MEDICAL STAFF

PRACTITIONER CODE OF CONDUCT

Monongalia County General Hospital Company
Mon Health Marion Neighborhood Hospital
Preston Memorial Hospital Corporation
Stonewall Jackson Memorial Hospital Company

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TABLE OF CONTENTS

PAGE

PAGE

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1. POLICY STATEMENT

1.A *Policy Objectives.*

(1) This Policy outlines progressive steps, beginning with collegial and educational efforts, which can be used by Mon Health System Hospitals ("the Hospital") and its Medical Staff Leaders to address conduct that does not meet expected standards. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve the concerns that have been raised in a constructive manner, and thus avoid the necessity of proceeding through the disciplinary process outlined in the Medical Staff Credentials Policy.

(2) This Policy is not intended to interfere with a Practitioner's ability to express, in a professional manner and in an appropriate forum:

(a) opinions on any topic that are contrary to opinions held by other Practitioners, Medical Staff Leaders, or Hospital personnel;

(b) disagreement with any Practitioner or Medical Staff Bylaws, policies, procedures, proposals, or decisions; or

(c) constructive criticism of the care provided by any Practitioner, nurse, or other Hospital personnel.

1.B *Scope of Policy.*

(1) This Policy applies to all Practitioners (as defined in Section 1.D) who provide patient care services at the Hospital.

(2) If the Practitioner involved is also employed by: (i) the Hospital; (ii) an entity that has the same corporate parent as the Hospital; or
(ii) an entity owned by the Hospital (the "employing entity"), Medical Staff Leaders may consult with appropriate representatives of the employing entity and then determine which of the following two processes will be used for the review:

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, a representative of the employing entity may be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any

interventions that may be necessary following the review. Documentation from the Medical Staff process will not be disclosed to the employing entity for inclusion in the employment file, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities in accordance with Hospital's policies related to information sharing; or

(b) If the matter will be reviewed by the employing entity pursuant to its policies:

(i) the Medical Staff process shall be held in abeyance and the Medical Staff Leadership Council notified;

(ii) human resources personnel will be primarily responsible for witness interviews, document review, data compilation, and similar fact-finding, though other members of the MSO Support Staff may assist as needed. Documentation of such fact-finding will be maintained in the Practitioner's human resources file, but will be disclosed to the MSO Support Staff if a decision is made to also review the matter under this Policy, as set forth below;

(iii) the Medical Staff Leadership Council will be kept informed of the progress and outcome of the review by the employing entity; and

(iv) the Medical Staff Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. In such case, human resources will provide a copy of documentation created pursuant to this section to the MSO Support Staff for use in the review under this Policy. Neither such a review by the Medical Staff Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the employing entity to take any action authorized by the employment contract with the Practitioner.

(3) All efforts undertaken pursuant to this Policy are part of the Hospital's performance improvement and professional practice evaluation/peer review activities.

(4) A flow chart depicting the review process for concerns regarding professional conduct pursuant to this Policy is attached as **Appendix A**.

1.C ***Expectations for Professional Conduct/Culture of Safety.***

Professional conduct is defined as the Hospital's core values in action. Respect, collegiality, collaboration and integrity are essential for the provision of safe and competent patient care. As such, all Practitioners must treat others with courtesy, compassion and dignity, and conduct themselves in a professional and cooperative manner.

In dealing with incidents of inappropriate conduct, the following are paramount considerations:

(1) the protection of patients, employees, Practitioners, and others and the orderly operation of the Medical Staff and Hospital;

(2) compliance with the law and providing an environment free from harassment and other forms of discrimination; and

(3) assisting Practitioners in resolving conduct issues in a constructive, educational, and successful manner.

1.D ***Definitions.***

(1) HEALTH SYSTEM means the Monongalia Health System, Inc. and its related Hospitals and affiliated entities.

(2) HOSPITAL means any of the following System Hospitals; Monongalia County General Hospital Company, Mon Health Marion Neighborhood Hospital, Preston Memorial Hospital Corporation, or Stonewall Jackson Memorial Hospital Company, including all their departments/ambulatory care settings.

(3) MEDICAL STAFF LEADERSHIP COUNCIL means the committee focused on addressing Medical Staff practitioner health and code of conduct issues.

(a.) The Council is comprised of the following voting members:

(1.) Chief of Staff, who will serve as Chair
(2.) Vice Chief of Staff
(3.) Secretary-Treasurer

(b.) The following individuals will serve as ex officio members, without vote, to facilitate the Medical Staff Leadership Council's activities:

(1.) VPMA or CAMD
(2.) CAO
(3.) System CMO
(4.) Medical Staff Office Representatives

(4) MEDICAL STAFF LEADER means any Medical Staff Officer, CMO, VPMA, CAMD, department chief, section chief, and committee chair.

(5) PRACTITIONER means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Providers.

(6) MSO SUPPORT STAFF means the Medical Staff Office staff who support the professional practice evaluation ("PPE") process generally and the reviews described in this Policy. This may include, but is not limited to, staff from the Medical Staff Office, human resources, quality department (e.g., clinical quality representatives), and/or the compliance/risk department.

2. EXAMPLES OF INAPPROPRIATE CONDUCT.

To aid in both the education of Practitioners and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

(a) abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

(b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

(c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

(d) intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

(e) offensive language (which may include profanity or similar language) while in the Hospital and/or while speaking with patients, nurses, or other Hospital personnel;

(f) retaliating against any individual who may have reported a quality and/or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

(g) inappropriate physical contact with another individual or other aggressive behavior that is threatening or intimidating;

(h) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

(i) repeatedly failing to renew legally required credentials prior to expiration;

(j) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or Hospital administrative channels;

(k) inappropriate medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;

(l) imposing idiosyncratic requirements on Hospital staff that have no impact on improved patient care, but serve only to burden the Hospital or Hospital employees with "special" techniques and procedures;

(m) falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(n) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(o) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(p) inappropriate access, use, disclosure, or release of confidential patient information;

(q) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(r) use of social media in a manner that involves inappropriate conduct as defined in this Policy or other Medical Staff or Hospital policies;

(s) disruption of hospital operations, Hospital or Medical Staff committees, or departmental affairs;

(t) inappropriately treating self or immediate family members as outlined in Medical Staff policies, Rules and Regulations;

(u) disregard of or refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees); and/or

(v) engaging in identity-based harassment as described in Section 8 of this Policy.

3. GENERAL GUIDELINES/PRINCIPLES

3.A *Immediate Referrals to Medical Executive Committee.*

This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about inappropriate conduct by Practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

3.B *Potentially Criminal Conduct.*

Anyone who observes or receives a credible report about a Practitioner's conduct that may be criminal in nature (e.g., misappropriation of drugs, assault, abuse of patient) shall report it directly through one's supervisor or chair to the Chief Administrative Officer, Chief Nursing Executive or Chief Medical Officer. The individual receiving the report will work with the Chief Administrative Officer and Hospital counsel to ascertain whether the conduct should be reported as criminal in nature. If so, appropriate law enforcement personnel will be notified in addition to pursuing the further steps in this Policy or other applicable policies.

3.C *Matter Involving Both Clinical and Behavioral Concerns.*

If a matter involves both clinical and behavioral concerns, the Chairs of the Medical Staff Leadership Council and the Hospital's Peer Review Committee or Professional Practice Evaluation Committee (PPEC) shall coordinate the reviews. The behavioral concerns may either be addressed by the Medical Staff Leadership Council pursuant to this Policy, with a report to the Peer Review Committee or PPEC or may be addressed by the Peer Review Committee or PPEC as part of its review under the appropriate Medical Staff Policy, using the provisions in this Policy for guidance.

3.D ***Coordination with Other Policies that Govern Professional Conduct.***

(1) If a report of inappropriate behavior involves an issue that is also governed by another Hospital policy that governs professional conduct (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a Practitioner), the Chief of Staff or Chief Medical Officer will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in this Policy or may discuss the matter with the Medical Staff Leadership Council or its representatives. Regardless of such efforts to coordinate reviews, this Policy shall not be interpreted as giving the Medical Staff Leadership Council or any other Medical Staff committee the authority to make determinations that are the responsibility of Hospital personnel or committees (including, but not limited to, the HIPAA Privacy Officer or the Corporate Compliance Officer.)

(2) Individuals responsible for other policies that govern professional conduct (such as the HIPAA Privacy Officer or Corporate Compliance Officer) shall use their discretion in deciding when the results of an audit or review of a complaint indicate that a Practitioner's conduct should be reported to the MSO Support Staff and evaluated pursuant to this Policy. For example, such individuals may decide that a disclosure of patient information that is inadvertent, minor, and isolated need not be reported to the MSO Support Staff. Such individuals should consult with the Chief of Staff, CMO, VPMA or CAMD if there is any question about whether a matter should be reported and reviewed pursuant to this Policy.

3.E ***No Legal Counsel or Recordings During Collegial Meetings.***

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) Practitioners may not create an audio or video recording of a meeting, nor may they broadcast it in any manner (e.g., via live streaming). If a recording is made in violation of this rule, the recording shall be destroyed. In their

discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

3.F ***Education Regarding Appropriate Professional Behavior.***

Medical Staff and Hospital leaders shall educate all Practitioners regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of inappropriate conduct.

3.G ***Delegation of Functions.***

(1) The Medical Staff Leadership Council is responsible for the professionalism/quality assurance process described in this Policy, subject to the oversight of the Medical Executive Committee and Board. To promote a prompt and effective review process, the Medical Staff Leadership Council hereby expressly delegates to the MSO Support Staff, Medical Staff Leaders, CMO and the CAMD or VPMA the authority to perform the functions described in this Policy on behalf of the Medical Staff Leadership Council. Actions taken by these individuals will be reported to and reviewed by the Medical Staff Leadership Council as set forth in this Policy.

(2) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(3) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

3.H ***Substantial Compliance.*** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

3.I ***Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions.***

(1) At any point in the review process described in this Policy, the Medical Staff Leadership Council or its representatives may ask a Practitioner to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner may also agree upon practice conditions that will protect the Practitioner, patients, and staff during the review process. Prior to any such action, the Practitioner shall be given the opportunity to discuss these issues with the Medical Staff Leadership Council or its representatives and provide written input regarding them.

(2) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

(3) In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

3.J ***Supervising Physicians and Advanced Practice Providers.*** A physician who is the primary supervising physician for an Advanced Practice Provider shall be kept apprised of any applicable concerns with the Advanced Practice Provider that are reviewed pursuant to this Policy. With the exception of cases of sexual harassment, the supervising physician will be copied on all correspondence that an Advanced Practice Provider is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising physician shall maintain in a confidential manner all information related to reviews under this Policy.

4. REPORTING OF INAPPROPRIATE CONDUCT AND INITIAL REVIEW

4.A ***Reports of Inappropriate Conduct.***

Any Hospital employee or Practitioner who observes, or is subjected to, inappropriate conduct by a Practitioner shall report the incident in a timely manner through the safety reporting system or any other Hospital reporting mechanism. Regardless of how concerns about a Practitioner's behavior are reported, they will be routed to the Medical Staff Office, which shall log the concern into the

confidential peer review database (a form that may be used to document this report is attached as **Appendix B**).

4.B ***Follow-up with Individual Who Filed Report.***

The MSO Support Staff, VPMA or the CAMD shall follow up with individuals who file a report by:

(1) thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;
(2) informing them that the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(3) informing them that no retaliation is permitted against any individual who raises a concern and to report any retaliation or any other incidents of inappropriate conduct; and

(4) informing them that, due to confidentiality requirements under state law, no further information can be provided regarding the outcome of the review.

As an alternative to sending a letter, the content of the letter may be used as talking points to discuss verbally with the individual who reported a concern regarding conduct (an example letter that may be used is attached as **Appendix C**).

4.C ***Initial Triage.***

The Chief of Staff and VPMA or CAMD will review the circumstances as reported and determine to proceed in one of the following two ways:

(1) ***Conduct additional fact-finding*** to determine if further action is necessary. In such case, the Chief of Staff and VPMA or CAMD will follow the steps set forth in Section 4.D of this Policy. Any allegation of sexual harassment or other identity-based harassment (as defined in Section 8 of this Policy) will result in additional fact-finding; or

(2) ***Resolve informally and promptly*** because the allegations as reported, even if true, do not rise to the level that further review under this Policy is necessary because: (1) the concern is minor in nature; and (2) there is no history or pattern with the Practitioner in question.

For matters that qualify for informal resolution, the Chief of Staff, VPMA or CAMD may speak with the Practitioner about the concern and will either dismiss the matter altogether (if the concern does not appear credible based on the Practitioner's input) or counsel the Practitioner verbally. If the Practitioner is counseled, the Chief of Staff, VPMA or CAMD will follow up with a brief note to the Practitioner memorializing the conversation. The

Chief of Staff , VPMA or CAMD will notify the MSO Support Staff that a minor concern has been resolved in this manner.

4.D. Employed Practitioner Triage.

(1) If a reported concern about behavior: (i) is not resolved informally as set forth in Section 4.C(2); and (ii) involves an Employed Practitioner, then Medical Staff Leaders will consult with appropriate representatives of the Employer (as defined below) and then determine which of the two processes described in this Section will be used for the review (a form that may be used to document this decision is attached as **Appendix D**).

(2) The reported concern may be reviewed under either the Medical Staff process or the Employer's process, as follows:

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, an appropriate representative of the Employer (as defined below) may be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. The Medical Staff Leadership Council may recuse the representative of the Employer during any deliberations or vote on a matter. Documentation from the Medical Staff process will not be disclosed to the Employer for inclusion in the employment file, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities; or

(b) If the matter will be reviewed by the Employer pursuant to its policies and/or the relevant contract:

(i) the Medical Staff process shall be held in abeyance and the Medical Staff Leadership Council notified;

(ii) the MSO Support Staff will assist the Employer with witness interviews, document review, data compilation, and similar factfinding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Medical Staff peer review file consistent with the state peer review statute, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

(iii) the Medical Staff Leadership Council will be kept informed of the progress and outcome of the review by the Employer; and

(iv) the Medical Staff Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. However, neither such a review by the Medical Staff Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the Employer to take any action authorized by the relevant contract with the Practitioner.

(3) For purposes of this Section, an "appropriate representative of the Employer" includes individuals with employment responsibilities (if Mon Health System or the Hospital is the Employer), or a peer review committee within the Employer (if the Employer is a Hospital-related entity or a qualifying private group).

4.E ***Preliminary Notification and Additional Fact-Finding to Determine Credibility.***

The steps set forth below apply to all reported concerns about behavior that are not resolved informally as set forth in Section 4.C(2):

(1) ***Preliminary Notification.*** The Chief of Staff, VPMA or CAMD should notify the Practitioner that a concern has been raised and the matter is being reviewed. Generally, this preliminary communication should occur via a telephone call or a personal discussion as soon as practical. The Practitioner should be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident are determined to be credible, but that he or she is also free to submit input at any time. The Practitioner should also be reminded to avoid any action that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner believes may have raised the concern or provided information about it). Instructions for preliminary notification to the practitioner is attached as **Appendix E**. Example letters that may be used to communicate with the practitioner is attached as **Appendix F and Appendix G.**

(2) ***Fact-Finding to Determine Credibility.*** The MSO Support Staff (including one or more representatives from human resources), the VPMA, CAMD and/or Chief of Staff shall interview witnesses or others who were involved in the incident and gather any other necessary documentation or information (e.g., interviews with core leaders or nurse/area leaders) needed to assess the credibility of the report.

(a) ***No Further Review Required.*** The VPMA or CAMD and Chief of Staff may determine that no further review is required. In such case, the matter shall be closed, and the Practitioner will be notified of this determination. The individual who filed the report may be notified that the report was not substantiated, at the discretion of the

Medical Staff Leadership Council. Intentionally false reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Medical Staff Leadership Council, while false reports by Hospital employees will be referred to human resources.

(b) ***Further Review Required.*** The VPMA or CAMD and Chief of Staff may determine that the matter should be reviewed further in accordance with this Policy. In such case, input will be obtained from the Practitioner as set forth in Section 5. The MSO Support Staff shall then prepare a summary report of the matter for review by the Medical Staff Leadership Council.

The Medical Staff Leadership Council will be notified of determinations made pursuant to this subsection, to allow it to conduct oversight and monitor the process for consistency.

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.***

For reports that require further review under this Policy, the Chief of Staff, CMO, CAMD, VPMA and/or MSO Support Staff will provide details of the concern to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident.

5.B ***Identity of Reporter.***

The specific identity of the individual reporting the inappropriate conduct or otherwise providing information about a matter will not be disclosed to the Practitioner unless:

(1) the individual specifically consents to the disclosure;

(2) the Medical Staff Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review (in these instances, the individual in question will be given prior notice that the disclosure will be made and informed that no retaliation will be permitted against the individual); or

(3) information provided by the individual is used to support an adverse professional review action that results in a Medical Staff hearing.

5.C ***Confidentiality.***

The Practitioner must maintain all information related to the review in a strictly confidential manner, as required by West Virginia law. The Practitioner may not

disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the written permission of the Medical Staff Leadership Council, except for any legal counsel who may be advising the Practitioner.

5.D ***Retaliation.***

The Practitioner may not retaliate against anyone who he or she believes may have raised a concern, provided information regarding the matter, or otherwise been involved in the review process. This means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual. If a Practitioner wishes to offer an apology to any individual, the Practitioner must contact the Medical Staff Leadership Council and comply with its requirements regarding the manner in which the apology is provided.

5.E ***Reminder of Practitioner's Obligations.***

The MSO Support Staff, VPMA, CAMD or Chief of Staff should remind the Practitioner of the obligations set forth in this section as part of seeking his or her input. The Practitioner may also be asked to sign a Confidentiality and Non-Retaliation Agreement if there are particular concerns about maintaining confidentiality or ensuring a professional, non-threatening environment for the individuals involved in a specific situation.

6. MEDICAL STAFF LEADERSHIP COUNCIL PROCEDURE

6.A ***Participants in Review.***

The Medical Staff Leadership Council shall invite the Chief Compliance Officer and the Chief Human Resources Officer to participate in reviews in a non-voting capacity. If the Medical Staff Leadership Council determines it would be necessary or helpful in addressing the reported concern, it may also consult with or include the appropriate department chief in the review or may appoint an ad hoc committee to review the incident and report back to it. All such individuals are an integral part of the review process and are bound by the same requirements of confidentiality and compliance with applicable policies as the standing members of the Medical Staff Leadership Council.

6.B ***Initial Review.***

The Medical Staff Leadership Council shall review the summary prepared by the MSO Support Staff and all supporting documentation, including the response from the Practitioner. If necessary, the Medical Staff Leadership Council may also meet with the individual who submitted the report and/or any witnesses to the incident.

6.C ***Meeting Between Practitioner and Medical Staff Leadership Council.***

A meeting may be held between the Practitioner and the Medical Staff Leadership Council to discuss the circumstances further if either the Medical Staff Leadership Council or the Practitioner believes that such a meeting would be helpful prior to the Medical Staff Leadership Council concluding its review and making a determination. The Medical Staff Leadership Council may also obtain additional written input from the Practitioner using the process set forth in Article 5. An interview tool is attached as **Appendix H**.

6.D ***Medical Staff Leadership Council's Determination and/or Intervention.***

Based on all of the information received, the Medical Staff Leadership Council may:

(1) determine that no further review or action is required;

(2) send the Practitioner a letter of guidance or counsel about the conduct;

(3) engage in face-to-face collegial intervention, education, and coaching efforts with the Practitioner, including, when appropriate, education about administrative channels that are available for registering concerns about quality or services, if the Practitioner's conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the Practitioner, if appropriate;

(4) develop a Performance Improvement Plan for Conduct, as described in Section 6.E below; or

(5) refer the matter to the Medical Executive Committee.

The Medical Staff Leadership Council shall also inform the relevant department chief of its determination and intervention.

6.E ***Performance Improvement Plan for Conduct.***

A Performance Improvement Plan for Conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner to a hearing or appeal as described in the Medical Staff Credentials Policy, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank.

(1) ***Meeting with Designated Group.*** The Practitioner may be required to meet with a designated group (including the Peer Review Committee, another Medical Staff committee, or an ad hoc group) to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff

Leaders, Hospital leaders, outside consultants, and/or the Board Chair or other Board members if the Medical Staff Leadership Council determines that Board member involvement is reasonably likely to impress upon the Practitioner involved the seriousness of the matter and the necessity for the Practitioner's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner after the meeting;

(2) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Practitioner may be required to meet periodically with one or more Medical Staff Leaders, or a mentor designated by the Medical Staff Leadership Council. The purpose of these meetings is to provide input and updates on the Practitioner's performance, as well as to offer assistance and support with any challenging issues the Practitioner may be encountering;

(3) ***Letter of Warning or Reprimand.*** The Medical Staff Leadership Council may send the Practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing;

(4) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Medical Staff Leadership Council may require the Practitioner to review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the Medical Staff Leadership Council summarizing the information reviewed and how it can be applied to the individual's practice;

(5) ***Behavior Modification Course.*** The Medical Staff Leadership Council may require the Practitioner to complete a behavior modification course that is acceptable to the Medical Staff Leadership Council; and/or

(6) ***Personal Code of Conduct.*** The Medical Staff Leadership Council may develop a "personal" code of conduct for the Practitioner, make continued appointment and clinical privileges contingent on the Practitioner's adherence to it and outline the specific consequences of the Practitioner's failure to abide by it.

6.F ***Failure of the Practitioner to Provide Requested Input or Attend Meeting.***

(1) ***Automatic Relinquishment for Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to provide written input or attend a meeting when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, but only if all of the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, the Chief of Staff, VPMA, CAMD, or the Medical Staff Leadership Council;

(b) the written request gives the Practitioner a reasonable amount of time (generally five days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

(2) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(3) ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

6.G ***Letters Placed in Practitioner's Confidential File.***

Copies of letters sent to the Practitioner as part of the efforts to address the Practitioner's conduct shall be placed in the Practitioner's confidential file. The Practitioner shall be given an opportunity to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

6.H ***Additional Reports of Inappropriate Conduct.***

If additional reports of inappropriate conduct are received concerning a Practitioner, the Medical Staff Leadership Council may continue to use the collegial and progressive steps outlined in this Section 6 as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

6.I ***Determination to Address Concerns through Practitioner Health Policy.***

The Medical Staff Leadership Council may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns, and the review process outlined in the Practitioner Health Policy is more likely to resolve the concerns.

7. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

7.A ***Referral to the Medical Executive Committee.***

At any point, the Medical Staff Leadership Council may refer the matter to the Medical Executive Committee for review and action because:

(1) the Practitioner refuses to participate in a Performance Improvement Plan developed by the Medical Staff Leadership Council;

(2) the Performance Improvement Plan options for conduct were unsuccessful; or

(3) the Medical Staff Leadership Council otherwise determines that Medical Executive Committee review is required.

The Medical Executive Committee shall be fully apprised of the actions taken previously by the Medical Staff Leadership Council to address the concerns. When it makes such a referral, the Medical Staff Leadership Council may also suggest a recommended course of action.

7.B ***Medical Executive Committee Review.***

The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Credentials Policy.

8. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

8.A ***Definition.***

(1) Identity-based harassment is verbal or physical conduct that: (i) is unwelcome and offensive to an individual who is subjected to it or who witnesses it; (ii) could be considered harassment from the objective standpoint of a "reasonable person"; and (iii) is covered by state or federal laws governing discrimination. Identity-based harassment includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination. Depending on the circumstances, any of the examples of inappropriate conduct described in Section 2 of this Policy may also qualify as identity-based harassment. Additional examples of identity-based harassment include, but are not limited to, the following:

(a) ***Verbal:*** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

(b) ***Visual/Non-Verbal:*** derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures;

(c) ***Physical:*** unwanted physical contact, including touching, interference with an individual's normal work movement, and assault; and

(d) ***Other:*** retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

(2) Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are not dispositive in determining whether conduct is identity-based harassment for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Medical Staff Leadership Council, Medical Executive Committee, and/or Board of Directors. The intent of this provision is to create higher expectations for professional behavior by Practitioners than the minimum required by federal or state law.

8.B ***General.***

All reports of potential identity-based harassment will be reviewed by the Medical Staff Leadership Council in the same manner as set forth above. However, because of the unique legal implications surrounding identity-based harassment, a single confirmed incident requires the actions set forth below.

Two or more members of the Medical Staff Leadership Council shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a formal letter of admonition and warning to be placed in the Practitioner's confidential file. This letter shall also set forth any additional actions or conditions imposed on the Practitioner's continued practice in the Hospital as a result of the meeting.

8.C ***Performance Improvement Plan.*** In addition to the letter of admonition and warning, concerns about identity-based harassment may also be addressed by a Performance Improvement Plan for conduct as described in this Policy (an example plan that may be used is attached as **Appendix I**) .

8.D ***Referral to Medical Executive Committee.***

The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such

conduct;

(2) there are confirmed reports of retaliation or further incidents of identity-based harassment, after the Practitioner agreed there would be no further such conduct; or

(3) the Medical Staff Leadership Council otherwise determines that Medical Executive Committee review is appropriate under the circumstances.

The Medical Executive Committee shall conduct its review in accordance with the Medical Staff Bylaws. Such referral shall not preclude other action under applicable Human Resources policies.

Appendix A: Review Process for Concerns Regarding Professional Conduct

Reported concern regarding professional conduct (see Note 1)

Log-in, Follow-Up, and Initial Triage

PPE Specialists:

1. Log in referral to peer review database
2. Follow up with individual who reported concern

Chief of Staff and VPMA or CAMD:

3. Determine if report involves ***minor concern*** or if ***additional fact-finding*** is needed (any report of sexual harassment or other identity-based harassment referred for ***additional fact-finding***)

Minor Concern

- Concern is minor ***and*** there is no pattern of behavior
- No fact-finding regarding event or need for Practitioner to respond to concern
- Chief of Staff, VPMA or CAMD communicates with Practitioner about matter (e.g., via brief conversation or note to Practitioner) and informs MSO Support Staff
- MSO Support Staff report aggregate data to Medical Staff Leadership Council to permit oversight

Additional Fact-Finding

- Concern is more significant, ***or*** a pattern exists
- Provide ***preliminary notification*** of concern to Practitioner
- Conduct ***additional fact-finding*** (e.g., interviews with witnesses and others)
- Chief of Staff and VPMA or CAMD then decide either:

(1) ***Further review required.*** Obtain input from Practitioner (use cover letter or more formal agreement to remind Practitioner of confidentiality and non-retaliation obligations) and then prepare summary for review by Medical Staff Leadership Council

(2) ***No further review required.*** Close matter and notify Practitioner and Medical Staff Leadership Council (to allow for oversight of process and consistency)

Medical Staff Leadership Council

General Conduct Concern

1. Review summary report and all supporting documentation
2. Consult with or include Department Chair if helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Meet with Practitioner, if necessary or if requested by Practitioner
5. ***Determination***
   - A. No issue
   - B. Educational Letter, providing guidance and counsel
   - C. Collegial Intervention, providing education or coaching
   - D. Performance Improvement Plan ("PIP") for Conduct
   - E. Refer to MEC

Sexual Harassment and Other Identity-Based Harassment

(e.g., based on gender, race, religion, etc.)

1. If there is a single confirmed incident:
   - A. Practitioner must acknowledge seriousness of matter, agree there will be no similar conduct in the future, and
   - B. Formal letter of admonition and warning or PIP for Conduct placed in file, as appropriate.
2. If Practitioner does not acknowledge concern or seriousness, or there are additional incidents, refer to MEC

As needed

MEC

Review under Medical Staff Bylaws because individual refuses to cooperate with Medical Staff Leadership Council, PIP for Conduct was unsuccessful, or Medical Staff Leadership Council determines MEC review is required.

Note 1: If the Practitioner involved is employed by: (i) the Hospital; (ii) an entity that has the same corporate parent as the Hospital; or (iii) an entity owned by the Hospital (the "employing entity"), Medical Staff Leaders and appropriate representatives of the employing entity may determine that: (1) any review under this Policy will be held in abeyance pending the outcome of the review by the employing entity; but (2) the Medical Staff Leadership Council may decide at any time to also review the matter under this Policy.

APPENDIX B

PROFESSIONAL CONDUCT REPORTING FORM
For Use by Employees and Practitioners

Instructions: Please use this form to report all incidents of inappropriate conduct and unprofessional behavior. Attach additional sheets if necessary. Please provide the following information as ***specifically*** and as ***objectively*** as possible and submit the completed form to the MSO Staff.

DATE, TIME, AND LOCATION OF INCIDENT

Date of incident:	Time of incident:	☐ a.m. ☐ p.m.

Location of incident:

Range of dates if your concerns are not limited to one particular event:
_____/_____/20_____ to _____/_____/20_____

PRACTITIONER INFORMATION

Name of Practitioner exhibiting inappropriate professional conduct: _____

PATIENT INFORMATION

Was a patient directly or indirectly involved in the event?	**Yes** ☐	**No** ☐	Medical Record # _____

Patient's Last Name: _____ Patient's First Name: _____

DESCRIPTION OF INCIDENT

Describe what happened as *specifically* and *objectively* as possible [attach additional pages if necessary]:

_____

_____

_____

OTHER INDIVIDUALS INVOLVED/WITNESSES

Name(s) of any other person(s) who were involved in or witnessed this event (e.g., visitors; family members, representatives):

_____ _____

_____ _____

EFFECT OF CONDUCT

How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work?

_____

_____

_____

_____

	Yes	No
Did you experience or witness any retaliation or threatened retaliation by the Practitioner?	☐	☐

If yes, please explain:

_____

_____

_____

_____

RESPONSE TO CONDUCT	Yes	No
Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?	☐	☐

If yes, please explain and indicate by whom:

_____

_____

_____

CONTACT INFORMATION

Your name:	Department:
Phone #:	Date this form completed:

E-mail address:

Note: Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless: (a) you consent; or (b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence). In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the Practitioner at issue may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the Chief of Staff, or another Medical Staff leader.

APPENDIX C

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS AN INCIDENT OF INAPPROPRIATE CONDUCT*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at Mon Health.

Your concerns will be reviewed in accordance with the Medical Staff Practitioner Code of Conduct Policy or other applicable policy. We will contact you if we need additional information.

Because your report may involve confidential matters under West Virginia law, it is important that you maintain confidentiality and only discuss this matter with individuals who are a formal part of the review process. Due to these same confidentiality requirements, we may not be permitted to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless:

(a) you consent; or

(b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence).

In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the individual who is the subject of your report may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to *[me/the MSO Staff, Chief of Staff, Vice President of Medical Affairs, or Clinical Affairs Medical Director]*.

Once again, thank you for bringing your concerns to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

MSO Staff, Chief of Staff, Vice President of Medical Affairs, or Clinical Affairs Medical Director

**** As an alternative to sending a letter or email, the content of this Appendix may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.***

APPENDIX D

EMPLOYED PRACTITIONER ROUTING FORM

***Note**: The purpose of this form is to document which of the following two review processes will be used when a behavioral concern is raised about an Employed Practitioner: (1) the Medical Staff process as set forth in this Code of Conduct Policy; or (2) the policies or employment contract of the Employer. See Section 4.D of this Code of Conduct Policy for additional information and requirements.*

Name of Practitioner: _____

Entity that employs the Practitioner: _____

Representative(s) of Employer involved in routing discussion: _____

Medical Staff Leader(s) involved in routing discussion: _____

A decision was made that:

- ☐ The process outlined in the ***Medical Staff Practitioner Code of Conduct Policy*** will be used to review the behavioral concern.
- ☐ ***The Employer's policies and/or employment contract*** will be used to review the behavioral concern.

Comments: _____

_____

_____

_____
Signature of individual completing form

_____
Date

APPENDIX E

PRELIMINARY NOTIFICATION TO PRACTITIONER (INSTRUCTIONS AND FORM)

I. PREPARATION PRIOR TO CONVERSATION BY INDIVIDUAL PROVIDING PRELIMINARY NOTIFICATION (Chief of Staff, Vice President of Medical Affairs, or Clinical Affairs Medical Director)

1. Review Section 4.E of the Practitioner Code of Conduct Policy ("Preliminary Notification to the Practitioner").

2. Decide whether to provide preliminary notification in person or over the telephone. *E-mail is strongly discouraged*.

3. If the Chief of Staff, Vice President of Medical Affairs or Clinical Affairs Medical Director and is not able to provide preliminary notification in a timely manner, Section 3.F of the Practitioner Code of Conduct Policy permits delegation of this function to a qualified designee.

4. Be cognizant that no information should be provided to the Practitioner during the discussion that would identify anyone who filed the complaint or provided information about the matter.

5. Be prepared to document any information the Practitioner provides about the incident in question on the Preliminary Notification Form, which is to be completed as soon as the notification is provided.

6. Review and revise, as necessary, the general script for the conversation, which follows.

II. GENERAL SCRIPT FOR CONVERSATION WITH PRACTITIONER

1. Notify the Practitioner that a concern about professionalism has been raised and that the purpose of this conversation is to provide a **BRIEF PRELIMINARY** notification to the Practitioner, in accordance with the Practitioner Code of Conduct Policy.

2. Inform the Practitioner that the matter is being reviewed and summarize how the review process works/next steps. *(See next two statements.)* Offer to provide the Practitioner with a copy of the Practitioner Code of Conduct Policy.

3. Explain that if the report is determined to **NOT BE CREDIBLE**, the Practitioner will be informed and the review will be closed.

4. Explain that if the report is determined to be **CREDIBLE**, the Practitioner will be given details of the concern and asked to provide his or her perspective on the incident, prior to the Conduct Committee taking any further action. However, the Practitioner is also free to submit input at any time if the Practitioner would like to do so.

5. Remind the Practitioner to avoid any action that could be perceived as **RETALIATION**. This includes speaking with anyone who the Practitioner believes may have raised the concern or provided information about the matter, because even well-intentioned conversations can be perceived as intimidating.

6. Remind the Practitioner of the crucial importance of **CONFIDENTIALITY** to avoid waiving the protections offered by the state peer review protection law.

After the conversation, complete the Preliminary Notification Form that is set forth on the next page and include it in the Practitioner's Confidential File.

APPENDIX F

COVER LETTER TO PRACTITIONER

ENCLOSING INFORMATION ABOUT REPORTED CONCERNS

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Information Related to Behavioral Concerns

Dear _____:

As you know from our conversation, concerns have been raised about your professional conduct at Mon Health _____ (the "Hospital"). As part of the review process, the Conduct Committee would like you to be fully aware of the relevant issues and have an opportunity to respond to them. Accordingly, enclosed is information that summarizes the concerns that have been raised. *[Alternatively, the concerns could be summarized in this letter.]*

The Conduct Committee would appreciate your perspective on these issues and any other information that you believe would be helpful to our review. Please provide your written response to me by _____ ***[date]***, so that it may be considered by the Conduct Committee at its next meeting. *Optional: Specifically, please respond to the following questions: _____ [list specific questions, if any].*

Your input into these issues is essential as we attempt to achieve our goal of having a timely, fair, and constructive review process. ***Please recognize that if you do not respond to this request for written input prior to the date set forth above, a process will commence (as set forth in the Practitioner Code of Conduct Policy) that could result in the automatic relinquishment of your clinical privileges until the information is provided.*** We trust this will not occur and look forward to your participation in the review.

Once the Conduct Committee reviews your written input, it will decide whether it believes a meeting with you would be helpful to discuss this matter further. If so, we will contact you to arrange a meeting. If the Conduct Committee believes a meeting is not necessary but you would nonetheless like to meet with the Council, you are welcome to meet with us at the next scheduled meeting of the Conduct Committee.

The Conduct Committee has an obligation to ensure that all peer review information (such as this letter) is maintained in a confidential manner. The Conduct Committee also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the Hospital.

Accordingly, as a courtesy, we wanted to remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Practitioner Code of Conduct Policy:

(1) Like the Conduct Committee, you must maintain all information related to this review in a ***strictly confidential*** manner, as required by West Virginia law. Specifically, you may not disclose this information to, or discuss it with, anyone ***except*** the following individuals without first obtaining

the written permission of the Hospital: (i) the Conduct Committee or its designees, or (ii) any legal counsel who may be advising you.

(2) You may not retaliate against anyone who you believe may have raised a concern about you, provided information regarding this matter, or otherwise been involved in the review process. ***This means that you may not, under any circumstances, discuss this matter with any such individual,*** because even well-intentioned conversations can be perceived as intimidating. ***Nor may you engage in any other retaliatory or abusive conduct*** such as confronting, ostracizing, or discriminating against such individual.

Please recognize that any retaliation by you, as described in the previous paragraph, is a very serious matter and will be grounds for referral for an independent review under the Medical Staff Practitioner Code of Conduct Policy.

Thank you for your anticipated cooperation with our review process. We look forward to an expeditious and constructive resolution of this matter. Please don't hesitate to contact me if you have any questions.

Sincerely,

Vice President of Medical Affairs, Clinical Affairs Medical Director or Chief of Staff

APPENDIX G

CONFIDENTIAL PEER REVIEW DOCUMENT
PROFESSIONALISM ISSUE SUMMARY FORM

Name of Practitioner: _____

Date of incident under review (or range of dates): _____

Nature of Concern Raised	Summary of concern raised: _____ _____ _____
Initial Triage by Medical Staff Leader and CMO/CAMD	Initial determination (*indicate choice made*): ☐ ***Informal Resolution Appropriate*** *(minor concern and no pattern of conduct)* ☐ ***Additional Fact-*** triage ***Finding Necessary*** *(more significant issue or pattern)* Individuals making initial triage decision: _____
If Initial Triage Results in Informal Resolution of Minor Concern:	Date of ***Informal Resolution***: _____ Individual(s) conducting: _____ ☐ N/A
If Initial Triage Results in Determination to Conduct Initial Fact-Finding:	***Additional Fact-Finding***. Based on witness interviews and documentation review, the Medical Staff Leader and CMO/CAMD determined as follows *(indicate choice made*): ☐ No further review necessary: ☐ Closed case, or ☐ Resolved informally with Practitioner ☐ Obtained Practitioner's response to concerns and then forwarded all information to Conduct Committee for its review and resolution ☐ N/A
Conduct Committee Determination and Action *(for cases referred to it)*	☐ No further review or action is required – close matter ☐ Educational Letter sent to Practitioner *(see attached letter)* ☐ Collegial Intervention conducted with Practitioner *(see attached letter)* ☐ Performance Improvement Plan for Conduct developed *(see attached letter)* ☐ Referred to MEC for review and action ☐ Referred to Employer for review and action ☐ N/A
MEC Determination and Action *(for cases referred to it)*	Summary of MEC determination and action: _____ _____ ☐ N/A
Employer Determination and Action *(for cases referred to it)*	Summary of Employer determination and action: _____ _____ ☐ N/A

*"Medical Staff Leader" means either the Chief of Staff or Department Chair.

APPENDIX H
INTERVIEW TOOL (SCRIPT AND QUESTIONS)

I. SCRIPT FOR INTRODUCTORY STATEMENTS

Instructions: Prior to the interview, the following information should be provided to each individual who is interviewed.

1. A concern about a Practitioner's behavior is being reviewed under the Hospital's Practitioner Code of Conduct Policy. We would like to speak with you because you *[raised the concern]* **or** *[may have relevant information]*.

2. Any information you provide will be treated with the utmost confidentiality. It will not be shared with anyone outside the Hospital's peer review process. Also, Hospital policy states that your identity will generally not be disclosed to the Practitioner whose behavior is being reviewed except in extremely rare situations (for example, a Medical Staff hearing).

3. As part of our culture of safety and quality care, no retaliation is permitted against you for *[reporting this matter]* **or** *[providing information about this matter]*. This means that the Practitioner under review may not approach you to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe you have been retaliated against, please report immediately to your supervisor or any Medical Staff Leader.

4. The state peer review protection law requires the Hospital to maintain any information related to this review in a ***strictly confidential*** manner, so we may not be able to inform you of the outcome of the review. However, if you have any questions about this review process following the interview, please direct them to the Chief of Staff, Vice President of Medical Affairs, Clinical Affairs Medical Director or MSO Staff.

II. SAMPLE INTERVIEW QUESTIONS

Note: The following questions are intended to elicit basic information about an incident. These questions may be modified as appropriate and should be supplemented with additional questions that specifically pertain to the incident being reviewed.

1. What was the date of the incident?

2. What time did the incident occur?

3. Where did the incident occur?

4. What is the name of the Practitioner who behaved inappropriately?

5. Who else was involved or witnessed the event? What are their titles and duties?

6. What happened? What did you see and hear?

7. Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?

8. Are there any notes or other documentation regarding the incident(s)?

9. Was a patient or a patient's family member directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Whom did you tell?
    b. When and where did you tell them?
    c. What did you tell them?

11. How did you react to this incident at the time?

12. Did you experience or witness any retaliation or threatened retaliation by the Practitioner?

13. How do you think this incident affected patient care generally, Hospital operations, the work of your team, or your ability to do your job?

14. Have other incidents occurred, either before or after this incident? ***[If yes, repeat above questions for each incident.]***

15. How would you like to see the situation resolved?

16. Do you have any other information we should know about this matter? Please contact me if you recall or learn something new after we are finished talking.

APPENDIX I

PERFORMANCE IMPROVEMENT PLAN OPTIONS FOR CONDUCT

IMPLEMENTATION ISSUES CHECKLIST

(For use by the Conduct Committee and Medical Executive Committee)

TABLE OF CONTENTS

PAGE

Note: The Implementation Issues Checklists in this Appendix may be used by the Conduct Committee and Medical Executive Committee in developing and monitoring Performance Improvement Plans ("PIPs"). Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the Conduct Committee/Medical Executive Committee and the Practitioner have a shared and clear understanding of the elements of the PIP. While Checklists may serve as helpful guidance, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP.

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Designated Group	***Who Should Meet with Practitioner?*** ☐ Medical Staff committee: _____ ☐ Other designated ad hoc group (may include Board Chair or other Board members), including: _____ ☐ May Practitioner bring a colleague (not legal counsel) to the meeting? ☐ Yes ☐ No Is pre-meeting to plan intervention necessary? ☐ Yes ☐ No If yes, where and when: _____ ***Scheduling Meeting with Practitioner*** ☐ Date of meeting: _____ ☐ Time of meeting: _____ ☐ ☐ Location of meeting: _____ ***Notice of Meeting*** Notice of meeting sent by: ☐ Chief of Staff ☐ Chief Medical Officer ☐ Clinical Affairs Medical Director ☐ Hospital CAO ☐ Other: _____ ☐ Practitioner notified that this is a peer review meeting with colleagues, therefore: ☐ No attorneys allowed at the meeting ☐ No audio or video recording of meeting ☐ Does notice state that failure to appear results in automatic relinquishment of clinical privileges? ☐ Yes ☐ No ***Method of Delivery*** ☐ In person/hand-delivered (preferred) ☐ Certified mail, return receipt requested ☐ Other: _____ ***Documentation*** ☐ If not already provided, will documentation/substance of reports regarding inappropriate conduct be shared before or during meeting? ☐ Yes ☐ No ☐ If yes, has Practitioner been provided a cover letter or agreement explaining his/her obligation to maintain the confidentiality of the information and not to retaliate against any individual who may have reported? ☐ Yes ☐ No ***Follow-Up*** ☐ Monitor for additional incidents ☐ Through standard reported concerns process ☐ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): ____

PIP OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Behavior Modification Course*** ☐ Acceptable programs include: _____ _____ ☐ Conduct Committee or Medical Executive Committee approval required before Practitioner enrolls: ☐ Program approved: _____ ☐ Date of approval: _____ ☐ Who pays for the behavior modification course? ☐ Practitioner subject to PIP ☐ Medical Staff ☐ Hospital ☐ Combination _____ Time Frame ☐ Practitioner must enroll by: _____ Date ☐ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ☐ Sign release allowing Conduct Committee or Medical Executive Committee to provide information to the behavior modification course (if necessary) and course to provide report to Conduct Committee or Medical Executive Committee _____ _____ ☐ Practitioner must submit ☐ Documentation of successful completion signed by course director ☐ Other: _____ ***Follow-Up*** ☐ Monitor for additional incidents ☐ Through standard reported concerns process ☐ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
• Personal Code of Conduct • Conditional Continued Appointment • Conditional Reappointment	***Drafting/Contents of Personal Code of Conduct*** Who will draft the Personal Code of Conduct? ☐ Chief of Staff ☐ Chief Medical Officer ☐ Clinical Affairs Medical Director ☐ Hospital CAO ☐ Legal Counsel ☐ Other: _____ ☐ Practitioner informed that he/she may provide response for inclusion in file. ☐ Copy of personal code of conduct included in Practitioner's credentials file. ☐ Is Practitioner required to agree in writing to abide by the personal code of conduct? ☐ Yes ☐ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ☐ Does the personal code of conduct describe the following consequences of a confirmed violation? ☐ Yes ☐ No ***Consequence of first violation (e.g., final warning):*** _____ _____ ☐ Practitioner notified of possible violation on: _____ Date ☐ Practitioner provided opportunity for input on: _____ Date ☐ Violation confirmed on: _____ Date ***Consequence of second violation (e.g., short-term suspension):*** _____ _____ ☐ Practitioner notified of possible violation on: _____ Date ☐ Practitioner provided opportunity for input on: _____ Date ☐ Violation confirmed on: _____ Date

PIP OPTION	IMPLEMENTATION ISSUES
There is wide latitude to utilize "other" ideas as part of PIP, tailored to specific concerns Examples: • Practitioner must have a chaperone • Practitioner must attend CME for communication issues; • Practitioner must study and present grand rounds on behavior/ patient safety connection; • Practitioner required to apologize in writing (letter must be approved before it is sent) or in person accompanied by appropriate Medical Staff leader.	***Consequence of third violation (e.g., recommendation for disciplinary action, perhaps limited hearing):*** _____ _____ ☐ Practitioner notified of possible violation on: _____ Date ☐ Practitioner provided opportunity for input on: _____ Date ☐ Violation confirmed on: _____ Date ***Review/Signature*** Who must review and approve the letter outlining the personal code of conduct? ☐ Chief of Staff ☐ Chief Medical Officer ☐ Clinical Affairs Medical Director ☐ Full Conduct Committee ☐ MEC ☐ Other Individuals: _____ Who signs/sends the letter outlining the personal code of conduct? ☐ Chief of Staff ☐ Chief Medical Officer ☐ Clinical Affairs Medical Director ☐ Hospital CAO ☐ Other: _____ ***Method of Delivery*** ☐ In person/hand-delivered (preferred) ☐ Certified mail, return receipt requested ☐ Other: _____ ***Follow-Up*** ☐ Monitor for additional incidents ☐ Through standard reported concerns process ☐ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____ _____