SANTA ROSA
MEMORIAL HOSPITAL

MEDICAL STAFF
PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

1. POLICY STATEMENT

1.A *Policy Objectives.*

(1) This Policy outlines progressive steps, beginning with collegial and educational efforts, which can be used by [Insert Hospital Name] (the "Hospital") and its Medical Staff Leaders to address conduct that does not meet expected standards. The goal of these efforts is to arrive in a constructive manner at voluntary, responsive actions by the Practitioner to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process outlined in the Medical Staff Credentialing 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 Medical Staff or Hospital 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 the Hospital or a Hospital-related entity (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 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. Actual 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 policies related to information sharing. Regardless of whether the matter is reviewed using the Medical Staff process in this policy, no 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; 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 Leadership Council notified of the status at regular intervals; if the Leadership Council is concerned that the process is not proceeding at an appropriate pace, it will discuss with the Chief Executive Officer;

(ii) the PPE Support Staff may, when requested by the Leadership Council, 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 Medical Staff peer review/quality file consistent with relevant California peer review statutes, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

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

(iv) the 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 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) If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and the Professional Practice Evaluation Committee ("PPEC") shall coordinate the reviews. The behavioral concerns may either be:

(a) addressed by the Leadership Council pursuant to this Policy, with a report to the PPEC; or

(b) addressed by the PPEC as part of its review under the Professional Practice Evaluation Policy, using the provisions in this Policy for guidance.

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

(5) 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.*** Communication, collegiality, and collaboration are essential for the provision of safe and competent patient care. As such, all Practitioners must treat others with respect, courtesy, 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.*** Definitions are located in the Professional Practice Evaluation Policy.

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 a complainant, discussing a complaint with the complainant, or discussing the matter with anyone who may have provided information during the process;

(g) talking about the complainant (or suspected complainant) with others not involved in the formal review process;

(h) inappropriate physical contact with another individual or other aggressive behavior that is threatening or intimidating, including blocking or cornering;

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

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

(k) false derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual;

(l) 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;

(m) 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;

(n) altering or 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);

(o) 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 editing and verifying that the information is accurate for the patient in question;

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

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

(r) audio, video, or digital recording while on Hospital property (unless permitted by Hospital policy);

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

(t) disruption of Hospital operations, Hospital or medical staff committees, or departmental affairs;

(u) treating self or family members, or treating any individual (including colleagues or coworkers) without first performing an appropriate assessment and creating a proper medical record;

(v) disregard of or refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Credentialing 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

(w) 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 ***Coordination with Other Policies That Govern Professional Conduct.*** 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 the 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 Leadership Council or its representatives.

3.C ***No Legal Counsel or Recordings During Collegial Meetings.*** In order to promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner whose conduct is at issue shall involve only the Practitioner and the appropriate Medical Staff and Hospital leaders (unless the Medical Staff or Hospital leaders determine otherwise in a particular situation). No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings, and no recording (audio or video) shall be permitted or made.

3.D ***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.E ***Delegation of Functions.***

(1) When a function in this policy is to be carried out by a member of the Hospital Administration, 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 one or more designees, unless the Bylaws and related policies and manuals express otherwise.

(2) When a Medical Staff Member is unavailable or unable to perform an assigned function in this policy, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual. If there are any questions as to who should perform the function, the Chief of Staff shall make the assignment.

(3) Except as provided in the next sentence, when a function in this policy is to be carried out by a person who is the subject of the complaint under review, or who has filed the complaint, the Chief of Staff shall designate another individual to perform that function. If the Chief of Staff is the subject of the complaint, or the person who filed the complaint, the Chief of Staff will not perform any function under this policy, and the Chief of Staff-Elect will perform the functions assigned to the Chief of Staff. If a member of one of the committees with duties under this policy is the subject of the complaint, or filed the complaint, the member shall recuse him- or herself from any meetings or other functions under this policy. In such cases, the Chief of Staff may, in his or her discretion, appoint a substitute member to participate on the committee.

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 by submitting a completed Professional Conduct

Reporting Form to the PPE Support Staff (see **Appendix B**) or through some other approved Hospital reporting mechanism. The PPE Support Staff shall log the referral into the confidential peer review database.

4.B ***Follow-up with Individual Who Filed Report.*** The PPE Support Staff or the Chief Medical Officer 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 California law, the Medical Staff may not be able to inform the individual of the specific outcome of the review.

A letter that can be used for this purpose is attached as **Appendix C**. 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.

4.C ***Preliminary Notification to Practitioner.*** If a concern initially appears to be credible, the Chief of Staff or Chief Medical Officer will 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 will be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident continue to be credible, but that he or she is also free to submit input at any time. The Practitioner will 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.) The Practitioner will <u>not</u> be informed of the identity of any person who raised the concern. Instructions and a form that may be used to help prepare for and document the preliminary notification described in this section are attached as **Appendix D**.

4.D ***Fact-Finding to Determine if Report Is Credible.*** The PPE Support Staff, the Chief Medical Officer, 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. **Appendix E** contains a script that may be used for interviews, along with sample interview questions.

(1) ***Report <u>Not</u> Credible.*** If the Chief Medical Officer and the Chief of Staff determine that a report is not credible or cannot be substantiated, the matter shall be closed and the Practitioner will be notified of this determination. The Leadership Council will also be notified, to allow it to conduct oversight and monitor the process for consistency. The individual who filed the report may be notified that the report was not substantiated, at the discretion of the 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. The report will be included in the Practitioner's credentials file, with the documentation of the fact-finding process and an attached statement that the report was evaluated and was either found not to be credible, or could not be substantiated.

(2) ***Report Determined to Be Credible.*** If the Chief Medical Officer and Chief of Staff determine that a report is credible, input will be obtained from the Practitioner as set forth in Section 5. The PPE Support Staff shall then prepare a summary report of the matter for review by the Leadership Council.

5. OBTAINING INPUT FROM THE PRACTITIONER

5.A ***General.*** For reports that are determined to be credible, the Chief of Staff, Chief Medical Officer, and/or PPE 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. A cover letter similar to the one set forth in **Appendix F** shall be used for this purpose. The cover letter will be sent with a summary of the reported concerns, but will not include a copy of any incident report. The identity of the person making the report will not be disclosed, expect as provided below.

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 (the Medical Staff is not required to ask the individual to consent);

(2) the Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review, in which case the individual will be notified; or

(3) the identity of the individual must be disclosed pursuant to the hearing and appeal provisions of the Medical Staff Bylaws.

5.C ***Confidentiality.*** The Practitioner must maintain all information related to the review in a strictly confidential manner, as required by the Medical Staff Bylaws, rules, policies, or other governing documents. Except to legal counsel who may be advising the Practitioner, 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 Leadership Council. Practitioner's legal counsel, if any, may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy; doing so would be considered a violation of the Medical Staff Bylaws, rules, policies, and procedures by 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 Leadership Council and comply with its requirements regarding the manner in which the apology is provided.

5.E ***Reminder of Practitioner's Obligations.*** The PPE Support Staff, Chief Medical Officer, or Chief of Staff will remind the Practitioner of the obligations set forth in this section as part of seeking his or her input. A cover letter similar to the one set forth in **Appendix F** shall be used for this purpose. The Practitioner may also be asked to sign the "Confidentiality and Non-Retaliation Agreement" that is attached as **Appendix G** before such a letter is sent, and will be asked to sign if there are particular concerns about maintaining confidentiality or ensuring a professional, non-threatening environment for the individuals involved in a specific situation.

6. LEADERSHIP COUNCIL PROCEDURE

6.A ***Initial Review.*** The Leadership Council shall review the summary prepared by the PPE Support Staff and all supporting documentation, including the response from the Practitioner. If necessary, the Leadership Council may also meet with the individual who submitted the report and/or any witnesses to the incident. If it determines that it would be necessary or helpful in addressing the reported concern, the Leadership Council may also consult with or include the appropriate Service Chair or Medical Director in the review. Alternatively, the Leadership Council may appoint an ad hoc committee to review the incident and report back to it.

6.B ***Meeting Between Practitioner and Leadership Council.*** A meeting may be held between the Practitioner and the Leadership Council to discuss the circumstances further if either the Leadership Council or the Practitioner believes that such a meeting would be helpful prior to the Leadership Council concluding its review and making a determination. The Leadership Council may also obtain additional written input from the Practitioner using the process set forth in Article 5.

6.C ***Leadership Council's Determination and/or Intervention.*** Based on all of the information received, the Leadership Council may do one or more of the following:

(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.D below; or

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

The Leadership Council shall also inform the relevant Service Chair of its determination and intervention.

6.D ***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. (**Appendix H** provides additional guidance regarding these and other Performance Improvement Plan options for conduct and their related implementation issues.)

Most Performance Improvement Plans will not require a report to any state licensing board or to the National Practitioner Data Bank. However, the issue of reporting must be assessed with each Performance Improvement Plan. Any question regarding whether a Performance Improvement Plan element must be reported should be referred to legal counsel for determination. Should the determination be made that any element of a Performance Improvement Plan must be reported, the Practitioner will be informed before the Performance Improvement Plan is finalized. A Performance Improvement Plan that requires a report will only go into effect if agreed to by the Practitioner. In such cases, the report will explicitly state that the Hospital does not consider the Performance Improvement Plan to be a disciplinary matter and, to the extent applicable, that the Practitioner is working constructively to address the issues identified and to improve the care provided. If, after being informed that one or more elements of the Performance Improvement Plan may have to be reported to the licensing agency or the National Practitioner Data Bank, the Practitioner does not agree to the Performance Improvement Plan, the matter will be referred to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentialing Policy. Refer to the Credentialing Policy regarding formal action.

(1) ***Meeting with Medical Executive Committee or Designated Group.*** The Practitioner may be required to meet with the Medical Executive Committee or a designated group (including the PPEC, 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 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 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 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 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 Leadership Council summarizing the information reviewed and how it can be applied to the individual's practice;

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

(6) ***Personal Code of Conduct.*** The 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.E ***Practitioner's Refusal to Provide Information or Meet with Leadership Council.***

(1) If the Practitioner fails or refuses to: (i) provide a written response to a request for information sent by the Leadership Council, or (ii) meet with the 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 Leadership Council to discuss why the requested input was not provided or the meeting was not attended. Failure of the Practitioner to either meet with the Leadership Council or provide the requested information prior to the meeting will result in the automatic suspension of the Practitioner's clinical privileges until the Practitioner meets with the Leadership Council or the information is provided, or until the Practitioner's privileges are automatically relinquished pursuant to the Credentialing Policy.

(2) 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, to the Medical Board of California, or to other California licensing agencies, unless statute or regulation requires otherwise. They do not entitle the Practitioner to a hearing or appeal under the Medical Staff Bylaws, unless statute or regulation requires otherwise.

6.F ***Communications Placed in Practitioner's Confidential File.*** Copies of communications 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.G ***Additional Reports of Inappropriate Conduct.*** If additional reports of inappropriate conduct are received concerning a Practitioner, the 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.H ***Determination to Address Concerns through Practitioner Health Policy.*** The 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 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 Leadership Council;

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

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

The Leadership Council will inform the Medical Executive Committee of all actions that it has taken so far regarding this issue. The Leadership Council may also make recommendations to the Medical Executive Committee regarding the best way to handle these issues.

7.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Credentialing Policy. These actions include all of the Performance Improvement Options set forth in **Appendix H**, as well as short-term suspensions, long-term suspensions, and/or the revocation of appointment and clinical privileges, subject to any procedural rights as set forth in the Medical Staff Credentialing Policy.

8. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

8.A ***Definition.*** 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 discrimination based on sex, gender identity and gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, and marital

status. 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:

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

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

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

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

8.B ***General.*** All reports of potential identity-based harassment will be reviewed by the 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 Leadership Council to inform human resources of the complaint, as well as the actions set forth below.

8.C ***Personal Meeting and Letter of Admonition and Warning.*** Two or more members of the 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.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, or

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

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

SANTA ROSA MEMORIAL HOSPITAL

Appendix A: Review Process for Concerns Regarding Professional Conduct

Reported concern regarding professional conduct ***(See Note 1)***

PPE Support Staff, Chief of Staff and Chief Medical Officer

1. Log-in referral to peer review database
2. Follow up with individual who reported concern
3. ***Initial triage*** to determine if:
   - A. Concern may be resolved informally (e.g., a brief conversation with the Practitioner) because it is minor and there is no pattern of behavior; or
   - B. Additional fact-finding is needed to determine if the report is credible and further action is necessary
4. For concerns that are not resolved informally:
   - A. Provide ***preliminary notification*** to Practitioner that concern has been raised (generally in person or via telephone)
   - B. ***Fact-finding*** to determine that report is credible, including interviews with witnesses and others:
     - (1) If report **not credible**, notify Leadership Council (to allow for oversight of process and consistency) and notify Practitioner that complaint was dismissed
     - (2) If report **credible**, obtain input from Practitioner (use cover letter or more formal agreement to remind Practitioner of confidentiality and non-retaliation obligations), and then prepare summary of matter for review by Leadership Council

Leadership Council

General Conduct Concern

1. Review summary report and all supporting documentation
2. Consult with or include Service Chair, if necessary or helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Appoint ad hoc committee to assess, if necessary
5. Meet with Practitioner, if necessary or if requested by Practitioner
6. Determinations/Interventions
   - A. No issue
   - B. Letter of guidance or counsel
   - C. Collegial intervention, education, or coaching
   - D. Performance Improvement Plan for Conduct (several options), or
   - E. Refer to MEC

Identity-Based Harassment (single confirmed incident)

1. Practitioner acknowledges seriousness of matter, agrees there will be no similar conduct in the future
2. Formal letter of admonition and warning placed in file
3. If Practitioner does not acknowledge concern or seriousness, or there are additional incidents, refer to MEC

MEC

Review under Medical Staff Credentials Policy because individual refuses to cooperate with Leadership Council, PIP Options for Conduct were unsuccessful, or Leadership Council determines MEC review is required

Note 1: If the Practitioner involved is also employed by the Hospital or a Hospital-related entity, Medical Staff Leaders will consult with appropriate representatives of the employing entity and determine whether: (1) the review will be conducted by the Medical Staff per this Policy, with input and involvement of the employing entity; or (2) the review will be conducted by the employing entity, in which case the Medical Staff process will be held in abeyance pending the outcome of that review. In the latter situation, the Leadership Council may decide at any time to also review the matter under this Policy.

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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 Hospital PPE Support Staff.

PRACTITIONER INFORMATION			
Name of Practitioner exhibiting inappropriate professional conduct: _____			
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_____			
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 other Practitioner(s) and/or Hospital employee(s) or others who witnessed this event: _____ _____ _____ _____			

EFFECT OF CONDUCT
Do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? If so, how? _____ _____ _____

	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; (b) the Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review, in which case you will be notified; 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 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 our Hospital.

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

Because your report may involve confidential matters under California 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 Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review, in which case you will be notified; 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 it immediately to *[me/the PPE Support Staff/and/or Chief Medical 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,

PPE Support Staff, Chief of Staff, or *Chief Medical Officer* [if applicable]

APPENDIX D

PRELIMINARY NOTIFICATION TO PRACTITIONER (INSTRUCTIONS AND FORM)

I. CHIEF OF STAFF PREPARATION PRIOR TO CONVERSATION

1. Review Section 4.C of the Professionalism 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 is not able to provide preliminary notification in a timely manner, Section 3.F of the Professionalism 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 Professionalism 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 Professionalism 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 Leadership Council taking any action. However, the

Practitioner is also free to submit input at any time, if the Practitioner would like to do so.

5. Instruct 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 California 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 D *(cont.)*

CONFIDENTIAL PEER REVIEW DOCUMENT

PRELIMINARY NOTIFICATION FORM
FOR PROFESSIONALISM ISSUE
(to be completed by Chief of Staff or designee)

Practitioner: _____

Service: _____

Date of Conversation: _____

Approximate Time of Conversation: _____

Did this conversation occur in person or via telephone call?	❑ In person	❑ Telephone
Was the script outlined in the Appendix D "Instruction" form substantially followed during the discussion?	❑ Yes	❑ No
Was the Practitioner instructed not to retaliate?	❑ Yes	❑ No
Was the Practitioner advised of confidentiality requirements?	❑ Yes	❑ No
Was the Practitioner notified of the opportunity to provide input, even at this preliminary stage of the review process?	❑ Yes	❑ No

Additional comments/summary of any information provided by the Practitioner:

_____

_____

_____

_____

_____
Name and Title

_____
Signature

APPENDIX E

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 Professionalism 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 California peer review protection law requires the Hospital to maintain any information related to this review in a ***strictly confidential*** manner. Accordingly, do not discuss this conversation or process with any unauthorized persons, and if you have any questions about this review process, please direct them to the Chief of Staff, the Chief Medical Officer, or the PPE 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 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 whose behavior resulted in the report?

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 visitor directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Who 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. Do you think this incident affected patient care generally, Hospital operations, the work of your team, or your ability to do your job? If so, how?

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

15. Now that you have made this report, what sort of results would you hope to see?

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 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 Santa Rosa Memorial Hospital (the "Hospital"). As part of the review process, the Leadership Council 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.

The Leadership Council would appreciate your perspective on these issues. Please provide your written response to me by _____ ***[date]***. *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. If you do not respond to this request for information prior to the date in the preceding paragraph, your privileges may be deemed to be automatically relinquished as set forth in the Medical Staff Professionalism Policy and the Credentialing Policy until the information is provided.

Once the Leadership Council reviews your written input, it will decide whether it believes a meeting with you would be helpful to address this matter further. If so, we will contact you to arrange a meeting. If the Leadership Council 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 Leadership Council.

The Leadership Council has an obligation to ensure that all peer review information is maintained in a confidential manner. The Leadership Council also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the Hospital.

Accordingly, we remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Professionalism Policy:

(1) You must maintain all information related to this review in a ***strictly confidential*** manner, as required by the Medical Staff Bylaws, rules, policies, and other governing documents . 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 Leadership Council, or (ii) any legal counsel who may be advising you (your legal counsel, if any, may not disclose this information outside of this review process; doing so would be treated as a violation *by <u>you</u>* of the Medical Staff Bylaws, rules, policies, and procedures);

(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, 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 immediate referral to the Medical Executive Committee for its review and disciplinary action pursuant to the Credentialing Policy.

Of course, you are fully permitted to raise any questions or concerns that you may have regarding the care being provided by a nurse or other Hospital employee, another Practitioner, or the Hospital itself. However, you must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.

Thank you for your attention to this matter.

Sincerely,

Chief of Staff

APPENDIX G

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my professional conduct at Santa Rosa Memorial Hospital (the "Hospital"). As part of the review process, the Leadership Council would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Leadership Council also wants to take appropriate steps to maintain the confidentiality of the information under California and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all the information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) the Leadership Council (or its designees), or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual(s) without first obtaining the express written permission of the Hospital. I understand that if my legal counsel discloses information covered under this agreement to any person outside of the review process, it will be treated as is if I have violated the confidentiality provisions in the Medical Staff Bylaws, rules, policies, and other governing documents.

2. I understand that this information is being provided to me as part of the Medical Staff's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Leadership Council (or its designees), I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and Medical Staff have a responsibility to provide a safe, non-threatening workplace for my professional colleagues and for Hospital employees. I therefore agree that:

   (a) ***I will <u>not discuss</u> this matter with any individual who may have expressed concerns about me or otherwise provided information in this matter. I understand that the act of discussing this matter with any individual who may have raised a concern or provided information will be viewed as retaliation.***

   (b) I will not engage in any other retaliatory or abusive conduct with respect to these individuals. This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

4. I understand that any retaliation by me, as described in the previous paragraph, is a very serious matter and cannot be tolerated. Any such conduct by me will be grounds for

immediate referral to the Medical Executive Committee for its review and disciplinary action pursuant to the Medical Staff Credentialing Policy.

By signing this Agreement, I understand that I am ***not waiving*** any of the rights or privileges afforded to me under the Medical Staff Bylaws or Credentialing Policy and related documents.

I also understand that I am fully permitted to raise any question or concern that I may have regarding the care being provided by a nurse or other Hospital employee, another Practitioner, or the Hospital itself. ***However, I understand that I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These mechanisms are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

_____, M.D./D.O. Date

Note: After this agreement is signed, a copy shall be returned to the Practitioner for reference.

APPENDIX H

PERFORMANCE IMPROVEMENT PLAN OPTIONS FOR CONDUCT

IMPLEMENTATION ISSUES CHECKLIST
(For use by the Leadership Council and Medical Executive Committee)

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Note: The Implementation Issues Checklists in this Appendix may be used by the Leadership Council 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 Leadership Council/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 Medical Executive Committee or Designated Group	***Who Should Meet with Practitioner?*** ❑ Medical Executive Committee ❑ Other 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 ❑ Chief Quality Officer ❑ President ❑ 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

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Medical Executive Committee or Designated Group ***(cont'd.)***	***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
Letters of Warning or Reprimand	***Drafting/Contents of Letter*** ❑ Who will draft the letter? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ President ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file ❑ Copy included in Practitioner's credentials/quality file ***Review/Signature*** ❑ Who must review and approve the letter? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ Full Leadership Council ❑ MEC ❑ Other: _____ ❑ Who signs/sends the letter? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ President ❑ 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): _____

PIP OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Behavior Modification Course*** ❑ Acceptable programs include: _____ _____ ❑ Leadership Council 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 of the following: _____ ❑ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Leadership Council or Medical Executive Committee to provide information to the behavior modification course (if necessary) and course to provide report to Leadership Council 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 ❑ Chief Quality Officer ❑ President ❑ Legal Counsel ❑ Other: _____ **** LEGAL COUNSEL MUST REVIEW ALL PERSONAL CODES OF CONDUCT.*** ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of personal code of conduct included in Practitioner's credentials/ quality 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
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)*** ***(cont'd.)***	***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 ❑ Chief Quality Officer ❑ Full Leadership Council ❑ MEC ❑ Other Individuals: _____ **** LEGAL COUNSEL MUST REVIEW ALL LETTERS OUTLINING A PERSONAL CODE OF CONDUCT.*** ❑ Who signs/sends the letter outlining the personal code of conduct? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ President ❑ 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): _____

PIP OPTION	IMPLEMENTATION ISSUES
Suspensions of Less Than 14 days ***(for use by Medical Executive Committee only)*** ***The matter must be referred to legal counsel prior to implementation to discuss possible reports to the licensing board or NPDB.***	***Date/Duration of Suspension*** ❑ Suspension begins on: _____ Date ❑ Suspension ends on: _____ Date ***Patient Care Arrangements*** ❑ If suspension begins immediately, what arrangements are made for patients currently admitted? _____ ❑ What arrangements are made for on-call responsibilities? _____ ***Drafting/Contents of Notice of Suspension*** ❑ Who will draft the notice of suspension? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ President ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of notice included in Practitioner's credentials/quality file. ***Review/Signature*** ❑ Who must review and approve the notice of suspension? ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ MEC ❑ Other Individuals: _____ ❑ Notice of suspension signed by: ❑ Chief of Staff ❑ Chief Medical Officer ❑ Chief Quality Officer ❑ President ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____

PIP OPTION	*IMPLEMENTATION ISSUES*
Suspensions of Less Than 14 days ***(cont'd.)***	***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*
"Other" ***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.*** ***If any action may restrict practice, whether involuntarily or voluntarily, the matter must be referred to legal counsel prior to implementation to discuss possible reports to the licensing board or NPDB.***	