MEMORIAL HEALTH

JACKSONVILLE MEMORIAL HOSPITAL

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

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1. OBJECTIVES AND SCOPE OF POLICY

1.A ***Objectives.*** The primary objectives of the Professional Practice Evaluation ("PPE") process of Jacksonville Memorial Hospital (the "Hospital") are to:

(1) Establish a positive, educational approach to performance issues and a culture of continuous improvement for individual Practitioners, which includes:

(a) fairly, effectively, and efficiently evaluating the care being provided by Practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

(b) providing constructive feedback, education, and performance improvement assistance to Practitioners regarding the quality, appropriateness, and safety of the care they provide;

(2) Effectively disseminate lessons learned and promote education sessions so that all Practitioners in a relevant specialty area will benefit from the PPE process and also participate in the culture of continuous improvement; and

(3) Promote the identification and resolution of system process issues that may adversely affect the quality and safety of care being provided to patients (e.g., protocol or policy revisions that are necessary; addressing patient handoff breakdowns or communication problems).

1.B ***Scope of Policy.***

(1) This Policy applies to services provided at the Hospital by Practitioners.

(2) The Hospital's PPE process includes several related but distinct components:

(a) The PPE process described in this Policy is used when questions or concerns are raised about a Practitioner's clinical performance. This process has traditionally been referred to as "peer review."

(b) The process used to confirm an individual's competence to exercise newly granted privileges is described in the FPPE Policy to Confirm Practitioner Competence and Professionalism (New Members/New Privileges).

(c) The process used to evaluate a Practitioner's competence on an ongoing basis is described in the Ongoing Professional Practice Evaluation (OPPE) Policy.

(d) Concerns regarding a Practitioner's professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy or Practitioner Health Policy, respectively.

2. STEP-BY-STEP REVIEW PROCESS. This section describes each step in the clinical review process. These steps are illustrated in the Flowchart of Professional Practice Evaluation Process and the Leadership Council Case Review Algorithm, both of which are included in Appendix A to this Policy.

2.A ***Cases to Be Reviewed.***

(1) ***Specialty-Specific Triggers.*** The Leadership Council will approve adverse outcomes, clinical occurrences, or complications that will trigger PPE. Theses triggers will be reviewed periodically to evaluate their effectiveness.

(2) ***Reported Concerns.*** Any Practitioner or Hospital employee may report to the PPE Specialists concerns related to the safety or quality of care provided to a patient by an individual Practitioner. A form that may be used for this purpose (FOCUS Form – Fast and Open Communication for Unmatched Safety) is included as PPE-2 in the Professional Practice Evaluation Manual ("PPE Manual").

(3) ***Other Cases or Issues.*** Cases or issues may be identified for review through any other means, including but not limited to those described in PPE-1 in the PPE Manual (PPE Triggers That Prompt the PPE Review Process).

2.B ***Follow-up with Individuals Who Report Concerns.*** The PPE Specialists shall follow up with individuals who report concerns, either verbally or in writing. A template Response to Reported Concerns is included as PPE-3 in the PPE Manual.

2.C ***PPE Specialists.***

(1) ***Log-in.*** All cases or issues identified for review shall be referred to the PPE Specialists, who will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet).

(2) ***Fact-Finding at the Direction of the Leadership Council.***

(a) The Chief Medical Officer ("CMO"), Leadership Council Chair, or Leadership Council member, each acting on behalf of the Leadership Council, will confer with the PPE Specialists and direct

that a review of the case be conducted. The PPE Specialists will review, as necessary, the medical record, other relevant documentation, and the Practitioner's professional practice evaluation history. The PPE Specialists may also interview and gather information from Hospital employees, Practitioners, patients, family, visitors, and others who may have relevant information.

(b) For any Practitioner-specific concerns that may be referred for review from the serious safety event or sentinel event review processes, interviews and other fact-finding should be coordinated between the two processes, to the extent possible, to avoid redundancy and duplication of effort.

(3) ***Review and Determination.*** The PPE Specialists shall consult with the Chair or a member of the Leadership Council or the CMO if there is any uncertainty about the proper determination or review process for a case. The PPE Specialists will then:

(a) determine that no further review is required and close the case. The PPE Specialists will provide periodic reports to the Leadership Council of cases closed pursuant to this subsection. Such reports should include the specialty-specific trigger that caused the case to be identified so the Leadership Council can evaluate the utility of such triggers;

(b) send an Informational Letter (see Section 3 of this Policy and the Sample Informational Letter at PPE-16 in the PPE Manual for additional information on Informational Letters); or

(c) determine that further review is required.

(4) ***Preparation of Case for Further Review.*** The PPE Specialists shall prepare cases that require further review. Preparation of the case may include the following:

(a) completion of the appropriate portions of the applicable case review form (CSR Case Review Form (Individual), CSR Case Review Form (Committee), or AR Case Review Form (set forth as PPE-4.1, PPE-4.2 and PPE-5, respectively, in the PPE Manual);

(b) as needed, modifying the case review form to reflect specialty-specific issues, as may be directed by a CSR, the Leadership Council Chair, or the CMO;

(c) preparation of a time-line or summary of the care provided;

(d) identification of relevant patient care protocols or guidelines; and

(e) identification of relevant literature.

(5) ***Referral of Case for Further Review.***

(a) ***Referrals to Leadership Council.***

(1) The PPE Specialists shall refer a case to the Leadership Council if the case involves:

(A) a concern for which immediate or expedited review is needed;

(B) professional conduct;

(C) a Practitioner health issue; or

(D) a refusal to cooperate with utilization oversight activities.

(2) If a Voluntary Enhancement Plan is currently in effect, the PPE Specialists will consult with the Leadership Council Chair to determine if the case should be referred directly to the Leadership Council.

(3) The Medical Staff President or Leadership Council Chair, in conjunction with the CMO, may direct the PPE Specialists to refer a case directly to the Leadership Council if they determine that the case raises unusual or significant concerns for which direct referral to the Leadership Council is the most appropriate review process.

(b) ***Referrals Involving Certain Complex Cases.*** If a case involves:

(1) Practitioners from two or more specialties;

(2) the CSR who would otherwise be expected to review the case; or

(3) a matter for which necessary clinical expertise is not available on the Medical Staff,

the PPE Specialists will consult with the Leadership Council Chair or CMO regarding referral of the case. The Leadership Council Chair or CMO will determine the appropriate review process, and

may decide that two or more CSRs will review the case and complete assessments simultaneously, that an Assigned Reviewer will complete the review, or that the case will be referred to the Leadership Council so that an external review may be obtained. (See Section 5.A of this Policy for additional guidance on external reviews.)

(c) ***Referral to Clinical Specialty Reviewer.*** All other cases shall be referred by the PPE Specialists to the appropriate CSR.

2.D ***Clinical Specialty Reviewer.***

(1) ***Review.*** As noted in the definition of Clinical Specialty Reviewer, the Leadership Council may appoint an individual or a committee to serve as a CSR for a particular specialty. The review process will vary slightly depending on whether an individual or a committee is appointed.

(a) ***Individual as CSR.*** Individuals who serve as CSRs shall either:

(i) review the case, consult with an Assigned Reviewer (if needed), and complete the CSR Case Review Form (Individual) (see PPE-4.1 in the PPE Manual); or

(ii) assign the review to an Assigned Reviewer, who shall evaluate the care provided, complete the AR Case Review Form (see PPE-5 in the PPE Manual), and report his or her findings back to the individual CSR.

In all cases, the individual CSR remains responsible for completing the appropriate portions of the CSR Case Review Form (Individual) (see PPE-4.1 in the PPE Manual).

(b) ***Committee as CSR.*** When a case is referred to a committee that functions as a CSR ("CSR Committee"), a committee member designated by the chair shall either:

(i) review the case personally and complete the initial portion of the CSR Case Review Form (Committee) (see PPE-4.2 in the PPE Manual); or

(ii) assign the review to an Assigned Reviewer, who shall evaluate the care provided, complete the AR Case Review Form (see PPE-5 in the PPE Manual) as may be requested, and report his or her findings back to the CSR Committee member who assigned the review.

In all cases, the CSR Committee member will remain responsible for completing the CSR Case Review Form (Committee) (see PPE-4.2 in the PPE Manual) and submitting the form to the full CSR Committee.

The CSR Committee will review the findings set forth on the CSR Case Review Form (Committee) prepared by the CSR Committee member (see PPE-4.2 in the PPE Manual). The CSR Committee will then either adopt the member's assessment, modify that assessment, or determine to obtain additional information from the Practitioner before completing its review. These actions will be documented on the CSR Case Review Form (Committee).

(2) ***Input from Practitioner.*** If a CSR or an Assigned Reviewer has any questions or concerns about the care provided by the Practitioner, the CSR or Assigned Reviewer shall obtain input from the Practitioner prior to making any final findings. Section 4 of this Policy and PPE-9 in the PPE Manual ("Request for Input from Practitioner sent by CSR, AR, or Leadership Council") contain additional information on obtaining input from the Practitioner.

(3) ***Determinations.*** CSRs may:

(a) with the agreement of the Leadership Council Chair or CMO:

(i) determine that no further review is required and the case is closed;

(ii) send an Educational Letter to the Practitioner (see Section 3.C of this Policy for additional guidance on Educational Letters and PPE-18 in the PPE Manual for a Sample Educational Letter);

(iii) conduct or facilitate Collegial Counseling with the Practitioner (see Section 3.C of this Policy and PPE-19 and PPE-20 for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling); or

(b) report their findings to the Leadership Council for determination.

2.E ***Leadership Council.***

(1) ***Review.*** The Leadership Council shall consider the Case Review Forms, supporting documentation, input obtained from the Practitioners involved, findings, and recommendations for all cases referred to it.

(2) ***Information Sharing with Employer.***

(a) If the Practitioner involved is employed by the Hospital, the Leadership Council may notify an appropriate Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a Hospital-related entity or a qualifying private entity, the Leadership Council may notify a representative of the peer review committee within the Employer and request assistance in addressing the matter.

(b) The Employer is generally notified when the concern is more significant. By way of example, the Leadership Council may choose to not notify the Employer if an Educational Letter will be sent, but may choose to involve the Employer if a Voluntary Enhancement Plan may be necessary to resolve a concern.

(c) If the Employer is notified, a representative of the Employer may be invited to attend meetings of the Leadership Council, participate in discussions and deliberations, and participate in any interventions.

(d) Any information or documentation that may be shared with the Employer will be maintained only in a peer review-protected file at the Hospital or the Employer, and ***not*** maintained in the employment or personnel file of the Practitioner.

(3) ***Case Presentation at Leadership Council Meeting.*** The CSR responsible for the initial assessment, an Assigned Reviewer, or the Leadership Council Chair shall present the case to the Leadership Council.

(4) ***Determination if Additional Expertise or Information is Required.*** The Leadership Council or the Leadership Council Chair shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the Leadership Council or the Leadership Council Chair may:

(a) invite a specialist on the Medical Staff with the appropriate clinical expertise to attend a Leadership Council meeting (either in person or electronically) as a guest, without vote, to assist the Leadership Council in its review of issues, determinations, and follow-up actions;

(b) assign the review to any Practitioner on the Medical Staff with the appropriate clinical expertise, with a report of the assessment back to the Leadership Council; or

(c) arrange for an external review from an individual not on the Medical Staff in accordance with Section 5 of this Policy.

The Leadership Council or the Leadership Council Chair shall also determine if additional cases or data related to the Practitioner should be reviewed to better understand any potential clinical concerns, prior to the Leadership Council making a determination.

(5) ***Input from Practitioner.*** If the Leadership Council has any questions or concerns about the care provided by the Practitioner, the Leadership Council may obtain additional input from the Practitioner beyond what has already been obtained, prior to making any final determinations or findings. Section 4 of this Policy and PPE-11 in the PPE Manual (Request for Additional Input from Practitioner Sent by Leadership Council) contain additional information on obtaining input from the Practitioner.

(6) ***Determinations.*** Based on its review of all information obtained, including input from the Practitioner, the Leadership Council may:

(a) determine that no further review or action is required. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination. A letter that may be used for that purpose is included at PPE-14 in the PPE Manual (Notice to Practitioner That No Further Review or Action is Required When Input Had Been Requested);

(b) send an Educational Letter (see Section 3.C of this Policy for additional guidance on Educational Letters and PPE-18 in the PPE Manual for a Sample Educational Letter);

(c) conduct or facilitate Collegial Counseling (see Section 3.C of this Policy for additional guidance on Collegial Counseling and PPE-19 and PPE-20 for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling);

(d) develop a Voluntary Enhancement Plan (see Section 3.C of this Policy for additional guidance on Voluntary Enhancement Plans and PPE-21 through PPE-27 for Voluntary Enhancement Plan Documents;

(e) refer the matter to the Leadership Council;

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

(g) 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 make one of the other determinations set forth in this subsection.

In making its determination, the Leadership Council should consult the guidance in the Case Review Algorithm set forth in Appendix A.

2.F ***Time Frames for Review.***

(1) ***General.*** The time frames specified in this Section are provided only as guidelines. However, all participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final determination, within 90 days.

(2) ***Assigned Reviewers.*** Assigned Reviewers are expected to submit completed AR Case Review Forms (see PPE-5 in the PPE Manual) to, or consult with, the CSR or the Leadership Council, depending on who assigned the review, within 14 calendar days of: (i) the review being assigned; or (ii) their receipt of any requested input from the Practitioner, whichever is later.

(3) ***Clinical Specialty Reviewers.***

(a) If the CSR is an individual, the CSR is expected to complete a review within 14 calendar days of the following, whichever is later: (i) the review being assigned; (ii) their receipt of an AR Case Review Form (see PPE-5 in the PPE Manual) or other information from an Assigned Reviewer, if applicable; or (iii) their receipt of any requested input from the Practitioner, if applicable.

(b) If the CSR is a committee, the committee member that commences the review is expected to submit the completed portion of the CSR Case Review Form (Committee) (see PPE-4.1 in the PPE Manual) within 14 calendar days of: (i) the review being assigned; (ii) their receipt of an AR Case Review Form (see PPE-5 in the PPE Manual) or other information from an Assigned Reviewer, if applicable; or (iii) their receipt of any requested input from the Practitioner, whichever is later. The CSR Committee is then expected to complete its review within 30 calendar days of the following, whichever is later: (i) its receipt of the committee member's assessment; or (ii) its receipt of any additional input requested from the Practitioner.

(4) ***External Reviewers.*** If an external review is sought as set forth in Section 5 of this Policy, those involved will use their best efforts to take the steps

needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for the review).

2.G ***No Further Review Required.*** Cases may be closed according to the process set forth in this Policy if a determination is made that there are no clinical issues or concerns presented in the case that require further review. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination. A letter that may be used for that purpose is included as PPE-14 in the PPE Manual (Notice to Practitioner That No Further Review or Action is Required When Input Had Been Requested).

2.H ***Exemplary Care.*** If the Leadership Council determines that a Practitioner provided exemplary care in a case under review, the Practitioner should be sent a letter recognizing such efforts.

2.I ***Referral to the Medical Executive Committee.***

(1) ***Referral by the Leadership Council.*** The Leadership Council may refer a matter to the Medical Executive Committee if:

(a) it determines that a Voluntary Enhancement Plan may not be adequate to address the issues identified;

(b) the individual refuses to participate in a Voluntary Enhancement Plan developed by the Leadership Council;

(c) the Practitioner fails to abide by a Voluntary Enhancement Plan; or

(d) the Practitioner fails to make reasonable and sufficient progress toward completing a Voluntary Enhancement Plan.

(2) ***Pursuant to the Medical Staff Credentials Policy.*** This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee pursuant to the Medical Staff Credentials Policy or the elimination of any particular step in the Policy when deemed necessary under the circumstances.

3. OPTIONS TO ADDRESS CLINICAL CONCERNS

3.A ***General.*** This Policy and the Case Review Forms in PPE-4.1, PPE-4.2 and PPE-5 of the PPE Manual discourage the use of any scoring, leveling, or grading of cases

because those practices, while traditional, foster a punitive, isolating, and destructive culture surrounding PPE activities. Instead, this Policy focuses on specific efforts to address any issues that may be identified in a constructive and educational manner and thus foster a culture of continuous improvement. As such, this Policy encourages the use of Initial Mentoring Efforts and Progressive Steps by Medical Staff Leaders in order to successfully address questions relating to an individual's clinical practice.

3.B ***Initial Mentoring Efforts.*** Initial Mentoring Efforts may include, but are not limited to, discussions, mentoring, coaching, and sharing of comparative data. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, brief documentation is encouraged to help determine if any pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's confidential file. A Description of Initial Mentoring Efforts and Progressive Steps is included as PPE-15 in the PPE Manual.

3.C ***Progressive Steps.*** For matters that are reported to, or identified by, the PPE Specialists and reviewed under the PPE Policy, Medical Staff Leaders will generally use Progressive Steps to address any performance issues that may be identified. Additional information on each of the following Progressive Steps may be found in the PPE Manual. A Description of Initial Mentoring Efforts and Progressive Steps is included as PPE-15 in the PPE Manual.

(1) ***Informational Letters.***

(a) Informational Letters are intended to make Practitioners aware of an expectation or requirement. They are non-punitive, informational tools to help Practitioners self-correct and improve their performance through timely feedback.

(b) The Leadership Council will prepare a list of objective occurrences for which an Informational Letter will be sent to a Practitioner. The list may be modified by the Leadership Council at any time, without the need for approval by the Medical Executive Committee or Board. However, notice of any revisions shall be provided by the Leadership Council to the Medical Executive Committee and the Medical Staff.

(c) PPE Specialists will generate an Informational Letter to be sent to a Practitioner upon the occurrence of an event which has been identified ahead of time by the Leadership Council. The Informational Letter will be signed by the Leadership Council Chair.

(d) A Sample Informational Letter is included as PPE-17 in the PPE Manual.

(2) ***Educational Letters.***

(a) Educational Letters describe the opportunities for improvement that were identified in the care reviewed and offer specific recommendations for future practice.

(b) Educational Letters may be sent by a CSR, with the agreement of the Leadership Council Chair or CMO, or by the Leadership Council.

(c) A Sample Educational Letter is included as PPE-18 in the PPE Manual.

(3) ***Collegial Counseling.***

(a) A CSR, with the agreement of the Leadership Council Chair or CMO, or the Leadership Council may decide that Collegial Counseling will be used to address concerns with a Practitioner.

(b) Collegial Counseling is a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders, with the Leadership Council designating the individuals to conduct the counseling.

(c) Collegial Counseling shall be followed by a letter that summarizes the discussion and the recommendations and expectations regarding the Practitioner's future practice in the Hospital.

(d) A Collegial Counseling Checklist to help prepare for such a meeting and a Sample Follow-Up Letter to Collegial Counseling are included as PPE-19 and PPE-20, respectively, in the PPE Manual.

(4) ***Voluntary Enhancement Plan.***

(a) The Leadership Council may develop a Voluntary Enhancement Plan to bring about sustained improvement in an individual's practice. The PPE Manual provides examples of the elements that may be included in a Voluntary Enhancement Plan. However, a Voluntary Enhancement Plan may include any activity that the Leadership Council determines will help the Practitioner to improve. Additional guidance on Voluntary Enhancement Plans is included as PPE-21 to PPE-27 in the PPE Manual, including Voluntary Enhancement Plan Options – Implementation Issues Checklist (PPE-21) and a Voluntary Enhancement Plan Template Letter (PPE-22).

(b) If a Practitioner disagrees with the need for a Voluntary Enhancement Plan developed by the Leadership Council, the Practitioner is under no obligation to participate in the Voluntary Enhancement Plan. In such case, the Leadership Council cannot compel the Practitioner to agree with the Voluntary Enhancement Plan. Instead, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy.

(c) Voluntary Enhancement Plans are not disciplinary in nature. Because a Voluntary Enhancement Plan is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, the Voluntary Enhancement Plan is not reportable to the National Practitioner Data Bank or any Illinois licensing board.

3.D ***Documentation.*** Informational Letters, Educational Letters, and follow-up letters to Collegial Counseling will be placed in the Practitioner's confidential file and considered in the reappointment process.

3.E ***Confidentiality.*** All Initial Mentoring Efforts and Progressive Steps are part of the Hospital's confidential performance improvement and PPE/peer review activities. Information related to them will be maintained in a confidential manner consistent with their privileged status under Illinois and federal law.

4. OBTAINING INPUT FROM THE PRACTITIONER

4.A ***Input Required.*** Obtaining input from the Practitioner under review is an essential element of a transparent and constructive review process. Accordingly, no Educational Letter, Collegial Counseling, or Voluntary Enhancement Plan shall be implemented until the Practitioner is first notified of the specific concerns and provides input as described in this Section. Prior notice and a request for input are not required before an Informational Letter is sent to a Practitioner. (See PPE-9, PPE-10, and PPE-11 in the PPE Manual for sample Requests for Input.)

4.B ***Manner of Providing Input.*** The Practitioner shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the correspondence to the Practitioner (e.g., email or letter). Upon the request of either the Practitioner or the person or committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals (as determined by the individual or committee conducting the review) to discuss the issues.

4.C ***Office Records.*** As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner to provide a copy of, or

access to, medical records from the Practitioner's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input.

4.D ***Sharing Identity of Any Individual Reporting a Concern.*** Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") will not be disclosed to the Practitioner unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

4.E ***Retaliation Prohibited.*** Retaliation by the Practitioner against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed by the Leadership Council through the Professionalism Policy.

4.F ***Discussions Outside Committee Meetings.*** Individual members of the Leadership Council should not engage in separate discussions with a Practitioner regarding the review of a case unless the committee in question 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 the PPE Specialists or to any other individual and ask that individual to relay that verbal input to an individual or committee involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Practitioners must also refrain from any discussions or lobbying with other Medical Staff members or Board members outside the authorized review process outlined in the PPE Policy.

4.G ***Failure to Provide Requested Input or Attend Meeting.***

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

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

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

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

See PPE-12 in the PPE Manual for a sample letter regarding Notice of Automatic Relinquishment Because of Failure to Provide Input.

(2) ***Hearing Regarding Automatic Relinquishment.*** A Practitioner who is the subject of an automatic relinquishment of clinical privileges may request a hearing with the Medical Executive Committee as set forth in Section 6.E.7 of the Medical Staff Credentials Policy.

(3) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. See PPE-13 in the PPE Manual for a sample letter regarding Notice of Automatic Resignation for Continued Failure to Provide Input.

4.H ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Policy are administrative actions that occur by operation of the PPE Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any Illinois licensing board or agency.

5. ADDITIONAL PROVISIONS GOVERNING THE CLINICAL REVIEW PROCESS

5.A ***External Reviews.***

(1) Obtaining an external review is within the discretion of the Leadership Council, acting in consultation with the Chief Executive Officer *or CMO*. No Practitioner has the right to demand that the Hospital obtain an external review in any particular circumstance.

(2) Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with Memorial Health.

(3) If a decision is made to obtain an external review, the Practitioner involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner shall be provided a copy of the reviewer's report (except that any comments related to care provided by other individuals shall be redacted).

(4) The report of the external reviewer is a record of the committee that requested it and will be maintained in a confidential manner as described in this Policy.

(5) The PPE Manual includes the following documents to assist with the use of external reviewers: PPE-6 (Letter Agreement with External Review Entity); PPE-7 (Letter Agreement with External Reviewer – Individual); and PPE-8 (Letter to External Reviewer Enclosing Information for Review).

5.B ***System Process Issues.*** Quality of care and patient safety depend on many factors in addition to Practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the appropriate Hospital department or committee and/or the PPE Specialists. The referral shall be reported to the Leadership Council and will stay on the Leadership Council's agenda until it determines, based on reports from the Hospital department or individuals charged with addressing the system issue, that the issue has been resolved.

5.C ***Peer Learning Sessions/Dissemination of Lessons Learned.*** Peer Learning Sessions and the dissemination of educational information through other mechanisms are integral parts of the PPE/peer review process and assist Practitioners in continuously improving the quality and safety of the care they provide. These activities will be conducted in a manner consistent with their confidential and privileged status under the Illinois peer review protection law and any other applicable federal or state law. Additional guidance on Peer Learning Sessions is included as PPE-31 to PPE-34 in the PPE Manual.

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

(1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under Illinois or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(2) ***Verbal Communications.*** Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(3) ***E-mail.*** Hospital e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line. E-mail should not be sent to non-hospital accounts unless the e-mail merely directs recipients to check their Hospital e-mail.

(4) ***Risk Management.*** Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

(5) ***Participants in the PPE Process.*** All individuals involved in the PPE process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals should sign an appropriate Confidentiality Agreement. Any breaches of confidentiality by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by Hospital employees will be referred to human resources. The PPE Manual includes the following Confidentiality Agreements that may be used to implement this subsection: PPE-37 (Confidentiality Agreement – Medical Staff Leader); PPE-38 (Confidentiality Agreement – Assigned Reviewer); and PPE-39 (Confidentiality Agreement – Hospital Employee).

(6) ***Practitioner Under Review.*** The Practitioner under review must also maintain all information related to the review in a strictly confidential manner, as required by Illinois law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the 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 Medical Staff Professionalism Policy.

5.E ***Communications with Practitioner That Include a Deadline.*** Before any paper or electronic correspondence that includes a deadline for a response (for example, a request for input or to attend a meeting) is mailed or e-mailed to a Practitioner, a text message should be sent or a phone call should be made (or voice mail left) to alert the Practitioner that the correspondence is being sent. The intent of any such text message or phone call is to make the Practitioner aware of the correspondence so that the deadline is not missed. However, failure to send a text message or make a phone call shall not be cause for the Practitioner to miss a deadline.

5.F ***Supervising Physicians and Advanced Practice Professionals.*** Except as noted below, 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 whom 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. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

5.G ***Legal Protections.*** Practitioners have significant personal legal protections from various sources when they perform functions described in this Policy as long as they maintain confidentiality and act in accordance with the Policy. These legal protections are described in Article 7 of the Medical Staff Bylaws.

5.H ***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.

5.I ***No Legal Counsel or Recordings During Collegial Meetings.***

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

(2) Practitioners may not create an audio or video recording of a meeting nor may they broadcast it in any manner (e.g., via live streaming). If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

5.J ***Professional Practice Evaluation Reports.***

(1) ***Practitioner PPE History Reports.*** A Practitioner history report showing all cases that have been reviewed for a Practitioner within the past two years and their dispositions should be generated for each Practitioner for consideration and evaluation by the Credentials Committee in the reappointment process. A Sample Practitioner History Report is included as PPE-42 in the PPE Manual.

(2) ***Reports to Medical Executive Committee, Medical Staff, and Board.*** The Leadership Council shall prepare reports at least annually that provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases, including numbers of cases closed at each level of the process; listing of education initiatives based on reviews; listing of system issues identified). These reports shall be disseminated to the Medical Executive Committee, all Practitioners at the Hospital, and the Board for the purposes of reinforcing the primary objectives outlined in Section 1.A of this Policy and permitting appropriate oversight. A sample PPE Activity Summary Report to be Provided to All Practitioners, MEC, and Board is included as PPE-43 of the PPE Manual.

(3) ***Reports on Request.*** The PPE Specialists shall prepare reports as requested by the Credentials Committee, Leadership Council, Medical Executive Committee, or the Board.

5.K ***Conflicts of Interest.*** To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. It is also important to recognize that effective peer review involves "peers" and that the Leadership Council does not make any recommendations that would adversely affect the clinical privileges of a Practitioner (which is only within the authority of the Medical Executive Committee). As such, the conflict of interest guidelines outlined in the Medical Staff Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy. Those conflict of interest guidelines are summarized in Appendix B.

5.L ***PPE Manual.*** The Leadership Council shall approve forms, checklists, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Professional Practice Evaluation Manual ("PPE Manual"). Such documents shall be developed and maintained by the PPE Specialists. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary.

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

5.N ***Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions.***

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

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

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

5.O ***Definitions and Acronyms.***

(1) ***Definitions.***

ASSIGNED REVIEWER means a Practitioner, or an individual who has been granted clinical privileges at another entity affiliated with Memorial Health, who is appointed by a CSR or the Leadership Council to either: (i) serve as a consultant to the individual or committee performing the review; or (ii) conduct a review, document his/her clinical findings on the AR Case Review Form (see PPE-5 in the PPE Manual), submit the form to the individual or committee that assigned the review, and be available to discuss

his/her findings and answer questions. The functions of an Assigned Reviewer may also be performed by a standing or ad hoc committee as requested by the CSR or the Leadership Council.

AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION of appointment and/or clinical privileges are administrative actions that occur by operation of the Medical Staff Credentials Policy and/or this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any Illinois licensing board.

CLINICAL SPECIALTY REVIEWER ("CSR") means a Medical Staff member, an Advanced Practice Professional, or a committee appointed by the Leadership Council to perform the functions set forth in this Policy for a particular specialty or type of case. The committees that may serve as CSRs include, but are not limited to, service line committees, system-wide committees, committees of Practitioners who provide services at one or more MH hospitals, a Trauma Committee, or a Stroke Committee. CSRs receive cases for review, obtain input from Assigned Reviewers as needed, complete the CSR Case Review Form (Individual) or CSR Case Review Form (Committee) (see PPE-4.1 and PPE-4.2 in the PPE Manual), and make a determination as described in Section 2.D of this Policy.

EMPLOYED PRACTITIONER means a Practitioner who is employed by an Employer.

EMPLOYER means:

(1) the Hospital; or

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

(a) has a formal peer review process and an established peer review committee; 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.

LEADERSHIP COUNCIL is a multi-specialty peer review committee under Illinois law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners in a constructive and educational manner to help address any clinical performance issues, and develops Voluntary Enhancement Plans as described in this Policy. The Leadership Council also handles issues of professional conduct pursuant to the Medical Staff Professionalism Policy and issues of Practitioner health

pursuant to the Practitioner Health Policy. The Leadership Council has no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the Leadership Council are described in the Medical Staff Organization Manual.

MEDICAL STAFF LEADER means any Medical Staff Officer or committee chair.

PPE SPECIALISTS means the clinical and non-clinical staff who support the professional practice evaluation process described in this Policy and who act at the direction of the Leadership Council. Such individuals may include, but are not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department. PPE Specialists act on behalf of the Leadership Council and documentation they create are records of the Leadership Council. The Leadership Council Chair or CMO may direct PPE Specialists to perform functions under this Policy on behalf of the Leadership Council.

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

PROFESSIONAL PRACTICE EVALUATION ("PPE") refers to the Hospital's routine peer review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise. The PPE process outlined in this Policy is applicable to all Practitioners and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

(2) ***Acronyms.***

CSR	Clinical Specialty Reviewer
FPPE	Focused Professional Practice Evaluation
MEC	Medical Executive Committee
OPPE	Ongoing Professional Practice Evaluation
PPE	Professional Practice Evaluation (Peer Review)
VEP	Voluntary Enhancement Plan

6. AMENDMENTS

6.A *Review by System Leadership Group.*

(1) If the MEC wishes to amend this Policy, it shall first submit the proposed amendments to a system leadership group comprised of the following: (a) the CMO of each MH Hospital (or the CEO if the hospital has no CMO); (b) the Medical Staff President of each MH Hospital; and (c) the MH General Counsel.

(2) The role of this system leadership group is to assess whether the amendment is appropriate and helpful for the Hospital, but also whether it would be beneficial for other MH Hospitals and foster the goals of sharing expertise within the system and promoting consistency.

(3) Following its assessment, the system leadership group will provide its report and recommendation to all relevant MH Hospitals.

6.B *Amendments Relevant to Only the Hospital.*

(1) After receiving a favorable recommendation from the system leadership group, the MEC may approve the amendment by a majority vote and then forward it to the Hospital Board for review and adoption.

(2) However, if the system leadership group has any questions or concerns about the proposed amendment, it will convene a meeting with the MEC to discuss and resolve whether to proceed with the amendment. If the disagreement cannot be resolved, the proposed amendment will be forwarded to the Hospital Board for its review with the concerns of the system leadership group being noted.

6.C *Amendments Relevant to More Than One MH Hospital.*

(1) After receiving a favorable recommendation from the system leadership group, the MEC for each relevant MH Hospital may approve the amendment by a majority vote and then forward the amendment to its Board for review and adoption.

(2) If there is any disagreement among the MECs concerning the amendment, a joint meeting of the MECs (or their representatives) and representatives of the system leadership group shall be scheduled to discuss and resolve the disagreement. In the unlikely event that a consensus cannot be achieved at that meeting, the proposed amendment shall be forwarded to the MH Board for further discussion and review.

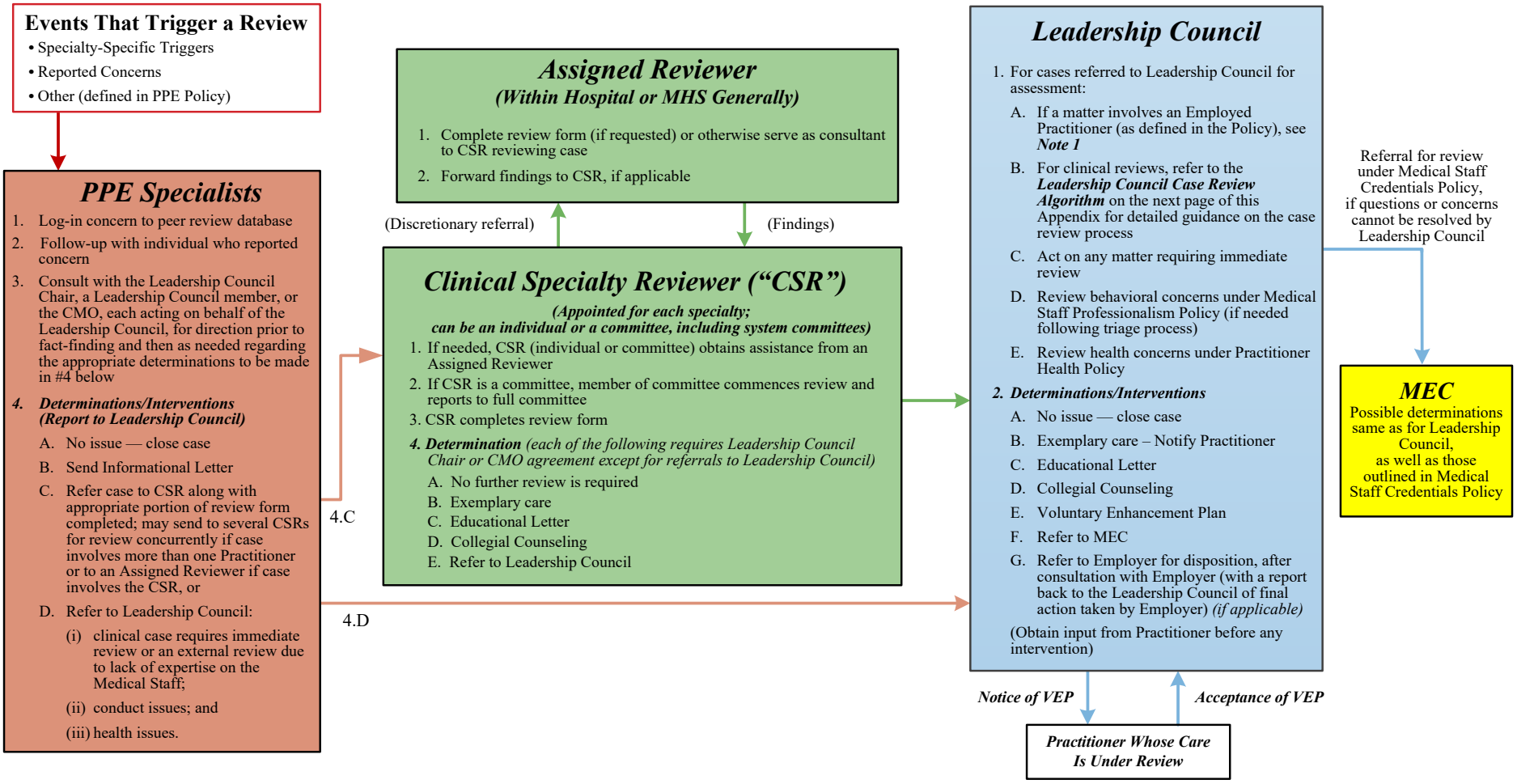
6.D ***Board Action.*** No amendment shall be effective unless and until it has been approved by the Hospital Board.

Adopted by the MEC: July 28, 2022.

Approved by the Board of Directors: August 31, 2022.

JACKSONVILLE MEMORIAL HOSPITAL

Appendix A: Flow Chart of Professional Practice Evaluation Process



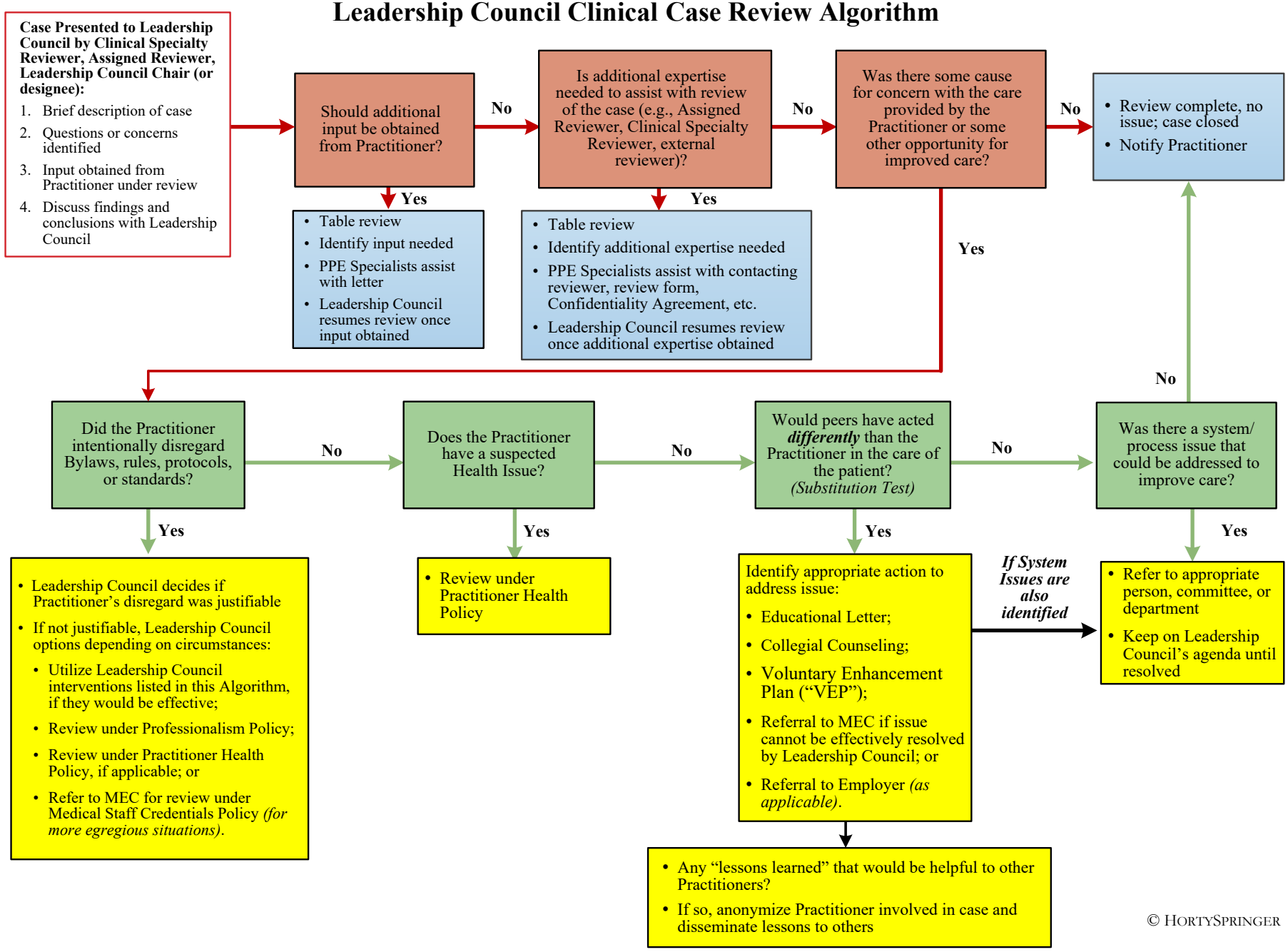
SYSTEM ISSUES identified at any level shall be referred to the appropriate person/committee and reported to the Leadership Council, which shall monitor the issue until resolved.

Any CSR or the Leadership Council may refer a case for review during a PEER LEARNING SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual practitioner has been completed.

Note 1: If the Practitioner is employed by the Hospital ("Employer"), the Leadership Council may notify a Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by Memorial Physician Services or a qualifying private entity (both also referred to as "Employer"), the Leadership Council may notify the peer review committee within the Employer and request assistance in addressing the matter. In all these situations, a representative of the Employer may be invited to attend meetings of the Leadership Council, participate in discussions and deliberations, and participate in any interventions that may be deemed necessary.

JACKSONVILLE MEMORIAL HOSPITAL

Leadership Council Clinical Case Review Algorithm



APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
			Committee Member					
	Provide Information	Clinical Specialty Reviewer (When Conducting Initial Case Review)	Credentials Committee	Leadership Council	MEC	Investigating Committee	Hearing Panel	Board
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	N	N	R
Relevant treatment relationship	Y	N	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	R	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	R	N	N	R

Y ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee and Leadership Council have no disciplinary authority.

In addition, the Chair of the Credentials Committee and Leadership Council always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N ("No") – means the Interested Member should not serve in the indicated role.

R ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the Medical Executive Committee prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.