LEGACY GOOD SAMARITAN HOSPITAL AND MEDICAL CENTER

ALLIED HEALTH PROFESSIONALS POLICY

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITIONS</td>
<td>1</td>
</tr>
<tr>
<td>1. INTRODUCTION AND CATEGORIES</td>
<td>2</td>
</tr>
<tr>
<td>1.A CLASSES</td>
<td>2</td>
</tr>
<tr>
<td>1.B SUPERVISION</td>
<td>2</td>
</tr>
<tr>
<td>2. PERMISSION TO PRACTICE</td>
<td>2</td>
</tr>
<tr>
<td>2.A QUALIFICATIONS FOR AUTHORIZATION TO PRACTICE</td>
<td>2</td>
</tr>
<tr>
<td>2.A.1 General</td>
<td>2</td>
</tr>
<tr>
<td>2.A.2 Specific Qualifications</td>
<td>3</td>
</tr>
<tr>
<td>2.A.3 No Entitlement to Authorization to Practice</td>
<td>4</td>
</tr>
<tr>
<td>2.A.4 Non-Discrimination Policy</td>
<td>4</td>
</tr>
<tr>
<td>2.B APPLICATION FOR INITIAL AUTHORIZATION TO PRACTICE</td>
<td>4</td>
</tr>
<tr>
<td>2.B.1 Information</td>
<td>4</td>
</tr>
<tr>
<td>2.B.2 Basic Responsibilities and Requirements for Applicants and Those</td>
<td>7</td>
</tr>
<tr>
<td>Granted Authorization to Practice</td>
<td>9</td>
</tr>
<tr>
<td>2.B.3 Burden of Providing Information</td>
<td>9</td>
</tr>
<tr>
<td>2.B.4 Grant of Immunity and Authorization to Obtain and Release</td>
<td>9</td>
</tr>
<tr>
<td>Information</td>
<td>9</td>
</tr>
<tr>
<td>2.C PROCEDURE FOR INITIAL APPLICATION</td>
<td>11</td>
</tr>
<tr>
<td>2.C.1 Pre-Application Review Process</td>
<td>11</td>
</tr>
<tr>
<td>2.C.2 Submission of Application</td>
<td>11</td>
</tr>
<tr>
<td>2.C.3 Verification of Identity</td>
<td>12</td>
</tr>
<tr>
<td>2.C.4 Section or Department Chair Procedure</td>
<td>13</td>
</tr>
<tr>
<td>2.C.5 Processing Applications When No Questions Are Raised and All</td>
<td>14</td>
</tr>
<tr>
<td>Information is Appropriate and In Order</td>
<td>15</td>
</tr>
<tr>
<td>Information</td>
<td>15</td>
</tr>
<tr>
<td>2.C.6 Credentials Committee Procedure</td>
<td>16</td>
</tr>
<tr>
<td>2.C.7 Credentials Committee Report</td>
<td>16</td>
</tr>
<tr>
<td>2.C.8 Medical Executive Committee Procedure</td>
<td>17</td>
</tr>
<tr>
<td>2.D SCOPE OF PRACTICE</td>
<td>18</td>
</tr>
<tr>
<td>2.D.1 General</td>
<td>18</td>
</tr>
<tr>
<td>2.D.2 Authorization to Practice New Procedures</td>
<td>19</td>
</tr>
<tr>
<td>2.E INFORMAL PROCEEDINGS</td>
<td>20</td>
</tr>
<tr>
<td>2.F CONFIDENTIALITY AND REPORTING</td>
<td>20</td>
</tr>
<tr>
<td>3. ACTIONS AFFECTING AHP’S WHO HAVE BEEN AUTHORIZED TO PRACTICE</td>
<td>20</td>
</tr>
<tr>
<td>3.A PROCEDURE FOR RE-AUTHORIZATION TO PRACTICE</td>
<td>20</td>
</tr>
<tr>
<td>3.A.1 Qualifications</td>
<td>21</td>
</tr>
</tbody>
</table>
DEFINITIONS

The following definitions shall apply to terms used in this policy:

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

(2) “Dependent Allied Health Professional” means practitioners who are authorized to function in the Hospital only as an employee of, or under direct supervision of, a physician or physicians appointed to the Medical Staff pursuant to a defined scope of practice. Dependent AHPs currently include but are not limited to Certified Registered Nurse Anesthetists, Physician Assistants, RNFAs, RN Assistants, Technical Assistants, Dental Assistants, Genetics Counselors, and Perfusionists.

(3) “Credentials Committee” means the credentials committee of Hospital.

(4) “Hospital” means Legacy Good Samaritan Hospital and Medical Center.

(5) “Medical Staff” means all physicians, dentists, podiatrists, psychologists and nurse practitioners who are given privileges to treat patients at Hospital.

(6) “Legacy” means Legacy Health.

(7) “Legacy Board” means the Board of Directors of Legacy Health, or its designee.

(8) “Legacy 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 Health and shall mean the Legacy CEO or designee.

(9) “Medical Executive Committee” means the medical executive committee of Hospital.

Words used in this policy 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 this policy.
ARTICLE 1
INTRODUCTION AND CATEGORIES

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

1.A. CLASSES:

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

(a) Independent AHP
(b) Dependent AHP

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

1.B SUPERVISION:

(a) The supervising physician(s) shall assume full responsibility and be fully accountable for the conduct of the AHP within the Hospital. It is the responsibility of the supervising physician to orient the AHP to the appropriate policies and rules and regulations of the medical staff and the Hospital. AHPs applying for or approved for practice at Hospital shall be required to comply with all appropriate medical staff, hospital, and Legacy Bylaws, Rules & Regulations and Policies.

ARTICLE 2
PERMISSION TO PRACTICE

2.A: QUALIFICATIONS FOR AUTHORIZATION TO PRACTICE

2.A.1. General:

(a) Authorization to practice is a courtesy which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this policy and in such policies as are adopted from time to time by the Legacy Board.

(b) All processes described in this Article shall be subject to the confidentiality provisions described in Section 2.J of this policy.

2.A.2. Specific Qualifications:

(a) Only those classes of AHP that have been approved by the Legacy Board shall be eligible to apply for permission to practice at Hospital.

(1) where applicable to their practice, have a current, active, license by order of the appropriate Oregon licensing board to practice in the State of Oregon;
(2) where applicable to their practice, have a current DEA certificate;

(3) are located (office and residence) close enough to the Hospital to fulfill their patient care responsibilities and to provide timely and continuous care to their hospitalized patients, in accordance with those specific requirements as approved by the Legacy Board;

(4) possess current, valid professional liability insurance coverage in amounts required by the Hospital and state law and regulation;

(5) have successfully completed an accredited training program or such other training as specifically defined by the Legacy Board for the requested practice area.

(6) can document their:
   (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 scope of practice requested, and
   (v) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them at the Hospital will receive quality care and that the Hospital and the Medical Staff will be able to operate in an orderly manner; and

(7) have never been convicted of a felony crime.

(b) The qualifications set forth in paragraphs (1), (2), (3), (4), (5), (6) and (7) above are deemed to be threshold criteria for application to practice at Hospital. Individuals who have an application for licensure and professional liability insurance pending shall be deemed to have satisfied the threshold criteria for the purpose of the pre-application process.

2.A.3. No Entitlement to Authorization to Practice

No individual shall be entitled to authorization to practice at 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, authorization to practice at any hospital or health care facility;
(d) resides in the geographic service area of the Hospital; or
(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.
2.A.4. Nondiscrimination Policy:

No individual shall be denied authorization to practice on the basis of sex, race, creed, religion, color, national origin, handicap, disability, or on the basis of any criteria unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital’s purposes, needs, and capabilities.

2.B: APPLICATION FOR INITIAL AUTHORIZATION TO PRACTICE

2.B.1. Information:

(a) Applications for authorization to practice shall be in writing, and shall be submitted on forms approved by the Legacy Board, upon recommendation of the Credentials Committee. Information regarding these forms shall be obtained from the Medical Staff Office.

(b) The application shall contain a request for the specific scope of practice desired by the applicant and shall require detailed information concerning the applicant’s professional qualifications, including:

(1) the names and complete addresses of at least three (3) physicians and/or practitioners in the same specialty area, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant’s present professional competence and character. These references may not be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;

(2) information as to whether the applicant’s authorization to practice has ever been voluntarily 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;

(3) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for authorization to practice or has resigned his authorization to practice before final decision by a hospital’s or health care facility’s governing board;

(4) information as to whether the applicant’s license to practice any profession in any state, or Drug Enforcement Administration license is or has ever been voluntarily or involuntarily suspended, modified, terminated, restricted, or is currently being challenged. (The submitted application shall include a list or copy of all the applicant’s current licenses to practice, as well as copies of Drug Enforcement Administration
license, professional school diploma, and certificates from all post graduate training programs completed);

(5) 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 practice or functions the applicant seeks to exercise at the Hospital;

(6) information concerning the applicant’s professional liability litigation experience, specifically information concerning pending matters, closed matters, final judgments, or settlements: (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 Credentials Committee Chair or the Credentials Committee, or the Legacy Board, may deem appropriate;

(7) a consent to the release of information from the applicant’s present and past professional liability insurance carriers;

(8) 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;

(9) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

(10) current information regarding the applicant’s ability to exercise the practice requested;

(11) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;

(12) a complete chronological listing of the applicant’s professional and educational practices, employment, or positions;

(13) information on the citizenship and/or visa status of the applicant;

(14) the applicant’s signature; and
signatures of all supervising physician Medical Staff appointees along with a statement from them acknowledging responsibility and supervision requirements.

such other information as the Credentials Committee or the Credentials Committee Chair, or the Legacy Board, may require.

The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criteria for authorization to practice. However, the mere presence of verdicts, settlements, or claims shall not, in and of themselves, be sufficient to deny authorization to practice. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual’s clinical competence, or whether a verdict, settlement, or claim in and of itself, represents such deviation from standard practice as to raise overall questions regarding the applicant’s competence, skill in the particular clinical function, or general behavior.

2.B.2. Basic Responsibilities and Requirements for Applicants and Those Granted Authorization to Practice

As a condition of consideration of an application for authority to practice, and as a condition of continued authority to practice, if granted, every AHP shall specifically agree to the following:

(a) to provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual has responsibility;

(b) to abide by all appropriate bylaws, policies, and rules and regulations of the Medical Staff, Hospital and Legacy as shall be in force during the time the individual is authorized to practice.

(c) to provide, with or without request, new or updated information to the Medical Staff Office, as it occurs, that is pertinent to any question on the application form;

(d) to attest that the applicant has had an opportunity to read a copy of the bylaws of the Hospital, Legacy, this policy, and the bylaws, rules and regulations of the Medical Staff as are in force at the time of application, and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not the requested authorization to practice is granted;

(e) to appear, if requested, for personal interviews in regard to the application;

(f) to agree that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, may constitute cause for immediate
cessation of the processing of the application and no further processing shall occur. In the event that an authorization to practice has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to constitute automatic relinquishment of authorization to practice. In either situation, there shall be no entitlement to any due process rights as set forth in this policy;

(g) to use the Hospital and its facilities sufficiently to allow the Hospital, thorough assessment by appropriate committees and Section or Department Chairs, to evaluate in a continuing manner the current competence of the AHP, or to provide adequate information from other facilities as requested by the Hospital to evaluate current competence;

(h) to refrain from fee splitting or other illegal inducements relating to patient referral;

(i) to refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(j) to seek consultation whenever necessary;

(k) to promptly notify the Legacy CEO, or a designee, and the President of the Medical Staff of any change in eligibility for payments by third-party payors 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 PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

(l) to abide by generally recognized ethical principles applicable to the AHP’s profession;

(m) to participate in the quality monitoring and evaluation activities of clinical service;

(n) to complete in a timely manner the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, this policy, and other applicable policies of the Hospital and/or Legacy;

(o) to work cooperatively and professionally with Medical Staff appointees, Medical Staff leadership, Hospital management, AHPs, nurses, and other Hospital personnel;

(p) to promptly pay any applicable dues and assessments, in accordance with the bylaws of the Hospital;

(q) to participate in continuing education programs as appropriate;
(r) to authorize the release of all information necessary for an evaluation of the individual’s qualifications for initial or continued authorization to practice;

(s) to agree that the due process procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at the Hospital;

(t) to agree not to sue the Hospital, Legacy, the Medical Staff, or anyone acting by or for the Hospital, Legacy, and its Medical Staff for any matter relating to the application for authorization to practice, renewal of authorization to practice, or relating to the evaluation of the applicant’s qualifications on any matter related to authorization to practice.

(u) to extend absolute immunity to the Hospital, its Medical Staff, Legacy, and all individuals acting by or for the Hospital and/or its Medical Staff and Legacy for all matters relating to authorization to practice or the individual’s qualifications for the same; and

(v) if the individual institutes legal action notwithstanding the provisions of subparagraphs (t) and (u), and does not prevail, he or she shall reimburse the Hospital, Legacy, and any Medical Staff members named in the action for all costs incurred in defending such legal action, including reasonable attorney’s fees.

2.B.3. Burden of Providing Information:

(a) The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(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 the Hospital, the application for authorization to practice will be deemed incomplete and will not be further processed. Should information provided in the initial application change during the course of an authorization to practice period, the AHP has the burden to provide information about such change to the Credentials Committee Chair sufficient for the Credentials Committee Chair’s review and assessment.

2.B.4. 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 this policy, are express conditions applicable to any AHP having or requesting authorization to practice at the Hospital. By applying for authorization to
practice, the applicant expressly accepts these conditions during the processing and consideration of the application, whether or not the request for authorization to practice is granted. This acceptance also applies during the time of any initial approval or continued approval or recredentialing.

(a) **Immunity:**
To the fullest extent permitted by law, the applicant or AHP releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, Legacy, their authorized representatives, and appropriate third parties, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or AHP who has been granted authorization to practice, concerning the following:

1. applications for authorization to practice, including temporary authorizations;
2. evaluations concerning renewal or changes in authorization to practice;
3. proceedings for suspension or reduction of authorization to practice or for revocation of authorization to practice, or any other disciplinary sanction;
4. precautionary suspension;
5. medical care evaluations;
6. utilization reviews;
7. other activities relating to the quality of patient care or professional conduct;
8. matters or inquiries concerning the AHP’s professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or
9. any other matter that might directly or indirectly relate to the AHP’s competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) **Authorization to Obtain Information:**
The AHP specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual’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 AHP’s or previously approved AHP’s satisfaction of the criteria for initial and continued authorization to practice. This authorization by the AHP 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 questions. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

(c) **Authorization to Release Information:**
The applicant or AHP specifically authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the AHP’s professional qualifications pursuant to a request for authorization to practice at the other facility.

2.C: PROCEDURE FOR INITIAL APPLICATION

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

(a) An application for authorization to practice shall be processed only for those individuals who, according to this policy (1) meet the threshold criteria set forth in Section 2.A.2 of this policy; (2) desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel; and (3) are not seeking to perform a function that is currently subject to an exclusive contract, unless the individual has been or is to be awarded such contract.

(b) An individual requesting appointment shall be sent a letter that outlines the threshold criteria for appointment and requiring that the individual attest that the threshold criteria for appointment can be met by the individual. A completed pre-application form must be returned to the Medical Staff Office within thirty (30) days after receipt of same if the individual desires further consideration.

(c) Those individuals who attest that they can meet the threshold criteria for medical staff appointment shall be given an application. Individuals who fail to meet the threshold 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 threshold criteria, processing shall be discontinued and the individual shall be notified of such action.

2.C.2. Submission of Application:

(a) A completed application form for authorization to practice with copies of all required documents must be returned within thirty (30) days of receipt 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 also review the application to determine that all questions have been answered, all references and other information or materials deemed pertinent have been received and that information deemed pertinent has been verified with primary sources. As part of the process of reviewing the application, the Medical Staff Office shall determine whether the application should be processed in accordance with Section 2.C.4. Thereafter, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate Section or Department Chair.
An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information deemed pertinent 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 anytime during the evaluation. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references.

The Medical Staff Office shall transmit the complete application and all supporting information to the appropriate Section or Department Chair for those individuals who meet the threshold criteria.

2.C.3. Verification of Identity:

(a) The credentialing process for granting authorization to practice includes the following mechanism to ensure that the individual requesting and exercising the scope of practice is the same individual identified in the credentialing documents.

(1) Applicants for authorization to practice must obtain a Legacy Photo Identification Badge prior to entering a clinical area or seeing a patient. Before issuing a Photo Identification Badge, the Legacy employee or representative will view a valid, government-issued photo identification (e.g., driver’s license, passport, etc.) to confirm that the individual is the applicant identified in the credentialing documents. Confirmation of the verification will be documented and forwarded to the Medical Staff Office.

(i) If the photo identification equipment is unavailable for any reason, a Temporary Identification Badge must be obtained as described below.

(ii) A permanent Legacy Photo Identification Badge must be obtained prior to the expiration of the Temporary Identification Badge.

(2) Before issuing a Temporary Identification Badge, the Legacy employee or representative will view a valid, government-issued photo identification (e.g., driver’s license, passport, etc.) to confirm that the individual is the applicant identified in the credentialing documents. Confirmation of the verification will be documented and forwarded to the Medical Staff Office.

(3) Electronic copies of photos obtained for Legacy Photo Identification Badges will be forwarded to the Medical Staff Office and made available
for access by Legacy staff on the Legacy Intranet and for other appropriate purposes.

2.C.4. Section or Department Chair Procedure:

(a) The Section or Department Chair of each service in which the applicant seeks authorization to practice shall provide the Credentials Committee or the Chairperson of the Credentials Committee with a written report concerning the applicant’s qualifications for authorization to practice and scope of practice. As part of the process of making this report, the Section or Department Chair has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested scope of practice.

(b) The Section or Department Chair, or the individual within the service to which the chair has assigned this responsibility, shall evaluate the applicant’s education, training, and experience, and may make inquiries with respect to the same to the applicant’s past or current training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.

(c) The Section or Department Chair shall be available to the Credentials Committee or the Chairperson of the Credentials Committee to answer any questions that may be raised with respect to that chair’s report and findings.

2.C.5. Processing Applications When No Questions are Raised and All Information is Appropriate and in Order:

(a) Applications which are deemed complete with all information deemed pertinent 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. the 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; and
4. Questions are raised about the applicant by the section or department chairperson.

(b) The Chairperson of the Credentials Committee, acting on behalf of the Credentials Committee, shall, after receiving the report from each appropriate Section or 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 determine whether the applicant has established and satisfied all of the necessary qualifications for authorization to practice and scope of practice requested.

(c) As part of the process of making its recommendation, the Credentials Committee Chairperson may meet with the applicant to discuss the applicant’s application, qualifications, and scope of practice requested.

(d) The Chairperson of the Credentials Committee shall prepare a report and forward the same to the Medical Executive Committee. All recommendations to approve authorization to practice must specifically recommend the scope of practice or job description functions to be granted.

(e) If the Chairperson of the Credentials Committee has any questions about the applicant’s qualifications or current clinical competence, the Chairperson shall refer the matter to the entire Credentials Committee and the routine credentialing process as set forth below shall be followed.

(f) The Medical Executive Committee, shall review the recommendation made by the Chairperson of the Credentials Committee. If the Medical Executive Committee concurs with the favorable recommendation, the recommendation shall be forwarded to the committee of the Legacy Board 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 action.

(g) The committee of the Legacy Board reviews and evaluates the qualifications and competence of the applicant and renders its decision. If it concurs with the favorable recommendation, the authorization to practice and the scope of practice or job description functions requested are granted. If the committee of the Legacy Board’s decision is adverse to the applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

(h) A report regarding all applicants who are granted an authorization to practice shall be forwarded to the Legacy Board. The Legacy Board shall consider, and if appropriate, ratify all positive committee decisions at its next regularly scheduled meeting. A report shall also be sent to the Credentials Committee for its information.

2.C.6. Credentials Committee Procedure:

(a) Except as expressly provided in Section 2.C.4, all other applications for initial authorization to practice and scope of practice shall be processed as set forth in Sections 2.C.5 through 2.C.7.
(b) The Credentials Committee shall examine evidence of the applicant’s character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chair of each clinical service in which authorization to practice is sought, whether the applicant has established and satisfied all of the necessary qualifications for the scope of practice requested.

(c) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss the applicant’s application, qualifications, and scope of practice requested.

(d) The Credentials Committee may use the expertise of the Section or Department Chair, or any member of the service, or an outside consultant, if additional information is required regarding the applicant’s qualifications.

(e) If, after considering the report of the clinical Section or Department Chair concerned, the Credentials Committee’s recommendation for authorization to practice is favorable, the Credentials Committee shall recommend authorization to practice. All recommendations for authorization to practice, must specifically recommend the scope of practice to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the committee.

(f) If the recommendation of the Credentials Committee is delayed longer than ninety (90) days after receipt of the Section 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, and to the Legacy CEO, explaining the reasons for the delay.

2.C.7. Credentials Committee Report:

(a) Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof to the Medical Executive Committee. The completed application and all supporting documentation shall accompany the Credentials Committee’s recommendations and findings. Each recommendation shall state one of the following:

   (1) that the applicant’s request be approved;

   (2) that the applicant’s application be deferred for further consideration; or

   (3) that the applicant be rejected.

(b) When the Credentials Committee recommends approval of authorization to practice, it shall also make a specific recommendation regarding the scope of
practice to be approved, and any limitations or conditions on the authorization to practice.

(c) 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 recommendation.

2.C.8. Medical Executive Committee Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
   (1) adopt the findings and recommendation of the Credentials Committee;
   (2) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
   (3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee’s recommendation.

(b) If the recommendation of the Medical Executive Committee is favorable to the applicant, it shall transmit its recommendation through the Legacy CEO to the Legacy Board, including the findings and recommendation of the Credentials Committee. All recommendations for approval must also specifically recommend the scope of practice to be granted, which may be qualified by any probationary or other conditions or restrictions.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to due process pursuant to this policy, the recommendation of the Medical Executive Committee, together with the complete application and all supporting documentation shall be forwarded, to the Legacy Board for further action after due process takes place.

(d) Upon receipt of a favorable recommendation from the Medical Executive Committee that the applicant be granted authorization to practice and the requested scope of practice, the Legacy Board (or its designated committee) may:
   (1) grant the scope of practice as recommended; or
   (2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or
   (3) reject the recommendation. If the Legacy Board determines to reject the favorable recommendation, it should first discuss the matter with the Chair of the Medical Executive Committee. If the Legacy Board’s determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the Legacy CEO, who shall
promptly notify the applicant in writing, certified mail, return receipt requested. The Legacy Board shall make no final decision until the applicant has exercised or waived the right to due process as outlined in this policy.

2.D: SCOPE OF PRACTICE

2.D.1. General:

(a) Each individual who has been authorized to practice as an AHP shall be entitled to exercise only the functions of the scope of practice or job description specifically granted by the Legacy Board.

(b) The scope of practice or job description recommended to the Legacy Board shall be based upon consideration of the following:

1. the applicant’s education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the functions requested;
2. the applicant’s ability to meet all current criteria for the requested scope of practice;
3. availability of qualified physician members of the medical staff to provide the required supervision or backup for the applicant;
4. adequate levels of professional liability insurance coverage with respect to the scope of practice requested;
5. the Hospital’s available resources and personnel;
6. any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;
7. any information concerning professional review actions, voluntary or involuntary termination of authorization to practice, or voluntary or involuntary limitation, reduction, or loss of authorization to practice at another hospital; and
8. other relevant information, including a written report and findings by the chair of each of the clinical services in which such authorization to practice is sought.

(f) The applicant shall have the burden of establishing qualifications for and competence to exercise the scope of practice requested.

(g) The reports of the chair of the clinical service in which authorization to practice is sought shall be forwarded to the Credentials Committee or Chairperson of the Credentials Committee, depending upon whether any questions are raised, and processed as a part of the initial application for staff authorization to practice.

2.D.2. Authorization to Practice New Procedures:
Whenever an AHP requests authorization to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

(a) The matter shall first be referred to the Credentials Committee to determine whether the matter is a new procedure or service (or technique).

(b) If the matter is a new procedure or service (or technique), the matter shall then be referred to the Legacy Board which, after receiving recommendations from the Medical Executive Committee and Credentials Committee, shall make a preliminary determination whether the new procedure or service (or technique) is one that will be offered to patients. One factor to be considered in reaching this determination is whether the Hospital has the capabilities to perform the procedure in question.

(c) Should the Legacy Board determine to offer the procedure, the next step is for the Credentials Committee to investigate the new procedure and to develop criteria for those individuals who should be permitted to perform the new procedure. Specifically, the Credentials Committee shall conduct research and shall consult with experts -- both those on the Hospital’s Medical Staff and those outside the Hospital -- and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the procedure in question, and (2) the extent of monitoring and supervision that should occur. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward all recommendations to the Legacy Board for final action.

(d) The Legacy Board shall then establish the minimum criteria and qualifications necessary to be able to perform the procedure in question.

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

2.E: INFORMAL PROCEEDINGS

Nothing in this policy or the Medical Staff Bylaws shall preclude collegial, educational, and/or informal efforts to address questions or concerns relating to an individual’s practice and conduct at the Hospital, and this policy specifically encourages voluntary structuring of scope of practice to achieve a clinical practice mutually acceptable to the individual, the Credentials Committee, the Medical Executive Committee, the Hospital, and the Legacy Board. All efforts of the Hospital and the Medical Staff leaders in this regard are intended to be and are part of the Hospital’s quality improvement and professional review activities.
2.F: CONFIDENTIALITY AND REPORTING

(a) Actions taken, recommendations made and information shared pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements as well as such policies regarding confidentiality as may be adopted by the Hospital and the Medical Staff. In addition, reports of actions taken pursuant to this policy shall be made by the Legacy CEO to such governmental agencies as may be required by law.

(b) Legacy Emanuel, Legacy Good Samaritan, Legacy Meridian Park, Legacy Mount Hood, and Legacy Salmon Creek Medical Centers shall maintain all of the information received from each other in strict confidence, and the release of any such information shall be in accordance with applicable Oregon law. No party shall disclose this information to any third party without the express written consent of the others.

ARTICLE 3
ACTIONS AFFECTING ALLIED HEALTH PROFESSIONALS WHO HAVE BEEN AUTHORIZED TO PRACTICE

3.A: PROCEDURE FOR REAUTHORIZATION TO PRACTICE
All terms, conditions, and procedures relating to initial authorization to practice shall apply to continued authorization to practice and scope of practice or job description approval.

3.A.1. Qualifications:

(a) To be eligible to apply for reauthorization to practice, an individual must have, during the previous authorization to practice term:

(1) completed all medical records;
(2) provided information regarding participation in continuing education related to the scope of practice to be exercised by the individual, if so required;
(3) continued to meet all qualifications and criteria applicable to practice and the scope of practice requested as outlined in the applicable bylaws, policies, rules and regulations of the Medical Staff, the Hospital and Legacy, including the qualifications outlined in Section 2.A.2 of this policy.

(b) To be eligible to apply for renewal of authorization to practice, an individual must have performed sufficient procedures, treatments, or therapies in the previous authorization to practice term to enable the appropriate Section or Department Chair and the Credentials Committee to assess the applicant’s current clinical
competence. Any individual seeking reauthorization to practice who has minimal activity level at the Hospital must cause to be submitted a copy of his/her confidential quality improvement profile from his/her primary hospital and/or such other information as may be requested before the individual’s reauthorization to practice application shall be considered complete and processed further.

3.A.2. Application:

(a) Each current AHP who is eligible to be recredentialed shall be responsible for completing a recredentialing application form and for paying any processing fee when an amount is determined by the MEC and approved by the Legacy Board.

(b) The recredentialing application shall be furnished to the AHP by the Medical Staff Office at least five (5) months prior to the expiration of the AHP’s current practice period. The completed recredentialing application shall be submitted to the Medical Staff Office at least three (3) months prior to the expiration of the AHP’s current authorization to practice period. Failure to submit an application at least two (2) months prior to the expiration of the AHP’s current term will result in automatic expiration of the AHP’s authorization to practice at the end of the then current term of authorization to practice.

(c) The recredentialing application shall be considered incomplete and shall not be processed unless the applicant is current with respect to the payment of any dues and assessments.

(d) Reauthorization to practice, if granted by the Legacy Board, shall be for a period of not more than two (2) years. The specific staggering of recredentialing shall be in a manner established by the Medical Staff Office.

3.A.3. Factors to be Considered:

Each recommendation concerning reauthorization to practice of an individual AHP currently authorized to practice shall be based upon such AHP’s:

(a) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;

(b) compliance with the applicable bylaws, policies, and rules and regulations of the Medical Staff, the Hospital and Legacy;

(c) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and general attitude toward patients, the Hospital and its personnel;
(d) use of the Hospital’s facilities for patients, taking into consideration the individual’s comparative utilization patterns;

(e) current information regarding the applicant’s ability to exercise the scope of practice requested and to perform the duties and responsibilities of such;

(f) capacity to satisfactorily treat patients as indicated by the results of the Hospital’s quality improvement activities or other reasonable indicators of continuing qualifications;

(g) satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation agencies;

(h) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

(i) current licensures, including currently pending challenges to any license or registration;

(j) voluntary or involuntary termination of authorization to practice or voluntary or involuntary limitation, reduction, or loss of authorization to practice at another hospital;

(k) relevant findings from the Hospital’s quality improvement activities; and

(l) other reasonable indicators of continuing qualifications.

3.A.4. Section or Department Chair Procedure:

(a) Prior to the end of the current authorization to practice period, the Medical Staff Office shall send to the chair of each service a current list of all AHP’s in that service, who are needing to be recredentialed, together with a description of the scope of practice each has been previously approved for, accompanied by copies of their applications.

(b) No later than thirty (30) days after receipt of the applications, the Section or Department Chair shall provide the Credentials Committee or the Chairperson of the Credentials Committee, depending upon whether questions are raised, a written report concerning each individual seeking reauthorization to practice. The chair shall include in each written report, when applicable, the reasons for any changes recommended in scope of practice, or for non-approval of reauthorization to practice. The chair of the service concerned shall be available to the Credentials Committee or the Chairperson of the Credentials Committee to answer any questions that may be raised with respect to any such report.
3.A.5. Processing Applications when no Questions are Raised and All Information is Appropriate and in Order:

(a) applications which are deemed complete from individuals seeking reappointment and renewal of clinical privileges 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) since the time of last appointment/reappointment review, the appointee has a current challenge to licensure or registration;
(2) since the time of last appointment/reappointment review, the 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 appointee; and
(3) the appointee has had involuntary limitation, reduction, denial or loss of clinical privileges or involuntary termination of membership at another organization.

(b) If the Chairperson of the Credentials Committee has any questions about the applicant’s qualifications or current clinical competence, the Chairperson shall refer the matter to the entire Credentials Committee and the routine credentialing process as set forth below shall be followed.

(c) The Medical Executive Committee shall review the recommendation made by the Chairperson of the Credentials Committee. If the Medical Executive Committee concurs with the favorable recommendation, the recommendation shall be forwarded to the committee of the Legacy Board 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 action.

(d) The committee of the Legacy Board reviews and evaluates the qualifications and competence of the applicant and renders it’s decision. If it concurs with the favorable recommendation, the authorization to practice and scope of practice requested are granted. If the committee of the Legacy Board’s decision is adverse to the applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

(e) A report regarding all applicants who are granted an authorization to practice shall be forwarded to the Legacy Board. The Legacy Board shall consider, and if appropriate, ratify all positive committee decisions at its next regularly scheduled meeting. A report shall also be sent to the Credentials Committee for its information.

3.A.6. Credentials Committee Procedure:
(a) Except as expressly provided in Section 3.A.5, all other applications for reauthorization to practice shall be processed as set forth in Sections 3.A.6 - 3.A.8.

(b) The Credentials Committee, after receiving the reports from each Section or Department Chair, shall review all pertinent information available, including all information provided from other committees and from hospital management, for the purpose of determining its recommendations for staff reauthorization to practice or for change in same for the ensuing authorization to practice period.

(c) The Credentials Committee shall have the right to require the AHP to meet with the committee to discuss any aspect of the individual’s recredentialing application or qualifications.

(d) The Credentials Committee may use the expertise of the Section or Department Chair, or any member of the service, or an outside consultant, if additional information is required regarding the AHP’s qualifications for reauthorization to practice.

(e) If, after considering the report of the clinical Section or Department Chair concerned, the Credentials Committee’s recommendation is favorable, it shall recommend reauthorization to practice and the specific scope of practice or job description to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.
3.A.7. Medical Executive Committee Procedure:

(a) The Credentials Committee shall forward its written findings and recommendations to the Medical Executive Committee in time for the Medical Executive Committee to consider the individual’s request for reauthorization to practice at its regularly scheduled meeting before the expiration of the applicant’s authorization to practice period. The completed application and all supporting documentation shall accompany the Credentials Committee’s findings and recommendation. Where non-reauthorization to practice or a change in scope of practice is recommended, the reason for such recommendation shall be stated. The Chair of the Credentials Committee shall be available to the Medical Executive Committee (or to the Legacy Board) to answer any questions that may be raised with respect to the recommendation.

(b) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee;
(2) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee’s recommendation.

(c) If the recommendation of the Medical Executive Committee is favorable, it shall transmit its recommendations through the Legacy CEO to the Legacy Board, including the findings and recommendations of the Credentials Committee. All recommendations for reauthorization to practice must also specifically recommend the scope of practice to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such.

(d) Any recommendation by the Medical Executive Committee that would entitle the affected individual to the due process rights provided in this policy shall be held until after the individual has exercised the due process rights, after which time the recommendation of the Medical Executive Committee, together with all supporting documentation shall be forwarded to the Legacy Board. The Chair of the Medical Executive Committee shall be available to the Legacy Board to answer any questions that may be raised with respect to the recommendation.

(e) In the event the Legacy Board determines to consider modification of the action of the Medical Executive Committee and such modification would entitle the individual to due process in accordance with this policy, it shall notify the affected individual, through the Legacy CEO, and shall take no final action until
the individual has exercised or has waived the due process rights provided in this policy.

3.A.8. Meeting with Affected Individual:

If, during the processing of an individual’s reauthorization to practice, it becomes apparent to the Credentials Committee or its Chair that the committee is considering a recommendation that would deny reauthorization to practice, the Chair of the Credentials Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it; however, 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 this policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the committee shall indicate as part of its report to the Medical Executive Committee and the Legacy Board whether such a meeting occurred, and shall include a summary of the meeting.

3.B: PROCEDURES FOR REQUESTING INCREASE IN SCOPE OF PRACTICE

3.B.1. Application for Additional Scope of Practice:

(a) Whenever, during the term of authorization to practice, additional scope of practice is desired, the AHP requesting the increase shall apply in writing to the Medical Staff Office. The application shall state in detail the specific additional functions desired and the AHP’s relevant recent training and experience which justify the addition. If the applicant meets the relevant threshold criteria for the change in question, this application shall be transmitted by the Medical Staff Office to the appropriate Section or Department Chair. Thereafter, it shall be processed in the same manner as an application for initial scope of practice.

(b) Whenever an AHP requests authorization to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the process set forth in Section 2.D.5 of this policy shall be followed.

3.B.2. Factors to be Considered:

(a) Recommendations for additional scope of practice shall be based upon:
   (1) relevant recent training;
   (2) observation of patient care provided;
   (3) review of the records of patients treated in this or other hospitals;
   (4) results of the Hospital’s quality improvement activities;
   (5) applicant’s ability to meet the qualifications and criteria for the requested change; and
(6) other reasonable indicators of the individual’s continuing qualifications for practice in question.

(b) The recommendation for such increased scope of practice may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

3.C PROCEDURE FOR QUESTIONS INVOLVING AHP’s

3.C.1 Automatic termination:

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

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

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

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

(a) Whenever a concern or question has been raised regarding:

(1) the clinical competence or clinical practice of any AHP;

(2) the care or treatment of a patient or patients or management of a case by any AHP;

(3) the known or suspected violation by any AHP of applicable ethical standards or the bylaws, policies, rules or regulations of the Hospital, Legacy or the Medical Staff, including, but not limited to the Hospital’s quality improvement, risk management, and utilization review programs; and/or

(4) behavior or conduct on the part of any AHP that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the AHP to work harmoniously with others; the President of the Medical Staff, Section or Department Chair, Chairperson of the Credentials Committee, or Legacy CEO shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible, after which it shall be submitted in writing to the Medical Executive Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Hospital and the AHP concerned, they may, but are not required to, discuss the matter with the affected AHP.

3.C.3 Procedure Thereafter:

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

3.D: OTHER ACTIONS

3.D.1. Failure to Complete Medical Records:

Authorization to practice by any AHP shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after notification by the medical records department of such delinquency. Such relinquishment shall continue until all the records are no longer delinquent and the AHP’s authorization to practice has been formally reinstated by the Legacy CEO. Failure to complete the medical records that caused relinquishment within sixty (60) days from the relinquishment shall constitute an automatic relinquishment of authorization to practice.


Action by the appropriate state licensing board or agency revoking or suspending an individual’s professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of authorization of practice as of that date, until the matter is resolved, and an application for reinstatement has been approved by the Credentials Committee and the Legacy Board. In the event the individual’s license is only partially restricted, the scope of practice that would be affected by the license restriction shall be similarly restricted.

3.D.3. Failure to be Adequately Insured:

If at any time an AHP’s professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the AHP’s authorization to practice shall be automatically relinquished or restricted as applicable as of that date until the matter is resolved, adequate professional liability insurance coverage is restored and the AHP has been formally reinstated by the Legacy CEO or designee.

3.D.4. Failure to Provide Requested Information:

If at any time an AHP fails to provide required information pursuant to a formal request by the Credentials Committee, the Medical Executive Committee, or the Legacy CEO,
the AHP’s authorization to practice shall be automatically relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section “required information” shall refer to (1) physical or mental examinations as specified elsewhere in this policy; (2) information necessary to explain an investigation, professional review action, or resignation from another facility or agency; or (3) information pertaining to professional liability actions involving the AHP.

3.D.5. Criminal Activity:

Any AHP who has been convicted of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, or Medicare, Medicaid, or insurance fraud or abuse, or any AHP who pleads guilty or nolo contendere to charges pertaining to the same, shall automatically relinquish his or her authorization to practice.


Any AHP whose participation in the Medicare or Medicaid programs is terminated by either or both of those programs, or who is otherwise excluded or precluded from participation in either or both of those programs, shall automatically relinquish all authorization to practice as of the effective date of the termination, exclusion, or preclusion. If the AHP’s participation in those programs is not fully reinstated by the expiration of the AHP’s then current reauthorization to practice term, the AHP will be deemed to have resigned at that time. It shall be the duty of all AHPs to promptly inform the Hospital of any action taken by either such program in this regard.

3.D.7. Procedure for Leave of Absence:

(a) AHP’s may, for good cause, be granted leaves of absence by the Legacy Board, for a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of authorization to practice, unless an exception is made by the Legacy Board upon recommendation of the Medical Executive Committee.

(b) Requests for leaves of absence shall be made to the President of the Medical Staff, and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff shall transmit the request together with a recommendation to the Legacy CEO for action by the Legacy Board.

(c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement at least 30 days prior to intended return with the Legacy CEO summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Hospital at that time. All this information shall be considered by the Credentials Committee and the Medical Executive Committee in arriving at a recommendation regarding reinstatement.
(d) If the leave of absence was for medical reasons, then the AHP must submit a report from his or her attending physician indicating that the AHP is physically and/or mentally capable of resuming a hospital practice and exercising the scope of practice requested. The AHP shall also provide such other information as may be requested by the Hospital at that time. After considering all relevant information, the Hospital, the Credentials Committee and the Medical Executive Committee shall then make a recommendation to the Legacy Board for final action.

(e) In acting upon the request for reinstatement, the Legacy Board may approve, may limit, or modify the scope of practice to be extended to the individual upon reinstatement.

ARTICLE 4
REMOVAL AND HEARING PROCEDURES

4.A. REMOVAL PROCEDURES:
The Hospital retains the right either through the Legacy CEO or his designee, or upon recommendation of the Medical Executive Committee, Section or Department Chair or Credentials Committee Chairman to suspend or terminate any or all of the scope of practice of an AHP. Allied health professionals are not entitled to any of the due process, hearings or appeal rights set forth in the Medical Staff Bylaws or Credentials Policy.

4.B. HEARING RIGHTS:

(a) When an Independent AHP who is also a Legacy employee is to be or has been terminated or scope or practice is or has been substantially curtailed, such termination or curtailment shall fall under the established policies, including any appeal rights, of the then current Legacy Health Human Resources Policies and Procedures.

(b) When any other AHP covered under this policy is to be terminated or scope of practice is to be or has been substantially curtailed, the supervising physician(s) and the Dependent AHP shall be notified in writing by the Legacy CEO or designee of the reasons for such action and, if the supervising physician so requests within thirty (30) days of receipt of notification, the Dependent AHP shall be entitled to have such action reviewed by the Medical Executive Committee, excluding such members who are in direct economic competition with the Dependent AHP. At any such meeting, the Dependent AHP and the supervising physician(s) shall be allowed to be present and fully participate but may not be present during final deliberation and vote by the MEC. The Medical Executive Committee can recommend to accept, reject or modify the decision to terminate or curtail, subject to review and final decision by the governing body.
4.C **APPEAL RIGHTS:***

(a) Independent AHPs who are also Legacy employees: Appeal rights shall fall under the established policies of the then current Legacy Health Human Resources Policies and Procedures.

(b) All other AHPs covered under this policy: Prior to action by the governing body, the decision of the MEC will be communicated in writing to the Supervising Physician and the Dependent AHP, and the Supervising Physician will be allowed 30 days to appeal the MEC’s decision in writing. If no written appeal is received within that time frame, the MEC’s recommendation will be forwarded to the governing body for final action.

**ARTICLE 5**

**AMENDMENTS**

(a) This policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee.

(b) In limited circumstances outlined below, this policy may also be amended by the Legacy Board on its own motion provided that any such amendment is first submitted to the Credentials Committee and the Medical Executive Committee for review and comment at least thirty (30) days prior to any final action by the Legacy Board on such amendment. Instances where such action by the Legacy Board shall be warranted shall be limited to the following:

1. action to comply with changes in federal and state laws that affect the Hospital and the Hospital corporation, including any of its entities;
2. action to comply with requirements imposed by the Hospital’s general and professional liability or Director’s and Officer’s insurance carrier; and
3. action to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.
ARTICLE 6
ADOPTION

This policy is adopted and made effective upon approval of the Legacy Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations or hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:
/s/Leslie Root, MD, PhD Date: 9/13/10
President of the Legacy Good Samaritan Hospital and Medical Center Medical Staff

Approved by the Legacy Health Board:
/s/ Jeffrey Fullman., M.D. Date: 9/16/10

Revised by the Medical Staff:
James Borden, MD Date: 4/3/13
President of the Legacy Good Samaritan Hospital and Medical Center Medical Staff

Revised by the Legacy Health Board:
/s/ Jeffrey Fullman., M.D. Date: 4/18/13