MEMORIAL HEALTH

JACKSONVILLE MEMORIAL HOSPITAL

PRACTITIONER HEALTH POLICY

Adopted by the MEC: July 28, 2022
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1. POLICY AND DEFINITION OF HEALTH ISSUE

(a) Jacksonville Memorial Hospital (the "Hospital") is committed to providing safe, quality care, which can be compromised if a Practitioner is suffering from a Health Issue that is not appropriately addressed. The Hospital is also committed to assisting Practitioners in addressing Health Issues so they may practice safely and competently.

(b) This Policy outlines the process that will be used to evaluate and collegially resolve concerns that a Practitioner may have a Health Issue. A flowchart that outlines the review process described in this Policy is set forth in Appendix A.

(c) A "Health Issue" is any physical, mental, or emotional condition that could adversely affect a Practitioner's ability to practice safely and competently. Examples of Health Issues are included at PHM-1 in the Practitioner Health Manual. Other definitions used in this Policy are included in Section 13.

2. REPORTS OF POTENTIAL HEALTH ISSUES

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

(1) ***General Duty.*** Practitioners who have a Health Issue are required to report it to a Medical Staff Officer, the Chief Medical Officer ("CMO"), or another Medical Staff Leader.

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

(a) A Health Issue that will be fully resolved before the Practitioner next exercises his or her clinical privileges; or

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

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

(1) ***General.*** Any Practitioner or Hospital employee who is concerned that a Practitioner may be practicing with a Health Issue shall report the concern to a Medical Staff Officer, the CMO, or another Medical Staff Leader.

(2) ***Reporting Form.*** A Health Issue Reporting Form that may be used to report potential Health Issues is set forth as PHM-2 in the Practitioner Health Manual. The form outlines warning signs to facilitate the objective reporting of these issues.

(3) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously. However, all individuals are encouraged to identify themselves when making a report so that the PPE Specialists may contact the reporter for additional information that may help the Practitioner and safeguard patients, if necessary.

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

In addition, the treating Practitioner should consider whether a mandatory report is required under state law to the applicable licensing board or any other state agency. If the treating Practitioner believes a mandatory report is necessary pursuant to Illinois law, he or she should notify the Practitioner and encourage the Practitioner to self-report prior to making the mandatory report. The treating Practitioner may consult with the CMO for assistance and resources in such matters, but should not disclose to the CMO information that identifies the Practitioner.

3. RESPONSE TO IMMEDIATE THREATS

3.A ***Scope of Section.*** This section applies if a potential Health Issue is reported that raises immediate concerns because either:

(1) The Practitioner is providing services at the Hospital at that time; or

(2) The Practitioner is expected to provide services in the very near future such that the Leadership Council would not have time to meet prior to the Practitioner's provision of services.

By way of example and not limitation, this section applies if a Practitioner seems disoriented or displays erratic behavior while rounding on patients, or is suspected of being under the influence of drugs or alcohol while working.

3.B ***Assessment of Immediate Threat and Related Testing of Practitioner.***

(1) If a report suggests that a Practitioner may have a Health Issue that poses an immediate threat to patients, the Practitioner, or others, a Medical Staff Officer, the CMO, or another Medical Staff Leader shall immediately and personally assess the Practitioner. If no such individual is reasonably available, a member of the Administrative Team may conduct the assessment.

(2) Any two Medical Staff Leaders, or one Medical Staff Leader and one member of the Administrative Team, may require the Practitioner to submit to a blood, hair, or urine test, or other appropriate physical or cognitive testing, to determine his or her ability to safely practice. If the individual who personally assesses the Practitioner is unable to contact a second Medical Staff Leader or member of the Administrative Team after reasonable efforts (e.g., at night or on a weekend), the individual who personally assessed the Practitioner may require the Practitioner to submit to the test described in the prior sentence.

(3) Failure of the Practitioner to undergo such testing upon request will result in the automatic relinquishment of the Practitioner's clinical privileges pending Leadership Council review of the matter. See Section 11 of this Policy for additional information on automatic relinquishment. A letter that may be used to notify the Practitioner of an automatic relinquishment is included as PHM-3 in the Practitioner Health Manual (Notice of Automatic Relinquishment for Refusal of Testing When There Are Immediate Concerns).

3.C ***Interim Safeguards to Protect Patients and Others.*** If the individual who assesses the Practitioner believes the Practitioner may have a Health Issue and that action is necessary to protect patients, the Practitioner, or others, the Practitioner should be asked to voluntarily refrain from exercising his or her clinical privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner either before or after any tests or evaluations regarding the Practitioner have been completed.

(1) ***Agreement to Voluntarily Refrain.*** If the Practitioner agrees to voluntarily refrain from exercising his or her privileges, the Medical Staff President or CMO may assign the Practitioner's patients to another individual with appropriate clinical privileges or to the appropriate Practitioner on the Emergency Department call roster. Affected patients shall be informed that the Practitioner is unable to proceed with their care due to an emergency situation. Any wishes expressed by patients regarding a covering Practitioner will be respected to the extent possible. The Practitioner's agreement to voluntarily refrain is not reportable to the National Practitioner Data Bank or state licensing board. Such agreements should be documented in a letter or other correspondence to the Practitioner that is maintained in the Practitioner's Confidential Health File.

(2) ***Other Action.*** If the Practitioner will not agree to: (i) voluntarily refrain from exercising his or her privileges; or (ii) conditions on his or her practice that are deemed necessary, an individual authorized by the Medical Staff Bylaws to impose a precautionary suspension will consider whether a

precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

3.D ***Referral for Log-in and Follow-up.*** Following the immediate response described above, the matter shall be referred to the PPE Specialists for log-in and follow-up as described in the next section.

4. LOG-IN AND FOLLOW-UP

4.A ***Logging of Reports and Creation of Confidential Health File.*** The PPE Specialists will log any report of a Health Issue and create a Confidential Health File that is maintained separately from the credentials or quality files (however, the existence of the Confidential Health File will be noted in the credentials or quality file). See Section 12 of this Policy for more information on Confidential Health Files.

4.B ***Follow-up with Individual Who Filed Report.*** The PPE Specialists or CMO shall follow up with individuals who file a report. A Response to Individual Who Reported Concerns About a Health Issue that may be used for this purpose is included as PHM-4 in the Practitioner Health Manual.

4.C ***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.D ***Fact-Finding.*** The PPE Specialists, Medical Staff President, and/or CMO, acting on behalf of the Leadership Council, shall interview witnesses or others who may have information and gather any other necessary documentation or information needed to assess the reported concern. An Interview Tool for Fact-Finding (Script and Questions) is included as PHM-5 in the Practitioner Health Manual.

4.E ***Referral to Leadership Council.*** All suspected Health Issues will be referred to the Leadership Council for its review as set forth in the next section.

5. LEADERSHIP COUNCIL REVIEW

5.A ***Individuals Participating in Review/Additional Clinical Expertise.*** If the Leadership Council determines that it would be necessary or helpful in addressing the reported concern, it may consult with or include a representative of the Employer, the Department Chair, a subject matter expert (e.g., an addictionologist, neuropsychologist, or psychiatrist) or any other individual with relevant expertise. Any individual who participates in a review is an integral part of the Hospital's review process, and shall be governed by the same responsibilities and legal

protections (e.g., confidentiality, indemnification, etc.) that apply to other participants in the process. The chair of the Leadership Council has the discretion to recuse the Employer representative during any deliberations or vote on a matter.

5.B ***Additional Fact-Finding.*** The Leadership Council may review any documentation relevant to the Health Issue. It may also meet with the individual who initially reported the concern and any other individual who may have relevant information. An Interview Tool for Fact-Finding (Script and Questions) is included as PHM-5 in the Practitioner Health Manual.

5.C ***Meeting with Practitioner.*** If the Leadership Council believes that a Practitioner may have a Health Issue, the Leadership Council shall meet with the Practitioner. At this meeting, the Practitioner will be advised of the nature of the concern, asked to provide input, and informed of the Leadership Council's recommendations. Talking Points for Meeting with Practitioner About Health Issue that may be used to help the Leadership Council prepare for and conduct such meetings are included as PHM-6 in the Practitioner Health Manual.

5.D ***Practitioner's Refusal to Obtain Assessment.*** If a Practitioner refuses to obtain a health assessment that is recommended by the Leadership Council or provide the results to the Leadership Council, the process outlined in Section 11 of this Policy will be followed.

5.E ***Self-Disclosure to Other Entities.*** In its discretion, the Leadership Council may encourage the Practitioner to self-disclose the Health Issue to other entities where the Practitioner practices. The Leadership Council may point out that Medical Staff Bylaws and related documents typically require Practitioners to self-disclose such information. If applicable, documentation confirming that the self-disclosure occurred should be obtained (e.g., e-mail confirmation from other entities).

5.F ***Review of Practitioner's Clinical Practice.***

(1) If the Leadership Council has concerns that a Practitioner's Health Issue may have affected the Practitioner's clinical practice prior to the Health Issue being identified, the Leadership Council may review a sample of the Practitioner's cases. In conducting this review, the Leadership Council may seek assistance from any Practitioner, an external reviewer or other sources. Confidentiality reminders should be provided to those assisting with the review.

(2) If a potential concern is identified, the Leadership Council will determine if the concern was likely caused by the Health Issue:

(a) If so, the Leadership Council will assess whether resolution of the Health Issue will also resolve any potential clinical concerns. Oversight of the Practitioner's clinical practice may be included as

part of any conditions of the Practitioner's continued practice. In addition, the Leadership Council shall assess whether it is necessary to contact any previous patients for purposes of obtaining additional testing or other interventions (e.g., concerns that previous radiologic interpretations may have been adversely affected by the Health Issue).

(b) If the clinical concern was likely not related to the Practitioner's Health Issue, the matter will be referred for review under the Professional Practice Evaluation Policy (Peer Review).

6. INTERIM SAFEGUARDS PENDING COMPLETION OF ASSESSMENT

If a Practitioner agrees to obtain an assessment, the Leadership Council may also recommend that the Practitioner voluntarily take one or more of the following actions while the assessment is pending:

(a) Agree to specific conditions on his or her practice, which could include obtaining assistance from other Practitioners during patient care activities;

(b) Refrain from exercising some or all privileges at the Hospital and at other practice locations as may be appropriate; or

(c) Take a leave of absence.

If a Practitioner does not agree to take a temporary voluntary action recommended by the Leadership Council while the assessment is pending, an individual authorized by the Medical Staff Bylaws to impose a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

7. ASSESSMENT OF HEALTH STATUS

7.A ***General.*** The Leadership Council may require the Practitioner to undergo a physical, mental, cognitive, or other examination or other assessment by an appropriate clinician. This may include, but is not limited to, an assessment by the Illinois Professionals Health Program. The Leadership Council may also ask the Practitioner to provide a letter from his or her treating physician confirming the Practitioner's ability to safely and competently practice, and authorize the treating physician to meet or speak with the Leadership Council.

7.B ***Person to Conduct Assessment.*** The Leadership Council shall select the health care professional or organization to perform any examination, testing, or evaluation, but may seek input from the Practitioner. More than one health care professional or organization may be asked to perform an examination, test, or

evaluation, and this may occur either concurrently or serially (e.g., a substance abuse assessment following a positive drug screen).

7.C ***Costs of Assessment.*** The Practitioner shall be responsible for any costs associated with the assessments described in the prior section, unless the Leadership Council determines otherwise.

7.D ***Forms.*** The Practitioner Health Manual includes the following forms, which should be used when implementing the provisions of this section:

(1) Consent for Disclosure of Information and Release from Liability (PHM-7), which authorizes the Hospital to release information to the health care professional or organization conducting the evaluation;

(2) Authorization for Release of Protected Health Information (PHM-8), which authorizes the health care professional or organization conducting the evaluation to disclose information about the Practitioner to the Leadership Council; and

(3) Health Status Assessment Form (PHM-9), which documents the results of an evaluation.

8. REINSTATEMENT/RESUMING PRACTICE

8.A ***Request for Reinstatement from Leave of Absence or to Resume Practicing.***

(1) ***Leave of Absence.*** If a Practitioner was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner must apply for reinstatement of privileges using the process set forth in the Medical Staff Bylaws.

(2) ***Agreement to Refrain Without Formal Leave of Absence.*** In all other circumstances where the Practitioner refrained from practicing (e.g., voluntary agreement between Practitioner and Leadership Council; Practitioner was absent from Medical Staff duties while participating in a treatment program or otherwise addressing a Health Issue), the Practitioner must submit a written request to the Leadership Council and receive written permission to resume exercising his or her clinical privileges.

8.B ***Additional Information.*** Before acting on a Practitioner's request for clearance to apply for reinstatement from a leave of absence or to resume practicing, the Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner to undergo a health assessment conducted by a physician or entity

chosen by the Leadership Council in order to obtain a second opinion on the Practitioner's ability to practice safely and competently.

8.C ***Determination by Leadership Council.***

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

(2) If the Leadership Council determines that conditions should be placed on a Practitioner's practice as a condition of reinstatement or resuming practice, it will follow the process outlined in the following Section.

9. CONDITIONS OF CONTINUED PRACTICE

9.A ***General.*** The Leadership Council may ask the Practitioner to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. Examples of Conditions of Continued Practice are included as PHM-10 in the Practitioner Health Manual.

9.B ***Refusal to Agree to Conditions.*** If the Practitioner does not agree to conditions requested pursuant to the prior paragraph, the Leadership Council cannot compel the Practitioner to comply with them. In that situation, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review under the Medical Staff Bylaws.

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

9.D ***Voluntary Agreement to Conditions Not a "Restriction."*** A Practitioner's voluntary agreement to conditions similar to the Examples of Conditions of Continued Practice at PHM-10 in the Practitioner Health Manual generally does not result in a "restriction" of that Practitioner's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank ("NPDB") or to any state licensing board or other government agency, nor would it entitle a Practitioner to a hearing under the Medical Staff Bylaws. However, the Leadership Council will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board or agency, the Leadership Council will consult with counsel

and communicate with the Practitioner about the matter prior to making any such report.

10. REFERRALS TO MEDICAL EXECUTIVE COMMITTEE OR EMPLOYER

10.A ***Referral to Medical Executive Committee.*** A matter shall be immediately referred to the Medical Executive Committee for its review and action pursuant to the Medical Staff Bylaws if the Practitioner fails to:

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

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

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

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

10.B ***Referral to Employer.*** The Leadership Council may refer a matter to the Employer for disposition, after consultation with the Employer. In such case, the Leadership Council will obtain a report from the Employer regarding the final action taken by the Employer. If the Leadership Council determines that the Employer's action is insufficient, the Leadership Council may take whatever action it deems necessary in accordance with this Policy.

11. AUTOMATIC RELINQUISHMENT/RESIGNATION FOR REFUSAL TO PROVIDE INFORMATION OR MEET WITH THE LEADERSHIP COUNCIL

11.A ***Refusal of Testing When There Are Immediate Concerns.*** If a Practitioner refuses to undergo testing or an assessment when there are immediate concerns about patient safety as described in Section 3, the refusal will result in the immediate and automatic relinquishment of the Practitioner's clinical privileges pending the Leadership Council's review of the matter.

11.B ***Other Refusals.*** If a Practitioner fails or refuses to:

(1) obtain a health assessment acceptable to the Leadership Council and provide the results to the Leadership Council when requested to do so pursuant to this Policy;

(2) provide other information requested by the Leadership Council; or

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

the Practitioner will be required to meet with the Leadership Council to discuss why the health assessment was not obtained, the requested information (including the results of a health assessment) was not provided, or the meeting was not attended. Failure of the Practitioner to either:

(i) meet with the Leadership Council and persuade it that the health assessment, requested information or meeting is not necessary; or

(ii) provide the requested information prior to the date of the Leadership Council meeting,

will result in the automatic relinquishment of the Practitioner's clinical privileges until the Practitioner either provides the requested information or attends the original meeting as requested. A Letter to Practitioner Requesting Meeting with the Leadership Council/Automatic Relinquishment Possibility if Failure to Meet is included as PHM-11 in the Practitioner Health Manual.

11.C ***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 the Medical Staff Bylaws.

11.D ***Automatic Resignation.*** If the Practitioner fails to meet with or provide information requested by the Leadership Council within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

11.E ***Reporting Requirements.***

(1) Generally, the automatic relinquishment or resignation of appointment and/or clinical privileges described above are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the NPDB or to any state licensing board or agency.

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

12. CONFIDENTIAL HEALTH FILES/REAPPOINTMENT PROCESS

12.A ***Creation of Confidential Health File.*** Reports of potential Health Issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's Confidential Health File, which shall be maintained by the PPE Specialists as a separate file and shall not be included in the credentials file or the quality file.

12.B ***Information Reviewed at Reappointment.***

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

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

(3) The Leadership Council will prepare a Confidential Summary Health Report to the Credentials Committee. The Summary Health Report shall be included in the credentials file and reviewed by the Credentials Committee subject to any conditions on the review of health information set forth in the Medical Staff Bylaws.

(4) The Leadership Council's Summary Health Report will state that it is actively monitoring, or has monitored in the past reappointment cycle, a Health Issue involving the Practitioner. It will not contain details or specifics regarding the Health Issue. The Summary Health Report will also include a recommendation regarding the Practitioner's ability to perform the duties of Medical Staff membership and safely exercise clinical privileges. A Sample Summary Health Report for Use at Reappointment is included as PHM-12 in the Practitioner Health Manual.

(5) If the Credentials Committee, Medical Executive Committee, or Board has any question about the Practitioner's ability to safely practice, a representative of the relevant entity will discuss the issue with a member of the Leadership Council, attend a meeting of the Leadership Council to discuss the issue, or have a member of the Leadership Council attend a Board meeting. If a committee or the Board still believes additional information is necessary, its representative may review the Practitioner's Confidential Health File in the Medical Staff Office along with a representative of the Leadership Council. If there are still concerns, the Confidential Health File will be reviewed at a meeting of the committee or

Board in executive session, with guidance regarding the need for strict confidentiality being provided prior to the review.

13. ADDITIONAL PROVISIONS GOVERNING THE REVIEW OF HEALTH ISSUES

13.A ***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 maintained in the Practitioner's Confidential Health File. 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. Access to the Confidential Health File for recredentialing purposes is governed by Section 12 of this Policy. Any other request to access the Confidential Health File must be approved by the Leadership Council.

(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 health review process, including with the Practitioner in question. 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) ***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 agreements are included as PHM-13 and PHM-14 in the Practitioner Health Manual). Any breaches of confidentiality will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by Hospital employees will be referred to human resources.

13.B ***Health Issues Identified During Credentialing Process.*** A Health Issue that is identified during the credentialing process shall be addressed pursuant to the Medical Staff Bylaws. The Credentials Committee may request assistance from the Leadership Council in assessing the Health Issue, if that would be helpful. If a determination is made by the Credentials Committee that the Practitioner is qualified for appointment and privileges, but has a Health Issue that should be

monitored or treated, the matter shall be referred to the Leadership Council for ongoing monitoring or oversight of treatment pursuant to this Policy.

13.C ***Immediate Referrals to Medical Executive Committee.*** Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy if necessary to effectively address a Practitioner Health Issue. Similarly, nothing in this Policy precludes referral of a matter to the Medical Executive Committee if a Practitioner fails to abide by this Policy or any agreement reached with the Leadership Council (for example, conditions of continued practice).

13.D ***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. 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.

13.E ***Identity of Individual Who Reports a Health Issue.***

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

(2) ***Exceptions.***

(i) ***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).

(ii) ***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.

(3) ***Practitioner Guessing the Identity of Reporter.*** This section does not prohibit the Leadership Council from notifying a Practitioner about a Health Issue 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 Leadership Council will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

13.F ***Supervising Physicians and Advance Practice Professionals.*** Except as set forth below, an appropriate supervising or collaborating physician shall be notified if a concern is being reviewed pursuant to this Policy involving an Advance Practice Professional with whom the physician has a supervisory or collaborative relationship. The disclosure to the supervising or collaborating physician will be limited to a general statement that a Health Issue is currently being reviewed and that additional information will be forthcoming once the Practitioner has signed an appropriate authorization. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

13.G ***Redisclosure of Drug/Alcohol Treatment Information.*** In the course of addressing a Health Issue pursuant to this Policy, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally-assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The Hospital may not redisclose such information without a signed authorization from the Practitioner. An Authorization for Redisclosure of Drug/Alcohol Treatment Information that may be used for this purpose is included as PHM-15 in the Practitioner Health Manual.

13.H ***Educational Materials.*** The Leadership Council shall recommend to the Medical Executive Committee educational materials that address Practitioner Health Issues and emphasize prevention, identification, diagnosis, and treatment of Health Issues. This Policy and any educational materials approved by the Medical Executive Committee shall be made available to Practitioners and Hospital personnel. In addition, the Medical Executive Committee shall periodically include information regarding illness and impairment recognition issues in CME activities.

13.I ***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.

13.J ***Practitioner Health 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 Practitioner Health 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.

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

13.L ***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 further described in Article 7 of the Medical Staff Bylaws.

13.M ***Reports to Medical Executive Committee and Board.*** The Leadership Council shall prepare reports at least annually that provide de-identified information regarding the review of Health Issues as set forth in this Policy. These reports should be disseminated to the Medical Executive Committee and the Board for the purposes of reinforcing the primary objectives outlined in Section 1 of this Policy and permitting appropriate oversight. A sample Summary Report for Practitioner Health Issue Review Activities to Be Provided to MEC and Board is included as PHM-16 in the Practitioner Health Manual.

13.N ***Definitions.***

(1) **"*Administrative Team"*** means the CEO, Chief Operating Officer, CMO, Chief Nursing Officer, or any Administrator on call.

(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:

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

(ii) 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) ***"Health Issue"*** is defined in Section 1 of this Policy.

(5) ***"Medical Staff Leader"*** means any Medical Staff Officer, Department Chair or committee chair.

(6) ***"PPE Specialists"*** means the clinical and non-clinical staff who support the review of issues related to health described in this Policy and who act at the direction of the Leadership Council. This may include, but is not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department. Documentation the PPE Specialists 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.

(7) ***"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 Advance Practice Professionals.

14. AMENDMENTS

14.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.

14.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.

14.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.

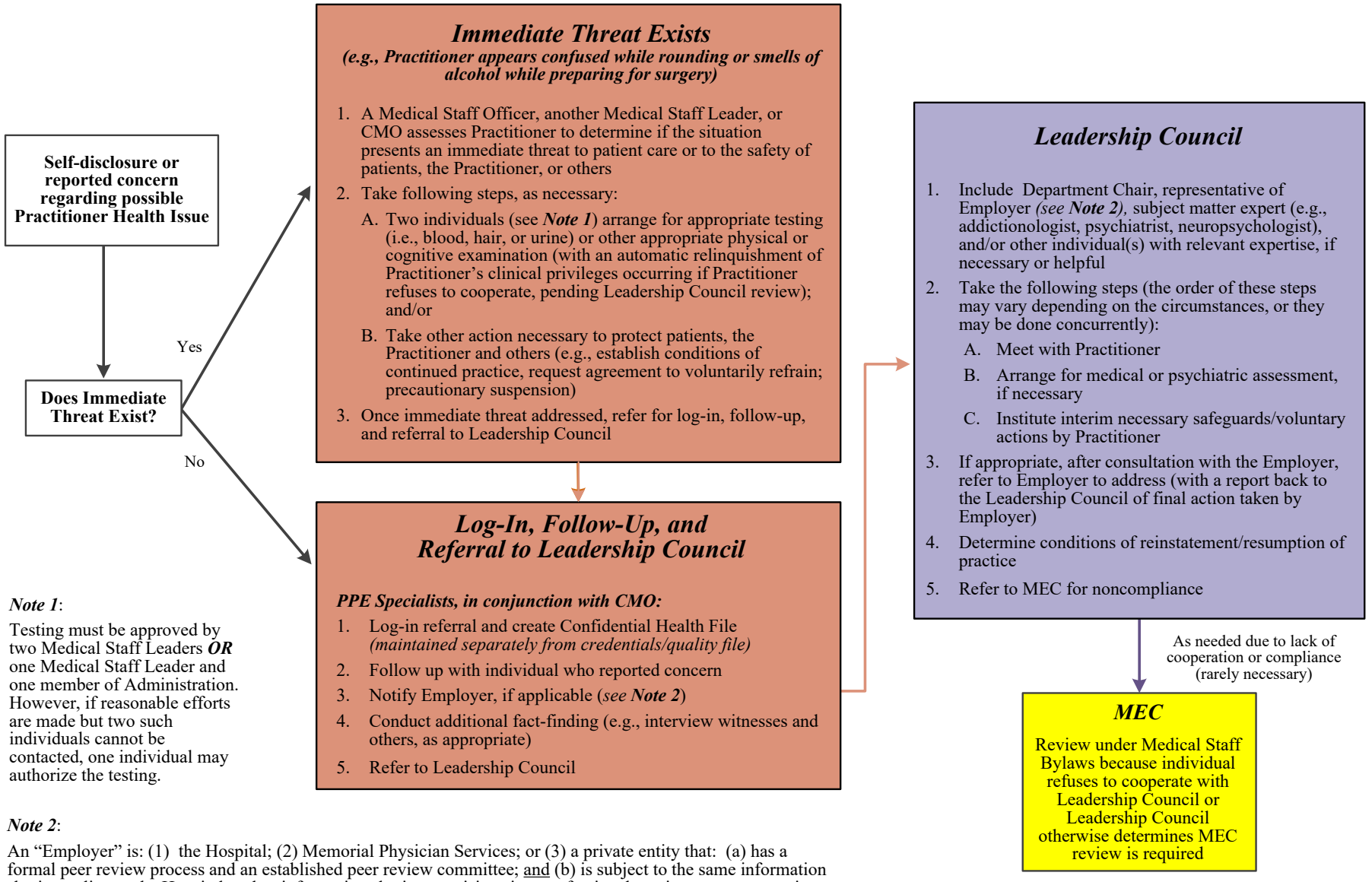
14.D ***Board Action.*** No amendment shall be effective unless and until it has been approved by the Hospital Board.

Adopted by the MEC: July 28, 2022.

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

JACKSONVILLE MEMORIAL HOSPITAL

Appendix A: Review Process for Practitioner Health Issues



Note 1:

Testing must be approved by two Medical Staff Leaders ***OR*** one Medical Staff Leader and one member of Administration. However, if reasonable efforts are made but two such individuals cannot be contacted, one individual may authorize the testing.

Note 2:

An "Employer" is: (1) the Hospital; (2) Memorial Physician Services; or (3) 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.