a Physician, an Oral Maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and Hospital/Medical Staff policy.

Additional requirements regarding completion and documentation of the H&P or outpatient assessment, as applicable, are set forth the Medical Staff Medical Staff Rules & Regulations.

## ARTICLE 16: CONFIDENTIALITY; PEER REVIEW PROTECTION

### 16.A: CONFIDENTIALITY AND REPORTING

Actions taken, recommendations made, and information shared pursuant to these Bylaws 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 Bylaws 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.

#### 16.B: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of ORS §41.675 & 41.685, RCW 4.24.240-260 & 70.41.200 or the corresponding provisions of any subsequent federal or state law providing protection to Peer Review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations, or investigations pursuant to these Bylaws shall be considered to be acting on behalf of Hospital and Legacy when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

#### 16.C: MEDICAL STAFF RECORDS

##### 16.C.1. Location and Security Precautions.

All Medical Staff Records are maintained in the Medical Staff Office under the custody of the Medical Staff Coordinator. The Medical Staff Office shall be locked except during those times that office staff is present and able to monitor access in accordance with these Bylaws. Medical Staff Records shall only be released from the Medical Staff Office in accordance with these Bylaws.

##### 16.C.2. Manner of Access; Parties Entitled to Access.

All requests for Medical Staff Records shall be directed to the Medical Staff Coordinator. Those requests which require Notice to, or approval by, other individuals shall be forwarded to those persons by the Medical Staff Coordinator. Unless otherwise required by law or provided in these Bylaws, persons granted access to Medical Staff Records shall be given a reasonable opportunity to review relevant records and take notes but shall not be allowed to remove records from the Medical Staff Office or to make copies of records, except with the express permission of the Medical Staff President (or designee).

Access by Persons Performing Authorized Hospital or Medical Staff Functions and Responsibilities. Medical Staff officers, committee Members, Members of the Board of Directors, the Legacy CEO or authorized representative, the Medical Staff Coordinator, and other persons participating in authorized Hospital or Medical Staff Peer Review Activities may have access to Medical Staff Records, other than their own files, to the extent necessary to perform such Peer Review Activities.

##### 16.C.3. Access by Member to Their Own Credentials File.

- (a) A Member may have access to their own credentials file, subject to the following conditions:

- (1) The review shall take place in the Medical Staff Office, during normal business hours, with Hospital or Medical Staff personnel present.
  - (2) A Member may review any documents in their credentials file which they prepared or provided personally (*e.g.*, initial appointment application, application for reappointment, request for Privileges, copies of licensure and certifications, or correspondence from themselves) or which were originally addressed to them.
  - (3) A Member may request copies of documents available for review. The Medical Staff office may charge the Member a reasonable fee for such copies.
  - (4) All other information may be disclosed only in written summary form. The summary shall contain the substance, but not the source, of the information.
  - (5) A Member may not modify, remove, cancel, destroy, or change any document or information in the file.
- (b) In the event of a hearing or appeal as set forth in these Bylaws, the Member may have access to all information in the file relevant to the hearing, appeal or underlying corrective action.

16.C.4. Access by Persons or Organizations Outside Hospital or Medical Staff.

- (a) Credentialing or Peer Review at Other Health Care Facilities.
  - (1) Medical Staff Records may be released in response to a written request from another health care facility or Medical Staff. Disclosure generally shall include verification of the Member's Medical Staff Membership and Clinical Privileges and may include additional information from the file when the Member has signed an acceptable authorization and release.
  - (2) If a Member has been the subject of corrective action at Hospital, special care shall be taken. All responses to inquiries regarding that Member shall be reviewed and approved by the Medical Staff Coordinator and/or Medical Staff President (or designee), with input from legal counsel.
- (c) Hospital Surveyors and Auditors. Hospital surveyors and auditors (*e.g.*, Joint Commission, CMS) may review Medical Staff Records on Hospital premises in the presence of Hospital or Medical Staff personnel provided that: (1) no originals or copies may be removed from the premises; (2) access is granted with the concurrence of the Medical Staff President (or designee) and the Legacy CEO (or designee); and (3) the surveyor or auditor demonstrates the following:
  - (1) Specific statutory, regulatory, or other authority to review the requested materials.
  - (2) The materials sought are directly relevant to the matter being surveyed or audited.
  - (3) The materials sought are the most direct and least intrusive means to carry out the survey or audit.
  - (4) Sufficient specificity to allow for the production of individual documents without undue burden to Hospital or Medical Staff.

- (5) In the case of requests for documents with practitioner identifiers not removed, the need for such identifiers is clear.
- (d) Subpoenas. All subpoenas of Medical Staff Records shall be referred to the legal department. The legal department shall work with the Medical Staff Office to determine the appropriate response to the subpoena.
- (e) Other Requests. All other requests by persons or organizations outside Hospital or Medical Staff for information contained in the Medical Staff Records shall be forwarded to the Medical Staff President (or designee) for review and action.

16.C.5. Credentials Files Changes.

A Member may request corrections, deletions, and additions to information in their credentials file, subject to the following conditions:

- (a) The request shall be made in writing to the Medical Staff President and shall include a reason for the action(s) requested.
- (b) The Medical Staff President (or designee) shall review such request within a reasonable period of time and decide whether to grant or deny the request. The Medical Staff President (or designee) may make reasonable modifications to the Member's request. The Member will be notified promptly, in writing, of the Medical Staff President's decision.
- (c) If granted, the appropriate action shall be taken, and the Member shall be so notified. If the request is denied, the Member shall be notified of the reason(s) for denial. The Member may request a review of the President's decision by the Medical Executive Committee. This review is not a hearing as described in Section 14.B. and does not entitle a Member to any due process rights to which they might otherwise be entitled under Section 14.B.
- (d) In any case, a Member has the right to add a short, relevant, written statement to their own credentials file to support or rebut any information contained therein.

ARTICLE 17: CONFLICT MANAGEMENT

In the event of conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted Medical Staff bylaw, rule, regulation, policy, or other issue of significance to the Medical Staff, a written petition signed by at least ten percent (10%) of the eligible voting Members of the Medical Staff shall be submitted to the President of the Medical Staff to trigger the conflict management process. The petition shall designate three Members of the Active Staff to serve as the petitioners' representatives.

Upon presentation of a valid petition, the President of the Medical Staff shall convene a meeting between the petitioners' representatives and an equal number of Members of the Medical Executive Committee as they shall select.

The representatives of the Medical Executive Committee and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve their differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee and the safety and quality of patient care at Hospital. Resolution of the conflict shall require a vote of the majority of the representatives of the Medical Executive Committee and a majority of the petitioners' representatives.

Differences which remain unresolved at the conclusion of this process shall be submitted to the Legacy Board for its consideration in making a final decision with respect to the bylaw, rule, regulation, policy, or issue. Nothing in the

foregoing is intended to prevent Medical Staff Members from communicating with the Legacy Board on a bylaw, rule, regulation, policy, or issue. The Legacy Board shall determine the method of communication.

#### ARTICLE 18: REVIEW, REVISION, ADOPTION AND AMENDMENT OF THE BYLAWS

##### 18.A: MEDICAL STAFF RESPONSIBILITY:

The Medical Staff shall have the responsibility to formulate, review periodically, adopt, and recommend to the Legacy Board Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Legacy Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner.

##### 18.B: METHODS OF ADOPTION AND AMENDMENT:

- (a) Amendments to these Bylaws may be proposed by a standing committee of the Medical Staff upon submission of a petition signed by at least five percent (5%) of the eligible voting Members of the Medical Staff.
- (b) All proposed amendments shall be reviewed and discussed by the Medical Executive Committee prior to submission to a vote of the eligible voting Members of the Medical Staff.
- (c) An amendment shall be recommended to the Legacy Board upon the affirmative vote of a majority of the eligible voting Members of the Medical Staff
- (d) The Medical Executive Committee may recommend amendments to the Legacy Board without a vote of the Medical Staff as are, in the committee's judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling or other errors of grammar or expression. The Medical Executive Committee shall notify the Medical Staff when it recommends such an amendment.
- (e) Amendments become effective upon approval by the Legacy Board.
- (f) Neither the Medical Staff nor the Legacy Board may unilaterally amend these Bylaws.

##### 18.C: RELATED RULES AND REGULATIONS

- (a) The Medical Executive Committee shall recommend to the Legacy Board Policies, rules, and regulations that further define the general Policies contained in these Bylaws. Amendments to such rules, regulations, and Policies may be recommended to the Legacy Board by the Medical Executive Committee after a majority vote of the Medical Executive Committee and shall be approved by the Legacy Board prior to becoming effective.
- (b) Notwithstanding the role of the Medical Executive Committee to review and recommend amendments to the Medical Staff rules, regulations, and Policies, a Member of the Active Staff may propose amendments to such rules, regulations, and Policies, upon submission of a petition signed by at least ten percent (10%) of the voting Members of the Medical Staff. An amendment shall be recommended to the Legacy Board upon the affirmative vote of a majority of the Medical Staff who cast ballots.
- (c) When the Medical Executive Committee proposes to adopt a Medical Staff rule, regulation, policy, or amendment thereto, it shall notify the Medical Staff of such proposal and shall allow fourteen (14) days for the Medical Staff to comment on the proposal. When the Medical Staff proposes to adopt a Medical Staff rule, regulation, policy, or amendment thereto, it shall notify the Medical Executive Committee of such proposal and shall allow fourteen (14) days for the Medical Executive Committee to comment on the proposal.

- (d) The Medical Executive Committee shall notify the Medical Staff when it adopts a rule, regulation, policy, or amendment thereto.
- (e) In the event it becomes necessary to amend a Medical Staff rule, regulation, or policy in order to comply with any law or regulation, the Medical Executive Committee shall have the authority to provisionally adopt and the Legacy Board may provisionally approve such amendment as may be required to comply with the law without prior communication to the Medical Staff. In such circumstances, the Medical Executive Committee shall immediately notify the Medical Staff, providing the basis for such urgent amendment with the written Notice. The Medical Staff shall have the opportunity to comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment shall remain in effect. If there is conflict over the provisional amendment, the conflict management process set forth in Article 17 shall be implemented.
- (f) Neither the Medical Staff nor the Legacy Board may unilaterally amend such rules, regulations, and Policies.

18.D: JOINT CONFERENCE AMENDMENT:

If the Legacy Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee, the Medical Executive Committee is entitled to a joint conference between the officers of the Legacy Board and the officers of the Medical Staff. Such joint conference shall be for the purpose of further communicating the Legacy Board’s rationale for its contemplated action and to permit the officers of the Medical Staff to fully articulate the rationale for the Medical Executive Committee’s recommendation. Such a joint conference shall be scheduled by the Legacy CEO within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

The Legacy Board shall consider the rationales presented at the joint conference in reaching its decision.

ARTICLE 19: ADOPTION

These Bylaws are 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 JANUARY 19, 2022.

Adopted by the Medical Staff:

/s/ Joseph Frankhouse, MD                      Date: 9/1/21  
 President of the Good Samaritan Medical Staff

Approved by the Legacy Health Board:

/s/ Charles Wilhoite                              Date: 1/19/22