YAKIMA VALLEY MEMORIAL

MEDICAL STAFF PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

1. POLICY, DEFINITIONS, AND DELEGATION OF FUNCTIONS

1.A ***Policy.*** Collegiality, collaboration and professionalism are essential for the provision of safe and competent patient care. Accordingly, all Practitioners at Yakima Valley Memorial (the "Hospital") must treat others with respect, courtesy, and dignity, and must conduct themselves in a professional and cooperative manner.

1.B ***Definitions of Unprofessional Conduct and Sexual Harassment/Other Identity-Based Harassment.***

(1) Unprofessional Conduct is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication. Examples of Unprofessional Conduct are included in **Appendix A** to this Policy ("Definitions of Unprofessional Conduct and Sexual Harassment and Other Identity-Based Harassment").

(2) Sexual Harassment and other Identity-Based Harassment are types of Unprofessional Conduct. A detailed definition and examples are included in **Appendix A** to this Policy ("Definitions of Unprofessional Conduct and Sexual Harassment and Other Identity-Based Harassment").

1.C ***Definitions of Other Terms.***

(1) ***"Collegial Intervention"*** means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial Intervention only occurs after a Practitioner has had an opportunity to provide input regarding a concern. If Collegial Intervention results from a matter that has been reported to the PPE Specialists and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the Practitioner's future practice in the Hospital. A copy of the follow-up letter will be included in the Practitioner's file along with any response that the Practitioner would like to offer. A ***Collegial Intervention Checklist*** that may be used to help Medical Staff Leaders prepare for a Collegial Intervention and a sample ***Follow-Up Letter to Collegial Intervention*** are included in the ***Professionalism Policy Manual***.

In contrast, informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for

Collegial Intervention are referred to as "Initial Mentoring Efforts." This Policy encourages the use of Initial Mentoring Efforts to assist Practitioners in continually improving their practices. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, documentation is recommended particularly if a pattern of behavior may be developing. Any documentation will be maintained in the Practitioner's confidential file.

(2) ***"Employed Practitioner"*** means a Practitioner who is employed by an Employer.

(3) ***"Employer"*** means:

(a) the Hospital; or

(b) a Hospital-related entity or a private entity that:

(a) has a coordinated quality improvement program that has been approved by the state; and

(b) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

(4) ***"Medical Staff Leader"*** means any Medical Staff officer, Department Chair, or committee chair or any designee acting on their behalf or on behalf of a department or committee at its request. The term shall also include the Chief Medical Officer when acting on behalf of, in conjunction with, or as liaison to, the Medical Staff. In addition, the Hospital may employ or contract with other individuals or organizations to provide administrative services and support to Medical Staff Officers, departments, and committees and when any such individuals or organizations are performing any credentialing, peer review, professional practice evaluation, patient safety, or other function by delegation of a Medical Staff Leader, they too will be deemed to be acting as a Medical Staff Leader.

(5) ***"PPE Specialists"*** means the clinical and non-clinical staff who support the professional practice evaluation ("PPE") process generally and the review of issues related to professionalism described in this Policy. This may include, but is not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department.

(6) ***"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, Licensed Independent Practitioners, and Advanced Practice Professionals.

1.D *Delegation of Functions.*

(1) When a function under this Policy is to be carried out 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.

(2) 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.

2. REPORTS OF UNPROFESSIONAL CONDUCT

2.A *Reports.*

(1) Hospital employees or Practitioners who observe, or are subjected to, Unprofessional Conduct by a Practitioner shall report the incident in a timely manner to their supervisor, via the Hospital's electronic reporting system, or in some other manner.

(2) Any individual receiving such a report will forward it to the PPE Specialists.

(3) The PPE Specialists shall notify the Medical Staff President and the Chief Medical Officer ("CMO") of all reported concerns and log them in a confidential peer review database.

2.B *Follow-up with Individual Who Filed Report.* The PPE Specialists or CMO shall follow up with individuals who file a report. Guidance for such follow-up communication is included in **Appendix B** to this Policy ("Response to Individual Who Reported Concerns").

3. INFORMAL RESOLUTION OF MINOR CONCERNS

3.A *Criteria for Informal Resolution.* A matter may be resolved informally, without the need for further review under this Policy, if the Medical Staff President and the

CMO determine that: (1) the reported concern is minor in nature; and (2) there is no history or pattern with the Practitioner in question.

3.B ***Procedure for Informal Resolution.*** For matters that qualify for informal resolution, the Medical Staff President or CMO will speak with the Practitioner about the reported concern and either:

(1) dismiss the matter altogether (if the behavior does not appear to constitute Unprofessional Conduct as defined in this Policy after discussions with the Practitioner); or

(2) make the Practitioner aware of the concern and counsel the Practitioner. In these situations, the individual performing the counseling may follow up with a brief note to the Practitioner memorializing the conversation.

The Medical Staff President or CMO will notify the PPE Specialists that a matter has been resolved informally. An ***Informal Resolution Documentation Form*** that may be used to document these informal resolutions is included in the ***Professionalism Policy Manual***.

3.C ***Reports to Leadership Council.*** The PPE Specialists will provide to the Leadership Council periodic reports of matters that have been informally resolved under this section to allow for oversight of the process and consistency.

4. PROCEDURE WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED

The steps set forth below apply to reported concerns about behavior that, as determined by the Medical Staff President and CMO, involve: (1) more serious allegations; or (2) a pattern of behavior.

4.A ***Preliminary Notification to Practitioner.*** The Medical Staff President or CMO should notify the Practitioner that a concern has been raised and that the matter is being reviewed. Generally, this preliminary communication should occur via a brief telephone call or a personal discussion as soon as practical. The Practitioner should be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident are determined to require further review, but that he or she is also free to submit input at any time. The Practitioner should also be reminded to avoid any action that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner believes may have raised the concern or provided information about it). ***Instructions for Providing a Preliminary Notification*** and a ***Form*** that may be used to document the preliminary notification are included in the ***Professionalism Policy Manual***.

4.B ***Notification to Employer.*** If a reported concern involves an Employed Practitioner, the PPE Specialists will notify the Employer that the matter is being reviewed

pursuant to this Policy. The Employer will be invited to provide any information that it believes may be relevant to the Employed Practitioner and the concern being reviewed. The Employer will also be informed that the Leadership Council may request the Employer's participation in the review.

4.C ***Fact-Finding.*** The PPE Specialists, Medical Staff President and/or CMO 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 reported concern. An ***Interview Tool: Script, Questions and Guidance*** that may be used for such interviews is included in the ***Professionalism Policy Manual***.

4.D ***Determination by Medical Staff President and CMO.***

(1) ***No Further Review Required.*** Following the interviews and fact-finding, the Medical Staff President and CMO may determine that a reported concern does not raise issues that need to be addressed pursuant to this Policy. In such case, the matter will be closed and the Practitioner and Leadership Council will be notified of this determination.

(2) ***Further Review Required.*** The Medical Staff President and the CMO may determine that a matter should be reviewed further in accordance with this Policy. In such case, input will be obtained from the Practitioner as set forth in **Appendix C** ("Obtaining Input from the Practitioner") and the matter shall be referred to the Leadership Council. The PPE Specialists shall prepare a summary report of the matter for review by the Leadership Council and provide the Leadership Council with all supporting documentation.

5. LEADERSHIP COUNCIL PROCEDURE

5.A ***Initial Review.*** The Leadership Council shall review the summary prepared by the PPE Specialists 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 any witnesses to the incident. The Leadership Council may consult with or include in the review the Department Chair, another Medical Staff Leader, or any other individual who would be helpful to the review.

5.B ***Meeting Between Practitioner and Leadership Council.*** A meeting may be held between the Practitioner and the Leadership Council to discuss the circumstances further and obtain more facts 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. In its discretion, the Leadership Council may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The

Leadership Council may also obtain additional written input from the Practitioner using the process set forth in **Appendix C** to this Policy ("Obtaining Input from the Practitioner").

5.C ***Refusal to Provide Information or Meet with Leadership Council.*** A Practitioner who refuses to provide information or meet with the Leadership Council will be deemed to have automatically relinquished his or her clinical privileges as set forth in **Appendix D** to this Policy ("Automatic Relinquishment for Refusal to Provide Information or Meet with Leadership Council").

5.D ***Employer Participation in Review.*** If a matter involves an Employed Practitioner, the Leadership Council may invite a representative of the Employer to attend relevant portions of committee meetings involving the Practitioner and participate in any interventions that may be conducted by the Leadership Council following the review. The chair of the Leadership Council may recuse the Employer representative during any deliberations or vote on a matter.

5.E ***Leadership Council Determination and Intervention.***

(1) ***Options.*** After its review of all relevant information, including input from the Practitioner, the Leadership Council may:

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

(b) send the Practitioner an Educational Letter, providing guidance and counsel;

(c) engage in a formal Collegial Intervention with the Practitioner and provide education and coaching (a ***Collegial Intervention Checklist*** and ***Follow-Up Letter to Collegial Intervention*** may be found in the ***Professionalism Policy Manual***);

(d) develop a Performance Improvement Plan for Conduct ("PIP"), as described in **Appendix E** to this Policy ("Performance Improvement Plans for Conduct");

(e) refer the matter to the Medical Executive Committee; or

(f) after consultation with the Employer, refer the matter to the Employer for disposition, with a report back to the Leadership Council regarding the action taken by the Employer. If the Leadership Council determines the Employer's action is insufficient, the Leadership Council may also make one of the other determinations set forth in this subsection.

(2) ***Voluntary Nature of PIPs.*** If a Practitioner agrees to participate in a PIP developed by the Leadership Council, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP developed by the Leadership Council, the Practitioner is under no obligation to participate in the PIP. In such case, the Leadership Council cannot compel the Practitioner to agree with the PIP. Instead, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Bylaws.

(3) ***Leadership Council Review Not an Investigation.*** A review conducted by the Leadership Council or by any individual pursuant to this Policy shall not constitute an investigation. As set forth in the Medical Staff Bylaws, only the Medical Executive Committee has the authority to commence an investigation.

5.F ***Additional Reports of Unprofessional Conduct.*** If additional reports of Unprofessional Conduct are received concerning a Practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

5.G ***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.

6. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

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

6.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Credentials Policy. These actions include, but are not limited to, Collegial Intervention efforts, development of a Performance Improvement Plan, commencement of an investigation, a short-term suspension, a long-term suspension, and/or a recommendation to revoke appointment and clinical privileges, subject to any procedural rights as set forth in the Credentials Policy.

7. REVIEW OF REPORTS OF SEXUAL HARASSMENT AND OTHER IDENTITY-BASED HARASSMENT

7.A ***Definition.*** A detailed definition of Sexual Harassment and other Identity-Based Harassment is included in **Appendix A** ("Definitions of Unprofessional Conduct and Sexual Harassment and Other Identity-Based Harassment").

7.B ***Review Process for Sexual Harassment and Other Identity-Based Harassment Concerns and Agreements to Voluntarily Refrain from Clinical Activities During Review.*** All reports of potential Sexual Harassment and other Identity-Based Harassment will be reviewed by the Leadership Council in the same manner as set forth above. In addition, while a Practitioner may be asked to voluntarily refrain from exercising clinical privilege pending the review of any behavioral matter under this Policy, particular attention will be paid to whether it is necessary to utilize such a temporizing safeguard while an allegation of Sexual Harassment or other Identity-Based Harassment is being reviewed.

7.C ***Personal Meeting and Letter of Admonition and Warning.*** Because of the unique legal implications surrounding Sexual Harassment and other Identity-Based Harassment, a single confirmed incident requires the actions set forth in this section. 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.

7.D ***Performance Improvement Plan.*** In addition to the letter of admonition and warning, concerns about Sexual Harassment and other Identity-Based Harassment may also be addressed by a Performance Improvement Plan for conduct as described in this Policy.

7.E ***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 Sexual Harassment or other 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 Bylaws. Such referral shall not preclude other action under applicable Human Resources policies.

8. ADDITIONAL REQUIREMENTS AND GENERAL PRINCIPLES GOVERNING THE PROFESSIONALISM REVIEW PROCESS

(a) The Appendices to this Policy contain: (1) additional requirements that expand upon specific steps outlined in this Policy; and (2) general principles that govern the implementation of this Policy.

(b) Each Appendix to this Policy is a binding and integral part of the Policy. The placement of a provision in an Appendix rather than in the body of the Policy is a drafting convention to facilitate comprehension of the primary PPE review process and has no effect on the validity or enforceability of any provision in an Appendix.

(c) A flowchart that outlines the review process described in this Policy is included as **Appendix G** to this Policy ("Flowchart of Review Process for Concerns Regarding Professional Conduct").

Adopted by the Medical Executive Committee on June 16, 2020.

Adopted by the Board on June 22, 2020.

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APPENDIX A

DEFINITIONS OF UNPROFESSIONAL CONDUCT AND SEXUAL HARASSMENT/OTHER IDENTITY-BASED HARASSMENT

1. ***Unprofessional Conduct.*** Unprofessional Conduct is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication.

   (a) To aid in both the education of Practitioners and the enforcement of this Policy, examples of "Unprofessional Conduct" include, but are not limited to:

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

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

      (3) 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;

      (4) 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;

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

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

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

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

(9) repeatedly failing to maintain and renew in a timely manner all credentials required by the Medical Staff Bylaws;

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

(11) unprofessional 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;

(12) 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);

(13) engaging in a pattern of behavior in which medical record entries are based on a template without considering the care actually provided to the patient, or in which the "copy and paste" or "pull forward" functions of the medical record are used to populate fields without verifying that the information is accurate for the patient in question;

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

(15) unprofessional access, use, disclosure, or release of confidential patient information;

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

(17) use of social media in a manner that involves Unprofessional Conduct as defined in this Policy or other Medical Staff or Hospital policies;

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

(19) refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, 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

(20) engaging in Sexual Harassment or other Identity-Based Harassment as described in Section 2 of this Appendix.

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

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

(2) disagreement with any Medical Staff or Hospital Bylaws, policies, procedures, proposals, or decisions; or

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

2. ***Sexual Harassment and Other Identity-Based Harassment.***

(a) Sexual Harassment and other Identity-Based Harassment is verbal or physical conduct that:

(1) is unwelcome and offensive to an individual who is subjected to it or who witnesses it;

(2) could be considered harassment from the objective standpoint of a "reasonable person"; and

(3) is covered by state or federal laws governing discrimination. This includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

(b) Depending on the circumstances, any of the examples of Unprofessional Conduct described in this Policy may also qualify as Sexual Harassment or other Identity-Based Harassment. Additional examples 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;

(4) ***Quid Pro Quo:*** suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action; and

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

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

APPENDIX B

RESPONSE TO INDIVIDUAL WHO REPORTED CONCERNS

The PPE Specialists or CMO shall follow up with individuals who file a report regarding a professionalism issue by:

(1) Thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care; and

(2) Informing them that:

(a) The matter will be reviewed in accordance with the Professionalism Policy and that they may be contacted for additional information;

(b) Due to confidentiality requirements under state law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process and not with colleagues or coworkers;

(c) Due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

(d) No retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

A sample ***Response to Reported Concerns*** is included in the ***Professionalism Policy Manual*** and can be used as a script for a verbal discussion with the individual who reported the concern or sent as a letter.

APPENDIX C

OBTAINING INPUT FROM THE PRACTITIONER

(1) ***General.*** When input is to be obtained under this Policy, the Medical Staff President, CMO or Leadership Council will provide details of the concern (but not a copy of the report) to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident. The ***Professionalism Policy Manual*** includes a sample ***Letter to the Practitioner Requesting Input*** which may be used for this purpose.

(2) ***Identity of Reporter.***

(a) ***General Rule.*** Since the Professionalism Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(b) ***Exceptions.***

(1) ***Consent.*** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(2) ***Medical Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(c) ***Practitioner Guessing the Identity of Reporter.*** This Policy does not prohibit notification to a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the identity of the reporter will not be confirmed and those involved in the review will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

(3) ***Reminder of Practitioner's Obligations.*** The Medical Staff President, CMO or Leadership Council will remind the Practitioner of the obligations set forth in this Policy (such as confidentiality and non-retaliation) as part of seeking his or her input. The sample ***Letter to the Practitioner Requesting Input*** in the ***Professionalism Policy Manual*** addresses these issues. If concerns about confidentiality and non-retaliation are more significant, the Practitioner may be required to sign a ***Confidentiality and Non-Retaliation Agreement*** (a copy of which is included in the ***Professionalism Policy Manual***) prior to providing detailed information regarding the concern to the Practitioner.

(4) ***Discussions Outside Committee Meetings*****.** Practitioners and individual members of the Leadership Council should not engage in separate discussions of a matter unless the Leadership Council has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to a member of the PPE Specialists or to any other individual and ask him or her to relay that verbal input to the Leadership Council. The goal of this requirement is to ensure that all individuals and committees involved in the review process receive the same, accurate information.

APPENDIX D

AUTOMATIC RELINQUISHMENT FOR REFUSAL TO PROVIDE INFORMATION OR MEET WITH LEADERSHIP COUNCIL

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

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, the Leadership Council;

(b) the written request is sent to the Practitioner by the Chief Medical Officer or a member of the Leadership Council;

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

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

Notwithstanding the foregoing, automatic relinquishment will occur based on a Practitioner's refusal to attend a meeting without being accompanied by counsel or another person, even if the conditions set forth above are not satisfied.

Any member of the Leadership Council may determine that written information provided by the Practitioner is responsive to the Leadership Council's request and that automatic relinquishment will therefore not occur (or that such relinquishment will end if it has already commenced).

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

(3) ***Extensions and Exceptions for Good Cause.***

(a) ***Unavailability of Practitioner.*** Automatic relinquishment or resignation as described in this Appendix will not occur if the Practitioner's failure to provide written input or attend a meeting is due to the unavailability of the Practitioner.

This may include, but is not limited to, a planned vacation, attendance at a conference, illness, family emergency or other cause beyond the Practitioner's control. In such case, the Leadership Council will establish a reasonable deadline depending on the circumstances.

(b) ***Other Valid Cause.*** If a Practitioner believes he or she has another valid reason for not providing written input or attending a meeting, the Practitioner may notify the Leadership Council of the reason and request an exception to the automatic relinquishment described in this Appendix.

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

APPENDIX E

PERFORMANCE IMPROVEMENT PLANS FOR CONDUCT

(1) ***General.*** The Leadership Council may determine it is necessary to develop a Performance Improvement Plan ("PIP") for the Practitioner. One or more members of the Leadership Council should personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

(2) ***PIP Options.*** A PIP for conduct may include, but is not limited to, one or more of the actions in this Appendix. None of these actions entitles the Practitioner to a hearing or appeal as described in the Medical Staff Bylaws, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. The ***Professionalism Manual Policy*** includes a ***Performance Improvement Plan Options for Conduct – Implementation Issues Checklist*** that may be used to assist with implementation of the following PIP options.

(a) ***Meeting with Designated Group.*** The Practitioner may be required to meet with a designated group (including the Committee for Professional Enhancement ("CPE"), 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;

(b) ***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;

(c) ***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;

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

(e) ***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; and/or

(f) ***Other.*** Elements not specifically listed above may be included in a PIP. The Leadership Council has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her performance and to protect patients and staff.

APPENDIX F

OTHER PROVISIONS THAT GOVERN THE PROFESSIONALISM REVIEW PROCESS

This Appendix contains various other provisions that govern aspects of the professionalism review process. Specifically, this Appendix contains guidance regarding the following matters:

1	Confidentiality Requirements
2	Immediate Referrals to Medical Executive Committee
3	Coordination with Other Policies That Govern Professional Conduct
4	No Legal Counsel or Presence of Others During Meetings
5	No Recording of Meetings
6	Education Regarding Appropriate Professional Behavior
7	Letters Placed in Practitioner's Confidential File
8	When Both Clinical and Behavioral Concerns Are at Issue
9	Supervising Physicians and Advanced Practice Professionals

1. ***Confidentiality Requirements.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

    (a) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to Hospital personnel and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Washington and federal law.

    (b) ***Participants in the Review Process.*** All individuals involved in the review process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement (sample ***Confidentiality Agreements*** are included in the ***Professionalism Policy Manual***). Violations of this provision by Practitioners will be reviewed under the Professionalism Policy. Violations by Hospital employees will be referred to human resources.

    (c) ***Practitioner Under Review.*** The Practitioner under review must maintain all information related to the review in a strictly confidential manner, as required by Washington law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in the Professionalism Policy

without first obtaining the permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Professionalism Policy.

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

3. ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of unprofessional 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 Medical Staff President or CMO 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 the Professionalism Policy or may discuss the matter with the Leadership Council or its representatives.

4. ***No Legal Counsel or Presence of Others During Meetings.***

   (a) The processes and procedures outlined in this Policy are designed to be carried out in an informal manner and in a manner that protects the confidentiality of the peer review process. Therefore, lawyers and other "representatives" or "advocates" will not be present for any meeting that takes place pursuant to this Policy. This includes, but is not limited to, friends, relatives, colleagues, and emotional support persons. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule, in which case all interested parties will be allowed to have lawyers present.

   (b) Unless an exception has been granted, if the Practitioner refuses to meet without his or her lawyer (or other individual) present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual declined to attend the meeting. Pursuant to the terms of this Policy and the Medical Staff Credentials Policy, that may result in the automatic relinquishment of membership and clinical privileges, upon notice to the Practitioner.

5. ***No Recording of Meetings.*** As set forth in the Medical Staff Credentials Policy, it is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings. The discussions that take place at such meetings are conducted with the expectation of privacy.

Therefore, individuals present at any meeting that takes place pursuant to this Policy are prohibited from making audio or video recordings at such meetings unless authorized, in writing, by the individual chairing the meeting or by the Chief Executive Officer.

6. ***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 Unprofessional Conduct.

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

8. ***When Both Clinical and Behavioral Concerns Are at Issue.*** If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and Committee for Professional Enhancement ("CPE") shall coordinate the reviews. The behavioral concerns may either be:

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

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

9. ***Supervising Physicians and Advanced Practice Professionals.*** An appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with which the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy.

YAKIMA VALLEY MEMORIAL

Appendix G: Review Process for Concerns Regarding Professional Conduct