MEDICAL STAFF

PRACTITIONER HEALTH POLICY

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

June 2023

PRACTITIONER HEALTH POLICY

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1. POLICY STATEMENT

1.A *General Policy.*

Monongalia Health System, Inc. and its related Hospitals and affiliated entities and its Medical Staffs are committed to providing safe, quality care, which can be compromised if a Practitioner is suffering from a Health Issue as defined in this Policy that is not appropriately addressed. The Hospitals and Medical Staffs are also committed to assisting Practitioners in addressing Health Issues so they may practice safely and competently.

1.B *Scope of Policy.*

(1) This Policy applies to all Practitioners who provide patient care services at Monongalia Health System, Inc. and its related Hospitals and affiliated entities.

(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 (iii) an entity owned by the Hospital (the "employing entity"), Medical Staff Leaders will 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 Hospital process as set forth in this Policy, a representative of the employing entity will 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 Hospital 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 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) the MSO Support Staff will assist the employing entity with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's Confidential Health File consistent with the state peer review statute, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities. However, any health assessment obtained by the employing entity will be maintained in a confidential manner in the employing entity's personnel files as required by the Americans with Disabilities Act;

(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. 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 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 Practitioner Health Issues is attached as **Appendix A** to this Policy.

1.C ***Definition of "Health Issue."***

(1) ***Definition.*** A HEALTH ISSUE means any physical, mental, or emotional condition that could adversely affect a Practitioner's ability to practice safely and competently. This Policy generally requires that Health Issues be reported and reviewed, with exceptions for certain conditions. (See Section 2.A for more information.)

(2) ***Examples.*** Examples of Health Issues may include, but are not limited to, the following:

(a) substance or alcohol abuse;

(b) use of any medication, whether prescription or over the counter, that can affect alertness, judgment, or cognitive function (such as, but not limited to, the use of pain or anti-anxiety medication following surgery);

(c) any temporary or ongoing mental health concern, including, but not limited to, bipolar disorders or disorders caused by a major family event (e.g., death of spouse or child, divorce) or a major job-related event (e.g., death or significant injury to patient);

(d) carotid, vertebral, or other brain artery surgery or intervention;

(e) chemotherapy with a drug known to effect neurotoxicity (brain) or to have cardiac or neurotoxicity (peripheral nerves);

(f) radiation therapy to head;

(g) medical condition (e.g., stroke or Parkinson's disease), injury, or surgery resulting in temporary or permanent loss of fine motor control or sensory loss;

(h) shoulder surgery, brachial plexus surgery, hand or carpal tunnel surgery for a surgeon;

(i) a back injury impacting ability to stand in the OR or other procedure lab;

(j) major surgery;

(k) infectious/contagious disease that could compromise patient safety or jeopardize other health care workers; and

(l) any form of diagnosed dementia (e.g., Alzheimer's disease, Lewy body dementia), or other cognitive impairment.

1.D ***Other 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.

1.E ***Role of Leadership Council.***

(1) Practitioner health issues shall be addressed by the Medical Staff Leadership Council as outlined in this Policy. The Medical Staff Leadership Council may request other Practitioners to assist it, on an ad hoc basis, if additional expertise or experience would be helpful in addressing the health concerns that are identified in a particular case.

(2) The Medical Staff Leadership Council shall recommend to the Medical Executive Committee educational materials that address Practitioner health

issues and emphasize prevention, identification, diagnosis, and treatment of health issues. This Policy and any educational materials approved by the Medical Executive Committee shall be made available to Practitioners and Hospital personnel. In addition, the Medical Executive Committee shall periodically include information regarding illness and impairment recognition issues in CME activities.

1.F ***Health Issues Identified During Credentialing Process.***

A Health Issue that is identified during the credentialing process shall be addressed pursuant to the Credentials Policy for Medical Staff and Advanced Practice Providers "Credentials Policy". If a determination is made that the Practitioner is qualified for appointment and privileges but has a Health Issue that should be monitored or treated, the matter shall be referred to the Medical Staff Leadership Council for ongoing monitoring or oversight of treatment pursuant to this Policy.

1.G ***Patient Care and Safety.***

Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy if necessary to effectively address a Practitioner Health Issue.

1.H ***Delegation of Functions.***

(1) The Medical Staff Leadership Council is responsible for the health/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 and the CMO 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.

1.I ***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. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings, and counsel must wait outside the meeting room as directed by the Medical Staff Leaders if counsel accompanies the Practitioner to the Hospital. 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. 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.

1.J ***Supervising Physicians and Advanced Practice Providers.***

Except as set forth below, an appropriate supervising or collaborating physician shall be notified if a concern is being reviewed pursuant to this Policy involving an Advanced Practice Provider with whom the physician has a supervisory or collaborative relationship. The disclosure to the supervising or collaborating physician will be limited to a general statement that a Health Issue is currently being reviewed and that additional information may be forthcoming once the Practitioner has signed an appropriate authorization. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy. Notification to the supervising or collaborating physician as described in

this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

1.K ***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.

2. REPORTS OF POTENTIAL HEALTH ISSUES AND RESPONSE TO IMMEDIATE THREATS

2.A ***Duty to Self-Report.***

(1) ***General Duty.*** Practitioners who have a Health Issue (as defined in this Policy) are required to report it to the Chief of Staff, Chief Medical Officer ("CMO"), Vice President of Medical Affairs (VPMA), Clinical Affairs Medical Director (CAMD), or another Medical Staff Leader.

(2) ***Exception.*** The duty to self-report does not apply to:

(a) a Health Issue that will be fully resolved before the Practitioner next exercises his or her clinical privileges and that will have no effect on the Practitioner's ability to safely and competently exercise his or her clinical privileges; or

(b) a Health Issue that was evaluated as part of a Practitioner's application for appointment or reappointment to the Medical Staff.

2.B ***Reports of Suspected Health Issues by Others.***

(1) ***Reports.***

(a) ***General.*** Any Practitioner or Hospital employee who is concerned that a Practitioner may be practicing while having a Health Issue, or who is told by a patient, family member, or other individual of a concern, shall report the concern to the Chief of Staff, CMO, VPMA, CAMD or another Medical Staff Leader. Individuals filing a report do not need to have "proof" of a potential Health Issue but should describe the facts that form the basis for their concern. However, 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) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously, but all individuals are encouraged to identify themselves when making a report. This identification promotes an effective review of the concern because it permits the MSO Support Staff to contact the reporter for additional information, if necessary.

(c) ***Warning Signs.*** Warning signs of a potential Health Issue include, but are not limited to:

(1) problems with judgment or speech;

(2) emotional outbursts;

(3) alcohol odor;

(4) behavior changes and mood swings;

(5) diminishment of motor skills;

(6) unexplained drowsiness or inattentiveness;

(7) progressive lack of attention to personal hygiene;

(8) unexplained frequent illness;

(9) patients with pain out of proportion to charted narcotic dose;

(10) arrests for driving under the influence; and

(11) increased quality problems.

(d) ***Treatment Relationships.*** A Practitioner who becomes aware of a Health Issue affecting another Practitioner as a result of his or her treatment relationship with that Practitioner is not expected to report the Health Issue internally pursuant to this Policy. However, the treating Practitioner should encourage the Practitioner to self-report the issue to the extent required by Section 2.A of this Policy.

In addition, the treating Practitioner should consider whether a mandatory report is required under West Virginia law to the applicable licensing board or any other state agency. If the treating Practitioner believes a mandatory report is necessary pursuant to state law, he or she should notify the Practitioner and encourage the Practitioner to self-report prior to making the mandatory report. The treating Practitioner may consult with the CMO, VPMA or CAMD for assistance and resources in such matters.

(2) ***Logging of Report.*** Any person receiving a report of a potential Health Issue shall notify the MSO Support Staff. The MSO Support Staff will log the report and create a Confidential Health File that is maintained separately from the credentials file (see Section 8 of this Policy for more information).

(3) ***Gathering Information.*** The person receiving the report may request the reporting individual to provide a written description of the events that led to the concern or may prepare a written description based on receipt of a verbal report. As necessary, the person receiving the report may also interview the reporting individual and gather any other relevant facts, including speaking with any other individuals who may have relevant information.

(4) ***Feedback to Reporter.*** The person receiving the report shall inform the individual who reported the concern that the report will be treated confidentially and that his or her identity will not be disclosed to the Practitioner unless:

(a) the individual specifically consents to the disclosure;

(b) 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

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

The individual shall also be informed that no retaliation is permitted against anyone who reports a concern. A sample letter that may be used for this purpose is attached as **Appendix B**. The individual who filed the report may subsequently be informed that follow-up action was taken, but the specifics of any action may not be shared in light of their confidential and privileged nature.

2.C ***Review of Health Issues That May Pose an Immediate Threat.***

(1) If a report suggests that a Practitioner may have a Health Issue that poses an immediate threat to patients, the Practitioner, or others, the Chief of Staff, CMO, VPMA, CAMD or another Medical Staff Leader shall immediately personally assess the Practitioner. The individual who assesses the Practitioner may require the Practitioner to submit to a blood, hair, or urine test, or to undergo some other physical and/or mental evaluation to determine his or her ability to safely practice. Failure of the Practitioner to undergo such testing upon request will result in the automatic relinquishment of the Practitioner's clinical privileges pending Medical Staff Leadership Council review of the matter. (See Section 7.B for additional information on automatic relinquishment.)

(2) If the individual who assesses the Practitioner believes the Practitioner may have a Health Issue and that action is necessary to protect patients, the Practitioner may be asked to voluntarily refrain from exercising his or her privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner either before or after any tests or evaluations regarding the Practitioner have been completed.

(a) If the Practitioner agrees to voluntarily refrain from exercising his or her privileges, the Chief of Staff, CMO, VPMA or CAMD, may assign the Practitioner's patients to another individual with appropriate clinical privileges or to the appropriate Practitioner on the Emergency Department call roster. Affected patients shall be informed that the Practitioner is unable to proceed with their care due to illness. Any wishes expressed by patients regarding a covering Practitioner will be respected to the extent possible.

(b) If the Practitioner will not agree to voluntarily refrain from exercising his or her privileges, an individual authorized by the Medical Staff Bylaws to initiate a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

(3) Following the immediate response described above, the matter shall be referred to the Medical Staff Leadership Council for review pursuant to this Policy.

2.D ***Review of Reports Not Posing an Immediate Threat.***

If the individual receiving the report believes there is enough information to warrant a review but that no immediate action is necessary to protect patients or others, the matter shall be referred to the Medical Staff Leadership Council for review pursuant to this Policy.

3. INITIAL ASSESSMENT OF HEALTH STATUS

3.A ***Initial Review.***

The Medical Staff Leadership Council shall act expeditiously in reviewing concerns regarding a potential Health Issue referred to it. As part of its review, the Medical Staff Leadership Council may meet with the individual who initially reported the concern, as well as any other individual who may have relevant information. **Appendix C** contains a script that may be used for interviews, along with sample interview questions.

3.B ***Individuals Participating in Review.***

If the Medical Staff Leadership Council determines that it would be necessary or helpful in addressing the reported concern, it may consult with or include in the review a relevant expert (e.g., an addictionologist or psychiatrist) or the relevant department chief. Any individual who participates in a review is an integral part of the Hospital's review process and shall be governed by the same responsibilities and legal protections (e.g., confidentiality, indemnification, etc.) that apply to other participants in the process.

3.C ***Meeting with Practitioner.***

If the Medical Staff Leadership Council believes that a Practitioner may have a Health Issue, the Medical Staff Leadership Council shall meet with the Practitioner. At this meeting, the practitioner should be told that there is a concern that his or her ability to practice safely and competently may be compromised by a Health Issue and advised of the nature of the concern. The Practitioner will not be told who initially reported the concern except as permitted by Section 2.B of this Policy. The Practitioner will also be reminded that retaliation against anyone who may have reported a concern is prohibited.

3.D ***Assessment of Health Status.***

(1) The Medical Staff Leadership Council may require the Practitioner to do one or more of the following to facilitate an assessment of the Health Issue:

(a) undergo a physical or mental examination or other assessment (e.g., neurocognitive, motor skills, sensory capacity, vision, hearing, infectious disease) by another individual;

(b) submit to an alcohol or drug screening test (blood, hair, or urine);

(c) be evaluated by a physician or organization specializing in the relevant Health Issue, and have the results of any such evaluation provided to it; and/or

(d) obtain a letter from his or her treating physician confirming the Practitioner's ability to safely and competently practice and authorize the treating physician to meet with the Medical Staff Leadership Council.

(2) The Medical Staff Leadership Council shall select the health care professional or organization to perform the examination, testing, or evaluation, but may seek input from the Practitioner. More than one health care professional or organization may be asked to perform an examination, test, or evaluation, and this may occur either concurrently or serially (e.g., a substance abuse assessment following a positive drug screen). The practitioner shall be responsible for any costs associated with obtaining this health status information.

(3) A form authorizing the Hospital to release information to the health care professional or organization conducting the evaluation is attached as **Appendix D**. A form authorizing the health care professional or organization conducting the evaluation to disclose information about the Practitioner to the Medical Staff Leadership Council is attached as **Appendix E**. A Health Status Assessment Form that may be used to document the results of an evaluation is attached as **Appendix F**.

3.E ***Interim Safeguards.***

While the assessment of health status described above is ongoing, the Medical Staff Leadership Council may recommend that the Practitioner voluntarily take one or more of the following actions based on the nature and severity of the potential Health Issue:

(1) agree to specific conditions on his or her practice;

(2) refrain from exercising some or all privileges;

(3) take a leave of absence; or

(4) relinquish certain clinical privileges.

3.F ***Referral to Medical Executive Committee.***

If a Practitioner does not agree to take the voluntary actions recommended by the Medical Staff Leadership Council while the assessment of the Practitioner's health status is ongoing, an individual authorized by the Medical Staff Bylaws to impose a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed. The matter shall then be referred to the Medical Executive Committee for review and further action pursuant to the Medical Staff Bylaws.

4. PARTICIPATION IN A TREATMENT PROGRAM

In some instances, the assessment described in Section 3 of this Policy will lead to a recommendation by the Medical Staff Leadership Council that the Practitioner enter a treatment program. In other instances, the need for a Practitioner to enter a treatment program will be self-evident, and each of the steps required in Section 3 may not be required. In either case, the Medical Staff Leadership Council will, as requested, assist the Practitioner in identifying an appropriate program.

5. REINSTATEMENT/RESUMING PRACTICE

5.A ***Request for Reinstatement or to Resume Practicing.***

(1) If a Practitioner was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner must apply for reinstatement of privileges using the process set forth in the Credentials Policy. However, prior to applying for reinstatement through the process outlined in the Credentials Policy, the Practitioner must first submit a written request to the Medical Staff Leadership Council for clearance to apply for reinstatement and be granted written permission by the Medical Staff Leadership Council.

(2) In all other circumstances where the Practitioner refrained from practicing (e.g., voluntary agreement between Practitioner and Medical Staff Leadership Council; Practitioner was absent from Medical Staff duties while participating in a treatment program or otherwise addressing a Health Issue), the Practitioner must submit a written request to the Medical Staff Leadership Council and receive written permission to resume exercising his or her clinical privileges.

5.B ***Additional Information.***

Before acting on a Practitioner's request for clearance to apply for reinstatement or to resume practicing, the Medical Staff Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner to undergo a health assessment conducted by a physician or entity chosen by the Medical Staff Leadership Council in order to obtain a second opinion on the Practitioner's ability to practice safely and competently.

5.C ***Determination by Medical Staff Leadership Council.***

(1) In evaluating: (i) a request for clearance to apply for reinstatement from a leave of absence; or (ii) a request to resume practicing where no leave of absence was taken, the Medical Staff Leadership Council will review all information available to it and determine if the Practitioner is capable of practicing safely and competently.

(2) If the Medical Staff Leadership Council determines that the Practitioner is capable of practicing safely and competently without conditions, this decision will be documented. The Practitioner may then: (i) proceed with the reinstatement process outlined in the Credentials Policy, if a leave of absence was taken; or (ii) resume practicing, if no leave of absence was taken.

(3) If the Medical Staff Leadership Council determines that conditions should be placed on a Practitioner's practice as a condition of reinstatement or resuming practice, it will consult with the Practitioner in developing any necessary conditions.

6. CONDITIONS OF CONTINUED PRACTICE

6.A ***General.***

The Medical Staff Leadership Council may ask the Practitioner to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. If the Practitioner does not agree to such conditions, the matter will be referred to the Medical Executive Committee as set forth in Section 7 of this Policy. By way of example and not of limitation, such conditions may include:

(1) ***Coverage.*** The Practitioner may be asked to identify at least one Practitioner who is informed of the Health Issue and is willing to assume

responsibility for the care of his or her patients in the event of the Practitioner's inability or unavailability.

(2) ***Changes in Practice.*** The Practitioner may be asked to make certain changes to his or her practice, such as changing the frequency and/or schedule with which the Practitioner takes call, limiting inpatient census to a manageable number, or beginning elective procedures prior to a certain time of day.

(3) ***Ongoing Monitoring.*** The Practitioner's exercise of clinical privileges may be monitored. The individual to act as monitor shall be appointed by the Medical Staff Leadership Council or the department chief. The nature of the monitoring shall be determined by the Medical Staff Leadership Council in consultation with the department chief.

(4) ***Periodic Reports of Health Status.*** If the Practitioner is continuing to receive medical treatment or to participate in a substance abuse rehabilitation or after-care program, the Medical Staff Leadership Council may ask the Practitioner to agree to submit periodic reports from his or her treating physician or the substance abuse rehabilitation/after-care program. If applicable, reports regarding compliance with the conditions outlined in an agreement with the West Virginia Medical Professionals Health Program may also be obtained. The nature and frequency of these reports will be determined on a case-by-case basis depending on the Health Issue.

(5) ***Random Alcohol or Drug Screens.*** A Practitioner who has undergone treatment for substance abuse may be asked to submit to random alcohol or drug screening tests at the request of any member of the Medical Staff Leadership Council.

6.B ***Reasonable Accommodations.***

Reasonable accommodations may be made consistent with Hospital policy to assist the Practitioner in resuming his or her practice. Examples of reasonable accommodations include, but are not limited to, providing assistive technology or equipment or removing architectural barriers. The Medical Staff Leadership Council will consult with Hospital executive personnel to determine whether reasonable accommodations are feasible.

6.C ***Voluntary Agreement Not a "Restriction."***

A Practitioner's voluntary agreement to conditions similar to those set forth in this section generally does not result in a "restriction" of that Practitioner's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank ("NPDB") or to any state licensing board or other

government agency, nor would it entitle a Practitioner to a hearing under the Credentials Policy or Bylaws. However, the Medical Staff Leadership Council will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board or agency, the Medical Staff Leadership Council will consult with Hospital counsel and communicate with the Practitioner about the matter.

7. NONCOMPLIANCE

7.A *Referral to Medical Executive Committee.*

A matter shall be immediately referred to the Medical Executive Committee for its review and action pursuant to the Medical Staff Bylaws and Credentials Policy if the Practitioner fails to:

(1) agree to conditions requested by the Medical Staff Leadership Council to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing;

(2) continually comply with any agreed-upon condition of reinstatement or continued practice; or

(3) cooperate in the monitoring of his or her practice.

Following its review, the Medical Executive Committee shall take appropriate action under the Medical Staff Bylaws**.** This may include, but is not limited to, initiating an investigation.

7.B *Automatic Relinquishment/Resignation.*

(1) If a Practitioner refuses to undergo testing or an assessment when there are immediate concerns about patient safety as described in Section 2 of this Policy, the refusal will result in the immediate and automatic relinquishment of the Practitioner's clinical privileges pending the Medical Staff Leadership Council's review of the matter.

(2) If a Practitioner fails or refuses to:

(a) complete a health assessment acceptable to the Medical Staff Leadership Council and provide the results to the Medical Staff Leadership Council;

(b) provide other information relevant to a review being conducted under this Policy to the Medical Staff Leadership Council; or

(c) meet with the Medical Staff Leadership Council or other specified individuals when requested to do so in accordance with this Policy,

the Practitioner will be required to meet with the Medical Staff Leadership Council to discuss why the health assessment was not obtained, why the requested information (including the results of the health assessment) was not provided, or why the meeting was not attended. Failure of the Practitioner to either meet with the Medical Staff Leadership Council or provide the requested information prior to the date of that meeting will result in the automatic relinquishment of the Practitioner's clinical privileges until the Practitioner meets with the Leadership Council or the information is provided.

(3) If the Practitioner fails to provide information requested by the Medical Staff Leadership Council 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.

(4) Generally, 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 NPDB or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

(5) Notwithstanding the foregoing, if the Medical Staff Leadership Council or Medical Executive Committee determines that a Practitioner's refusal to provide information or attend a meeting is a deliberate attempt to avoid review of a Health Issue, the Practitioner's action may be viewed as a resignation to avoid an investigation and is thus reportable to the NPDB and a state licensing board or agency. Hospital counsel shall be consulted in making such determinations.

8. DOCUMENTATION

8.A *Creation of Health File.*

Reports of potential health issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's Confidential Health File. The Practitioner's health file shall be maintained by the Medical Staff Office as a separate file and shall not be included in the credentials file.

8.B *Information Reviewed at Reappointment.*

(1) The information reviewed by those involved in the reappointment process will not routinely include all documentation in a Practitioner's health file. Instead, the process set forth in this subsection will be followed.

(2) When a reappointment application is received from an individual who has a Health Issue that is currently being reviewed or monitored by the Medical Staff Leadership Council, or that has been reviewed and resolved in the past reappointment cycle, the Medical Staff Office shall contact the Medical Staff Leadership Council.

(3) The Medical Staff Leadership Council will prepare a confidential summary health report to the Credentials Committee. The summary health report shall be included in the credentials file, and will be reviewed by the Credentials Committee only after the Credentials Committee has determined that the applicant is otherwise qualified for clinical privileges.

(4) The Medical Staff Leadership Council's summary health report will state that the Council is actively monitoring, or has monitored in the past reappointment cycle, a health issue involving the practitioner. The summary health report will also include a recommendation regarding the Practitioner's ability to perform the duties of Medical Staff membership and safely exercise clinical privileges.

(5) If the Credentials Committee, Medical Executive Committee, or Board of Trustees has any questions about the Practitioner's ability to safely practice, the relevant entity will discuss the issue with a member of the Medical Staff Leadership Council. If the relevant entity still believes additional information is necessary, members of that entity may review the Practitioner's Confidential Health File in the Medical Staff Office.

9. CONFIDENTIALITY, PEER REVIEW PROTECTION, AND REPORTING

9.A ***Confidentiality.***

Consistent with quality patient care, the Medical Staff Leadership Council and Medical Executive Committee will handle Health Issues in a confidential manner. Throughout this process, all parties should avoid speculation, gossip, and any discussions of this matter with anyone other than those described in this Policy.

9.B ***Peer Review Protection.***

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq., and West Virginia laws governing peer review. Furthermore, the committees or individuals charged with making reports, findings, recommendations or investigations pursuant

to this Policy shall be considered to be acting on behalf of the Hospital and the Board when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act.

9.C ***Required Reporting; Contact with Law Enforcement Authorities or Governmental Agencies.***

The Hospital Chief Executive Officer ("CEO") shall file reports with the appropriate West Virginia licensing board or the NPDB, as may be required by applicable statutes or regulations. In addition, if at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the Practitioner or others, the CEO, CAO, CMO, Chief of Staff, or the Hospital's counsel may contact law enforcement authorities or other governmental agencies.

9.D ***Redisclosure of Drug/Alcohol Treatment Information.***

In the course of addressing a health issue pursuant to this Policy, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The Hospital may not redisclose such information without a signed authorization from the Practitioner. **Appendix G** includes an authorization that may be used for this purpose.

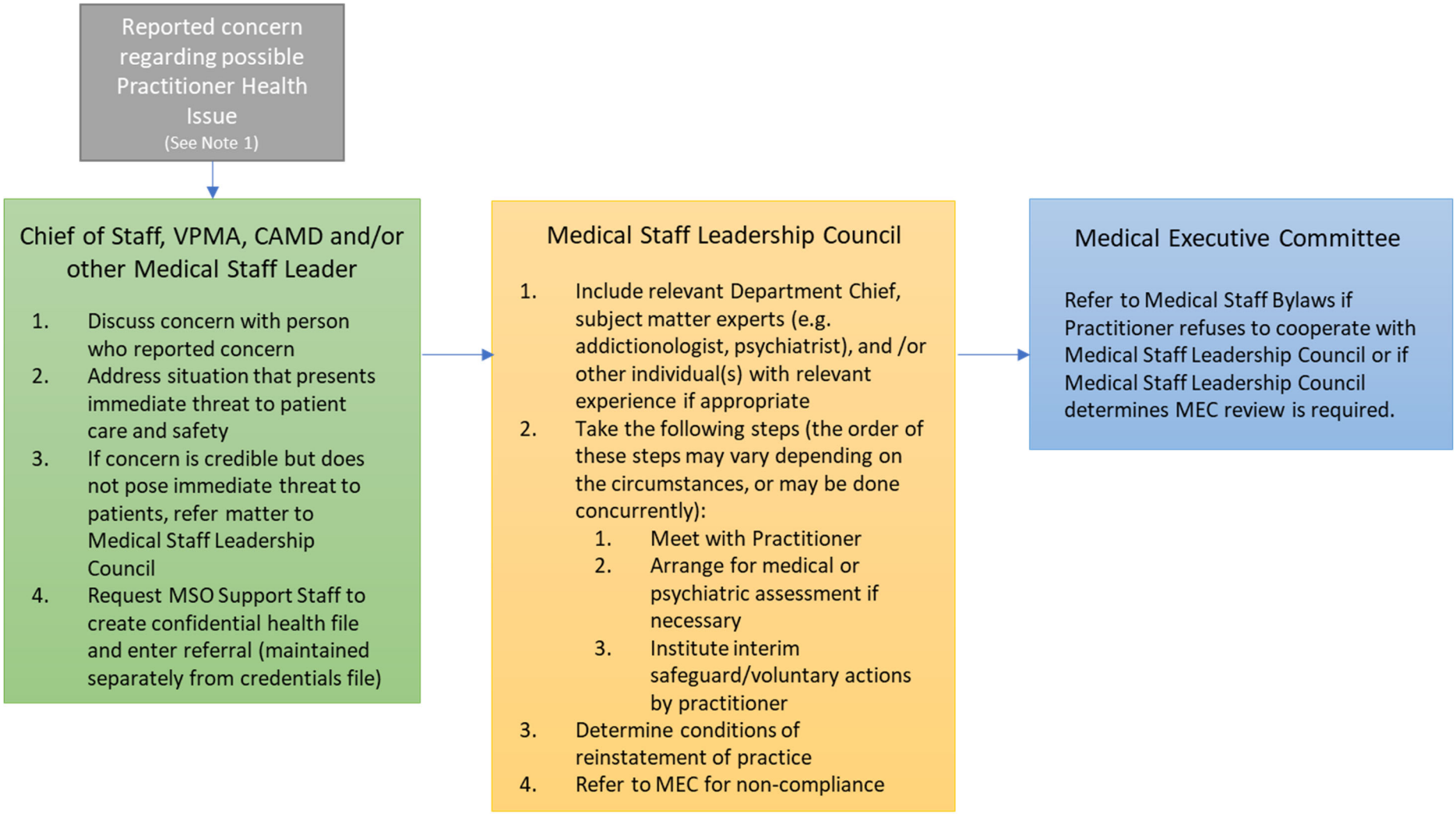
9.E ***Requests for Information Concerning Practitioner with a Health Issue.***

All reference requests or other requests for information concerning a Practitioner with a health issue shall be forwarded to the CMO, Chief of Staff, or CAO for response.

Approved by the Medical Executive Committee:

Approved by the Board:

Appendix A: Review Process for Practitioner Health Issues



Note 1: If the practitioner involved is also 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

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS POTENTIAL HEALTH ISSUE*

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 Practitioner Health Policy. We will contact you if we need additional information.

Because your report may involve matters that are confidential under West Virginia law, we may not be able 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;

(b) the Medical Staff Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review. In these instances, you will be given prior notice that the disclosure will be made; or

(c) 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 your supervisor, the Vice President of Medical Affairs, Clinical Affairs Medical Director, or any Medical Staff Officer.

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,

**** As an alternative to sending a letter, the content of this letter may be used as talking points to respond verbally to the individual who reported a potential Health Issue***

APPENDIX C

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 health is being reviewed under the Practitioner Health 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 health 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 and we may not be able to inform you of the outcome of the review. But, if you have any questions about this review process following this interview, please direct them to the Chief of Staff, Vice President of Medical Affairs, Clinical Affairs Medical Director, or MSO Support 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 health matter 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 in question?

5. Who was involved? 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. 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 D

CONFIDENTIAL PEER REVIEW DOCUMENT

CONSENT FOR DISCLOSURE OF INFORMATION AND RELEASE FROM LIABILITY

I hereby authorize Mon Health _____and its Medical Staff Leadership Council, Medical Executive Committee, and Medical Staff Leaders (the "Hospital") to provide _____ *[the facility or individual performing the health assessment]* (the "Evaluator") all information, written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow the Evaluator to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is protected by the West Virginia peer review law and that the Hospital, the Evaluator and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to that law.

I release from any and all liability, and agree not to sue, the Hospital, any of its officers, directors, or employees, any physician on the Hospital's Medical Staff, or any authorized representative of the Hospital, for any matter arising out of the release of information by the Hospital to the Evaluator.

I also release from any and all liability, and agree not to sue, the Evaluator or any of its officers, directors, employees, or authorized representatives for any matter arising out of the Evaluator's provision of an evaluation of my health status to the Hospital.

_____ _____

Date Signature of Practitioner

_____

Printed Name

APPENDIX E

CONFIDENTIAL PEER REVIEW DOCUMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ *[the facility or individual performing the health assessment]* (the "Evaluator") to provide all information, both written and oral, relevant to the Evaluator's assessment of my health status and my ability to safely practice, to Mon Health_____ and its employees, representatives and Medical Staff Leaders (the "Hospital"). The information to be released includes, but is not limited to, answers to the questions on the attached Health Status Assessment Form.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for Medical Staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

[Choose one of the following] *I understand that the willingness of the Evaluator to conduct this assessment or provide treatment does not depend on my signing this Authorization.* ***OR***

Since the Hospital is paying for the health assessment and/or treatment and has conditioned payment for the assessment and/or treatment on receipt of a report, the Evaluator may refuse to conduct the assessment or provide treatment if I refuse to sign this Authorization.

I understand that my health information is protected by a federal law known as the HIPAA Privacy Rule and may not be disclosed by the Evaluator without this Authorization. Once my health information is disclosed to the Hospital pursuant to this Authorization, the HIPAA Privacy Rule may no longer apply to the information. However, in that case, the Hospital would nonetheless be prohibited by the state peer review protection law from disclosing health information it received about me to anyone outside of its confidential review process, unless I signed another written authorization permitting the Hospital to do so. In addition, if the information in question relates to my treatment at a federally assisted drug or alcohol treatment facility, federal law would also prevent the Hospital from disclosing that information without me signing a separate Authorization form to do so.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Evaluator has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when the Evaluator has knowledge of it.

This Authorization expires when my Medical Staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Evaluator may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date	Signature of Practitioner
	Printed Name

APPENDIX F
CONFIDENTIAL PEER REVIEW DOCUMENT

HEALTH STATUS ASSESSMENT FORM

[Note: If the Hospital would like the person or entity conducting an assessment (the "Evaluator") to address specific issues, additional sections may be added to this Form, or those specific issues may be communicated to the Evaluator in a cover letter. In either case, the Hospital should confirm that all issues are addressed by the Evaluator in this Form and in any supplemental documentation that the Evaluator may return. In addition, if the Evaluator uses its own form to issue a report, the Hospital should ensure that such form addresses the issues identified below (most importantly, the Practitioner's ability to practice safely and competently).]

Please respond to the following questions based upon your assessment of the current health status of _____ (the "Practitioner"). ***If additional space is required, please attach a separate sheet.***

CURRENT HEALTH STATUS	YES	NO
1. Does the Practitioner have a medical, psychiatric, or emotional condition that could affect his/her ability to exercise safely the clinical privileges set forth on the attached list or to perform the duties of Medical Staff appointment, including response to emergency call? If "yes," please provide the diagnosis and prognosis: _____	❑	❑
2. Has the Practitioner been prescribed or is the Practitioner currently taking any medication that may affect the Practitioner's ability to practice? If "yes," please specify medications and any side effects: _____	❑	❑

ABILITY TO PRACTICE SAFELY AND COMPETENTLY	YES	YES, with conditions	NO
In your opinion, is the Practitioner currently capable of safely engaging in clinical practice and providing competent care to patients? If you answered "Yes, with conditions," please describe any conditions, limitations, monitoring or other accommodations necessary to permit the Practitioner to exercise privileges safely and to fulfill Medical Staff responsibilities: _____ _____ _____ _____ _____ _____ If you answered "No," please explain: _____ _____ _____ _____ _____ _____	❑	❑	❑

COMPLIANCE WITH ONGOING CARE	YES	NO	N/A
If the Practitioner is receiving ongoing medical treatment or therapy (e.g., a substance abuse program, ongoing visits with a specialist, counseling sessions, physical therapy or occupational therapy, etc.), is the Practitioner in compliance with all aspects of that treatment or therapy? If you answered "No," please explain: _____ _____ _____ _____	❑	❑	❑

_____
Date

_____
Signature of Evaluating Practitioner

_____
Printed Name

Attachment: Practitioner's Current Delineation of Clinical Privileges

APPENDIX G
CONFIDENTIAL PEER REVIEW DOCUMENT

AUTHORIZATION FOR REDISCLOSURE OF
DRUG/ALCOHOL TREATMENT INFORMATION

In the course of credentialing and peer review activities, Mon Health _____ and its Medical Staff Leadership Council, Medical Executive Committee, and Medical Staff Leaders (the "Hospital") have received information about me from _____, a federally assisted drug or alcohol treatment program governed by 42 C.F.R. Part 2 (the "Program").

I hereby authorize the Mon Health to redisclose to _____ (the "Receiving Entity") and _____, its point of contact for credentialing and peer review purposes, any and all information Mon Health received from the program regarding my treatment. This includes, but is not limited to, any written report or correspondence from the Program, notes to file regarding verbal conversations between the Program and Mon Health, and the contents of any verbal conversations between the program and Mon Health.

I understand that the purpose of the disclosure of this information is to allow the Receiving Entity to _____ *[describe the purpose of the disclosure, such as "allow the Receiving Entity to evaluate my health status and my ability to safely practice medicine"].*

I understand that I may revoke this authorization at any time, in writing, except to the extent that the Medical Center has already relied upon it in making a disclosure to the Receiving Entity. My written revocation will become effective when Mon Health has knowledge of it.

This authorization expires when my Medical Staff appointment and clinical privileges at any Mon Health Hospital end. Once this authorization has expired Mon Health may no longer disclose the information described above unless I sign a new authorization form.

I understand that this authorization is governed by 42 C.F.R. §2.31. I also understand that the Receiving Entity is prohibited from further disclosing my information unless I sign a separate authorization form.

_____ _____
Date Signature of Practitioner

_____
Printed Name