UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0007 *
INDEX TITLE: Medical Staff

SUBJECT: Practitioner Health Policy of UPMC
DATE: April 1, 2024

This Policy applies to the following United States based UPMC facilities, including any providers who practice therein:

[Check all that apply]

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

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PRACTITIONER HEALTH POLICY

1. POLICY AND DEFINITION OF HEALTH ISSUE

(a) UPMC and the Participating UPMC Hospitals (referred to individually as the "Hospital" in this Policy) are committed to providing safe, quality care, which can be compromised if a Practitioner is suffering from a Health Issue that is not appropriately addressed. UPMC and the Participating UPMC Hospitals are 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 12.

2. REPORTS OF POTENTIAL HEALTH ISSUES

2.A ***Self-Reports.*** Practitioners who have a Health Issue are expected to report it to a Medical Staff Officer, another Medical Staff Leader, or the Vice President of Medical Affairs ("VPMA"). However, this does not apply to

(1) A Health Issue that will be fully resolved before the Practitioner next exercises his or her clinical privileges (i.e., Health Issue does not require additional treatment, follow-up, or monitoring); or

(2) 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. The matter may be reported through a standard Hospital reporting mechanism or to a Medical Staff Officer, another Medical Staff Leader, or the VPMA.

(2) ***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 state law, he or she should notify the Practitioner and encourage the Practitioner to self-report prior to making the mandatory report.

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[1] would not have time to meet prior to the Practitioner's provision of services.

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, another Medical Staff Leader, or the VPMA shall immediately and personally assess the situation. If no such individual is reasonably available, a member of the Administrative Leadership may assess the situation.

(2) Any two Medical Staff Leaders, or one Medical Staff Leader and one member of the Administrative Leadership, may require the Practitioner to submit to a blood, hair, or urine test to determine his or her ability to safely practice. If the individual who personally assesses the situation is unable to contact a second Medical Staff Leader or member of the Administrative Leadership after reasonable efforts (e.g., at night or on a weekend), one individual 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 10 of this Policy for additional information on automatic relinquishment.

[1] Consistent with the duties of the committees described in the Hospital's Medical Staff Organization Manual or other document, the functions in this Policy that are assigned to the Leadership Council may be performed by a Physician Health Committee.

3.C ***Interim Safeguards to Protect Patients and Others.*** If the individuals who assess the situation believe 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 VPMA 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 the Practitioner or patients regarding a covering Practitioner will be respected to the extent possible. 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 Documentation and Follow-up.*** Following the immediate response described above, the matter shall be referred to the PPE Specialists Committee for documentation and follow-up as described in the next section.

4. DOCUMENTATION AND FOLLOW-UP

4.A ***Documentation of Reports and Creation of Confidential Health File.*** The PPE Specialists Committee will document any report of a Health Issue and create a Confidential Health File. See Section 11 of this Policy for more information on Confidential Health Files.

4.B ***Follow-up with Individual Who Filed Report.*** The PPE Specialists Committee or VPMA 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.*** In accordance with the Policy on Sharing Peer Review Information Among UPMC Entities, if a reported concern involves an Employed Practitioner as defined in this Policy, the PPE Specialists Committee will notify the Employer that the matter is being reviewed. 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. Neither the information sharing described in this section nor any other provision in this Policy affects an Employer's authority to take any action authorized by the Employer's policies or contract with a Practitioner.

4.D ***Fact-Finding.*** The PPE Specialists Committee, Medical Staff President, and/or VPMA may speak with witnesses and other individuals, review documentation, and engage in other fact-finding to assess the nature and potential severity of a reported concern about a Health Issue.

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.*** 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.

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. Prior to this meeting, the Practitioner may be advised of the nature of the concern and asked to provide input.

5.D ***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.

5.E ***Interim Safeguards.*** The Leadership Council may recommend that the Practitioner voluntarily take one or more of the following actions while the review is pending:

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

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

(3) 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 or Credentials Policy 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.

6. ASSESSMENT OF HEALTH STATUS

6.A ***General.*** Following the meeting with the Practitioner, the Leadership Council may ask the Practitioner to undergo a physical, mental, cognitive, or other examination by an appropriate clinician. This may include, but is not limited to, an assessment by the state Physicians Health Program.

6.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).

6.C ***Costs of Assessment.*** The Hospital (or Medical Staff) may elect to pay the costs for any assessment described in this Section that are not covered by the Practitioner's insurance. However, the Practitioner will be solely responsible for the costs of any follow-up care recommended as a result of the assessment.

6.D ***Forms.*** The Practitioner Health Manual includes a Consent for Disclosure of Information and Release from Liability which authorizes the Hospital and Medical Staff Leaders to release information to the health care professional or organization conducting the evaluation. This form shall be used when implementing the provisions of this section.

6.E ***Practitioner's Refusal to Obtain Assessment or Take Other Actions to Effectuate Review.*** See Article 10 of this Policy for the process to follow if a Practitioner refuses to obtain a health assessment that is recommended by the Leadership Council or take other actions necessary to effectuate the review.

7. REINSTATEMENT/RESUMING PRACTICE

7.A ***Request to Resume Practicing.*** A Practitioner who was granted a formal leave of absence or who otherwise refrained from practicing to address a Health Issue must submit a written request to the Leadership Council and receive written permission to resume exercising his or her clinical privileges. The request must be accompanied by a report from a health care professional acceptable to the Leadership Council indicating that the Practitioner is capable of resuming a hospital practice and safely exercising the Practitioner's clinical privileges.

7.B ***Additional Information.*** 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 resume exercising clinical privileges.

7.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 resume practicing.

(2) If the Leadership Council determines that the Practitioner should only resume practicing subject to certain conditions, it will follow the process outlined in the following Section.

(3) If the Leadership Council has concerns about the Practitioner's ability to resume practicing even with conditions described in the following Section, the reinstatement request shall be forwarded to the Medical Executive Committee for review under the Credentials Policy.

8. CONDITIONS OF CONTINUED PRACTICE

8.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.

8.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 or Credentials Policy.

8.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. REFERRALS TO MEDICAL EXECUTIVE COMMITTEE OR EMPLOYER

9.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 Credentials Policy 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 Credentials Policy.

9.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. Nothing in this Policy affects an Employer's ability to address a Practitioner Health Issue pursuant to its policies or contract with the Practitioner.

10. AUTOMATIC RELINQUISHMENT

10.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 temporary and automatic relinquishment of the Practitioner's clinical privileges pending the Leadership Council's review of the matter.

10.B ***Other Refusals.*** A Practitioner's clinical privileges will be temporarily and automatically relinquished if the Practitioner fails or refuses to:

(1) obtain a health assessment acceptable to the Leadership Council;

(2) execute releases to allow Medical Staff Leaders or the Leadership Council to communicate with the individual or entity conducting a review, and to

allow the individual or entity conducting the review to report the results to the Medical Staff Leaders or Leadership Council;

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

Automatic relinquishment will continue until the health assessment is obtained, the requested release is signed, the requested information is provided, or the meeting is attended.

10.C ***Review by Medical Executive Committee.*** A Practitioner who automatically relinquishes privileges may request, and will be granted, a review of the matter by the Medical Executive Committee. Such review will occur within 14 days of the request. The Medical Executive Committee may confirm the recommendation of the Leadership Council or may direct the Leadership Council to take some other action consistent with this Policy.

10.D ***Automatic Resignation.*** If the Practitioner fails to resolve the matter 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.

10.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, nor do they entitle the Practitioner to a hearing or appeal.

(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. Hospital counsel should be consulted in making such determinations and the Practitioner should be notified of the potential for a report.

11. CONFIDENTIAL HEALTH FILES/REAPPOINTMENT PROCESS

11.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 Committee as a separate file and shall not be included in the credentials

file or the quality file. However, the existence of the Confidential Health File will be noted in the credentials file or quality file.

11.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 Committee shall contact the Leadership Council.

(3) The Leadership Council will prepare a Summary Health Report and submit it 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 Credentials Policy.

(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.

(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.

12. ADDITIONAL PROVISIONS GOVERNING THE REVIEW OF HEALTH ISSUES

12.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 state 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 11 of this Policy.

(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 "Secure: Confidential PPE/Peer Review Communication" in the subject line. All participants in the PPE process are strongly encouraged to use their Hospital e-mail accounts to maximize peer review and HIPAA privacy protections. E-mail may also be sent to non-Hospital accounts when: (i) the e-mail merely directs recipients to check their Hospital e-mail, or (ii) the e-mail is encrypted in a manner approved by Hospital policy. Any e-mail containing a patient's protected health information must comply with the Hospital's HIPAA policies.

(4) ***Participants in the Review Process.*** All individuals involved in the review process (Medical Staff and Hospital employees) must maintain the confidentiality of all information generated during a review. All such individuals should sign an appropriate Confidentiality Agreement.

12.B ***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.

12.C ***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. 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.

12.D ***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.

12.E ***Supervising Physicians and Advanced Practice Professionals or Allied Health Professionals.*** Except as set forth below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional or Allied Health Professional for state licensure purposes shall be notified if a concern is being reviewed pursuant to this Policy involving the Advanced Practice Professional or Allied Health Professional. The disclosure to the primary 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 Advanced Practice Professional or Allied Health Professional has signed an appropriate authorization. The primary supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the primary 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.

12.F ***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.

12.G ***Educational Materials.*** This Policy and any educational materials approved by the Medical Executive Committee will be made available to Practitioners and Hospital personnel. In addition, the Medical Executive Committee will periodically include information regarding illness and impairment recognition issues in CME activities.

12.H ***Delegation of Functions.***

(1) The Leadership Council is responsible for the health/quality assurance process described in this Policy, subject to the oversight of the Medical Executive Committee and Board. To promote a prompt and effective review process, the Leadership Council hereby expressly delegates to the PPE Specialists Committee, Medical Staff Leaders and the VPMA the authority to perform the functions described in this Policy on behalf of the Leadership Council. Actions taken by these individuals will be reported to and reviewed by the Leadership Council as set forth in this Policy.

(2) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(3) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

12.I ***Practitioner Health Manual.*** Forms, checklists, template letters and other documents that assist with the implementation of this Policy are collectively known as the Practitioner Health Manual. Such documents will be developed and maintained by the PPE Specialists Committee. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary. However, failure to use such a document does not affect the validity of a review.

12.J ***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.

12.K ***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.

12.L ***Definitions.*** Unless otherwise indicated below, the terms used in this Policy are defined in the Medical Staff Credentials Policy.

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

(2) ***"Employer"*** means:

(a) the Hospital; or

(b) a UPMC-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.

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

(4) ***"PPE Specialists Committee"*** means a member of the PPE Specialists Committee at a Participating UPMC Hospital. This may include, but is not limited to, a Quality Department RN Reviewer, VPMA, applicable Department Chair, representatives from Medical Staff Services, and/or representatives of the Wolff Center who work on behalf of the Participating UPMC Hospital.

13. AMENDMENTS

(a) The Medical Staffs and Board at each Participating UPMC Hospital have independently adopted this Policy as their own by voting to approve it for use at each of their respective facilities. In doing so, the Participating UPMC Hospitals have delegated to the Medical Review Council the authority to develop and adopt amendments to this Policy.

(b) Notice of any amendments will be provided to the Medical Executive Committees at each Participating UPMC Hospital for their information. Any amendments to this Policy will take effect immediately upon receiving notice of the changes from the Medical Review Council.

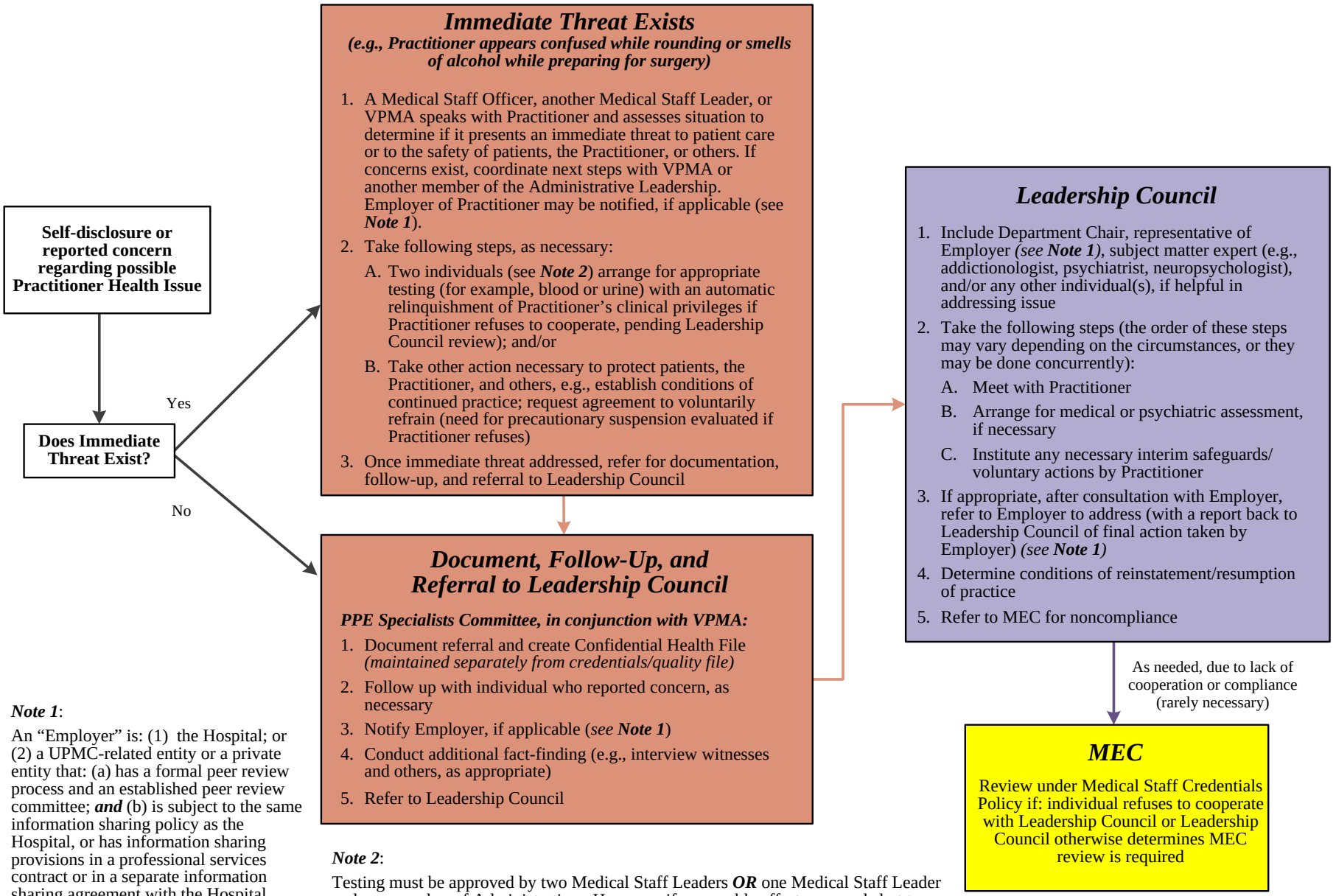
(c) If any Medical Executive Committee has concerns about an amendment, they may bring the concern to the attention of the Medical Review Council. The Medical Executive Committee may also recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

UPMC HOSPITALS

Appendix A: Review Process for Practitioner Health Issues



Note 1:

An "Employer" is: (1) the Hospital; or (2) a UPMC-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.

Note 2:

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.