I. PURPOSE

To ensure all physicians (including medical staff members and physicians-in-training) conduct themselves in a professional, cooperative, and appropriate manner that promotes a culture of safety while providing services as a practitioner at LPCH.

To encourage the prompt identification, management and prevention of unprofessional behavior, a process is required to evaluate and address any occurrences of unprofessional behaviors under the direction of Medical Staff leadership. Collegial and collaborative approaches to counseling and education to prevent future unprofessional behavior will generally be the initial approach. If unprofessional behavior continues, additional interventions will be implemented as necessary to manage and prevent further behavior that undermines the culture of safety.

II. DEFINITIONS

A. Involved individual
   a. Any member of the medical staff of LPCH (which includes physicians, dentists, podiatrists, psychologists) and physician-in-training (any intern, resident, or fellow).

B. Professional Practice Evaluation (PPE) Confidential Database
   a. A database managed by the PPE Program Managers and team to record and track PPE related functions. These functions include PPE case review documentation, professionalism documentation, performance review documentation and generation of reports. The database is confidential and only accessed by the PPE team and Analytics and Clinical Effectiveness team for OPPE reports.

C. Credentials File
   a. Contains all credentialing documentation, relevant quality information, such as Ongoing Professional Practice Evaluation (OPPE) reports, Performance Improvement reports and supplemental information or documentation regarding quality of care issues. These files will be kept in an electronic database on a secured server with encryption. The files are managed by the Medical Staff Services Department and any staff with a business need may have a secure

individual logon information in a designated security group to perform their job tasks.

D. iCare reports
   a. Lucile Packard Children's Hospital Stanford occurrence reporting system that can be used by all employees and medical staff to report all major or minor occurrences. Events that may have safety, quality or risk management considerations and may require further follow up from other departments are to be reported through this system.

E. Medical Staff Leaders
   a. The following are considered medical staff leaders: Chief Medical Officer (CMO), Associate CMO (ACMO), Division/Service Chiefs, and President of Medical Staff or designees.

F. Validated event
   a. An event described in an occurrence report or patient grievance that is a credible behavioral concern after discussion between the involved individual and the Service Chief, at a minimum. Corroboration of a credible behavioral concern from an occurrence report will be assessed by interviews conducted by Medical Staff leadership (or designee) with the involved individual, person submitted the report, service and/or department.

G. Collegial Intervention
   a. Intended to be the first form of intervention for a validated event. The intervention is a conversation between the Service Chief (or designee) or Medical Staff Leader(s) and the individual involved.

H. Potential Patient Safety report
   a. A report produced by the PPE team to inform the Service Chief of an occurrence report or patient grievance concerning a practitioner on their service. Following review by the Service Chief, discussion with the involved individual and determination of the validity of the event, the report is completed with the action taken to address the occurrence report or patient grievance. The report is returned via secure email to the PPE team.

l. Unprofessional Behavior

a. Unprofessional behavior is defined as any conduct that is considered abusive including sexual or other forms of harassment, or other forms or verbal or non- verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised. The Joint Commission defines unprofessional behavior as behavior that undermines the culture of safety. The Medical Staff Code of Professional Behavior (Appendix A) is required to be acknowledged and signed by all medical staff members upon reappointment.

b. Examples include:
-- conduct that constitutes sexual harassment
-- making or threatening reprisals for reporting unprofessional behavior
-- shouting or using vulgar or profane or abusive language
-- abusive behavior towards patients or staff
-- physical assault
-- intimidating behavior
-- refusal to cooperate with other staff members
-- noncompliance with procedure/process/policy

III. POLICY STATEMENT

It is the policy of the medical staff of LPCH that all practitioners who are members of, or affiliated with, the medical staff or with any physician training program at these facilities (i.e. residency, fellowship) shall conduct themselves in a professional and cooperative manner and shall not engage in unprofessional behavior.

IV. PROCEDURE

Identification of potential unprofessional behavior through patient or staff complaints, or occurrence reports and validation/corroboration of these events will be reviewed and managed by the Center for Quality and Clinical Effectiveness and Medical Staff leadership. The validated event will be assigned a severity level (see Appendix B, Severity Level Evaluation for Physician Behavioral Incidents) which will drive the intervention appropriate to the severity level as defined in Appendix C, Physician Behavior Escalation and Intervention Process and explained below.

The medical staff encourages collegial and educational efforts by leaders and management to address questions relating to an individual's clinical practice and/or

professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the questions that have been raised. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, focused review, and additional training or education. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders.

A. *Level 1- minor event, collegial approach*

1. Although the medical staff encourages the persons directly involved to informally resolve incidents of unprofessional behavior by a practitioner, it is recognized that, for various reasons, such a resolution may be impracticable. Therefore, any written or oral report of alleged unprofessional practitioner behavior should be reported through iCare. All reports involving unprofessional behavior by a practitioner will be sent to the respective Service Chief to address and validate the occurrence report. The initial intervention by the Service Chief (or designee) is meant to be collegial discussion with the individual involved (refer to the Physician Disruptive Behavior Escalation and Intervention Process- Appendix C). The Service Chief will be asked to document any action(s) or no action via a Potential Patient Safety report produced by the Professional Practice Evaluation (PPE) team. The Potential Patient Safety report is recorded in the PPE Confidential Database. For Medical Staff Members, the validated event will also be counted in their OPPE profile. Additionally, Medical Staff leadership or designee(s) can assist the Service Chief in addressing and validating the occurrence report.

2. For Physician Trainees (includes residents and fellows), the unprofessional behavior report is sent to the appropriate Residency Director or Fellowship Director to address. The Service Chief will also receive a copy of the report. The Residency/Fellowship Director will be asked to document any action(s) or no action via the Potential Patient Safety report produced by the Professional Practice Evaluation (PPE) team. The Potential Patient Safety report is recorded in the PPE Confidential Database.

B. *Level 2- moderate event*

1. When there is a second validated event in 6-12 months, or there is an

impact on patient care due to intimidation/disrespect of patients, families, staff or other team members, a severity level 2 is assigned (Appendix B). The process is escalated to include the Medical Staff leadership as well as their Service Chief (or designees). Following a meeting with the individual, the Medical Staff leadership and Service Chief (or designees) will determine intervention according to the Physician Behavior Escalation and Intervention Process (Appendix C). The Service Chief will be asked to document any action(s) or no action via the Potential Patient Safety report. The Potential Patient Safety report is recorded in the PPE Confidential database. For Medical Staff Members, the validated event will also be counted in their OPPE profile.

2. For Physician Trainees (includes residents and fellows), the repeated validated behavioral incidents or major behavior incidents are sent to the appropriate Residency Director or Fellowship Director to address. The Service Chief and Medical Staff leadership will also receive a copy of the report. The Residency/Fellowship Director will be asked to document any action(s) or no action via the Potential Patient Safety report produced by the Professional Practice Evaluation (PPE) team. The Potential Patient Safety report is recorded in the PPE confidential database

3. Following the meeting(s) with the involved individual, Medical Staff leadership and/or Service Chief (or designees) will prepare a written summary of the reported behavior and the meetings will be documented. In preparing the written summary of the reported behavior, the President of the Medical Staff leadership and Service Chief (or designee) should document all of the following: a) the date and time of the questionable behavior, b) the circumstances that precipitated the behavior, c) a factual, objective description of the behavior, d) the consequences of the behavior for culture of safety or hospital operations, e) the dates, times and participants in any meetings with the individual involved, staff, etc. about the behavior. The summary will be filed in the involved individual's credentials file. The involved individual will have the opportunity to respond in writing to the report.

4. The President of the Medical Staff leadership and Service Chief (or designees) will determine if a formal Performance Improvement Plan (PIP; Appendix D) for addressing the issues identified is required. The PIP includes the written summary as well as the specific corrective actions or goals to be achieved to address the issues, an implementation and

monitoring plan, and expectations and potential consequences of non-compliance. The PIP draft will be reviewed with the individual who will have the opportunity to provide input. The individual, Division Chief and Medical Staff leadership will sign the final version of the PIP. The PIP will be placed in the confidential PPE database, and the individual's Credentials File, with copies to the involved individual. The involved individual will have the opportunity to respond in writing.

D. *Level 3- severe event*

1. If a total of 3 or more incidents occur, or a single event that results in Staff/Patient harm, such as verbally/physically threatening or other egregious behavior (ex.- throwing instrument) occur concerning the same practitioner within a 2 year period, the Medical Staff leadership and Service Chief (or designees) will meet with the individual involved for a formal review of the reports. At their discretion, the Medical Staff leadership and Service Chief (or designee) will initiate an investigation and depending on results, will make a formal report the LPCHS Medical Executive Committee (MEC) for discussion, approval and possible recommendations for action. Examples include: suspension of privileges, commissioning a Focused Professional Practice Evaluation (FPPE), Performance Improvement Plan (PIP), or other actions in accordance with Medical Staff ByLaws. When appropriate, a formal letter of admonition will be sent to the individual.

2. For Physician Trainees (includes residents and fellows), the repeated validated behavioral incidents or major behavior incidents are sent to the appropriate Residency Director or Fellowship Director to address. The Service Chief and Medical Staff leadership will also receive a copy of the report. At this level, physician trainee incidents will be managed by the Residency/Fellowship Director and Graduate Medical Education (GME) leadership with input as necessary from Medical Staff leadership.

V. RELATED DOCUMENTS

A. Joint Commission on Accreditation of Healthcare Organizations Manual
B. Well Being Committee Policy
C. Medical Staff Code of Professional Behavior
Committee on Professionalism Policy

VI. APPENDICES

A. Medical Staff Code of Professional Behavior
B. Severity level for Physician Behavioral Incidents
C. Physician Behavior Escalation and Intervention Process
D. Sample Patient Safety Report for Service Chiefs

VII. DOCUMENT INFORMATION

A. Legal Authority/References
   1. Hospital legal counsel

B. Author/Original Date
   Lawrence Shuer, M.D., SHC Chief of Staff
   SHC/LPCH Well Being Committee
   1997

C. Gatekeeper of Original Document
   Medical Staff Services

D. Distribution and Training Requirements
   1. This policy resides in the Administrative Manuals of both hospitals.
   2. New documents or any revised documents will be distributed to Administrative Manual holders. This policy is on the Medical Staff Services website and is distributed to all medical staff at time of initial appointment

E. Review and Renewal Requirements
   This policy will be reviewed and/or revised every three years or as required by change of law or practice.

F. Review and Revision History
   Written 1997
   Reviewed 2000
   Reviewed and revised 2003; 2006, 2010, 2016, 2019, 2023

G. Approvals
   Well Being Committee Jan, 2003,
   LPCH Policy Committee, May 2010, Mar 2013, Sept 16, 10/19, 2/22, 9/23
   LPCH Medical Executive Committee Feb, 2003; July 2006, 5/10, 3/13, 9/16, 10/19, 3/22, 9/23
   LPCH Board of Directors Feb, 2003; July 2006, 5/10, 4/13, 9/16, 10/19, 4/22, 9/23

APPENDIX A

Medical Staff Code of Professional Behavior

Professional behavior, ethics and integrity are expected of each individual member of the Medical Staff at Stanford Hospital and Clinics (SHC) and Lucile Packard Children's Hospital (LPCH). This Code is a statement of the ideals and guidelines for our professional community. The professional and personal behavior of the Medical Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, society and among themselves, should aim to promote the highest quality of patient care, trust, integrity and honesty.

All Medical Staff members have an affirmative duty to take reasonable action to prevent, stop, or report violations of the Code of Professional Behavior. Each Medical Staff member is responsible for the welfare, well-being, and betterment of the patients being served. In addition, the Medical Staff member has responsibilities to the community and to themselves. The organization must contribute to a culture of well-being and safety. As members of the community, Medical Staff contribute by contributing to their own professional and personal well-being. Medical Staff are expected to maintain a reputation for truth and honesty. The following community norms are intended to outline how individuals contribute to the culture of the organization.

Guidelines for Interpersonal Relationships

- Treat all medical staff, hospital staff, housestaff or students, and patients with dignity, equality, justice, courtesy and respect
- Strong positive relationships with patients and colleagues require us to concern ourselves with the impact of our behavior on recipients. Good intentions alone do not excuse potential negative impact on others.
- Reject all forms of discrimination and harassment towards any individual within the community, including identity, diversity, race, prejudice, stereotype, discrimination, racism, xenophobia, nationalism, intolerance, homophobia, transphobia, bullying, and hate speech.
- Develop and use conflict mitigation skills and direct verbal communication in managing disagreements with associates and staff. When needed, utilize formalized complaint/escalation procedures.
- Intervene when witness to behaviors not in alignment with our community standards
- Cooperate and communicate with other providers, displaying regard for their dignity
- When relationships are harmed, make good faith efforts to resolve conflict and restore relationships between self and others
- Be truthful at all times
- Wear attire that reflects your professional role and respects your patients
- Develop and institute a plan to manage your stress and promote your well being
- Advocate for systemic supports to reduce systemic sources of harm

- **The following behaviors are not in alignment with our community standards:**
  - Blatant failure to respond to patient care needs or staff requests
  - Lack of cooperation without good cause
  - Refusal to return phone calls, pages or other messages concerning patient care
  - Risk patient safety by treating patients while impaired by alcohol, drugs, or illness.
  - Revealing confidential patient or staff information to anyone not authorized to receive it. The duty for confidentiality and respect for persons extends beyond privacy regulations.
  - Inappropriate comments written in Medical Records
  - Inappropriate comments or behaviors at meetings
  - Condescending, degrading, demeaning abusive, threatening or disrespectful language regarding patients and their families, nurses, physicians, hospital personnel and/or the hospital. This includes name-calling, belittling, berating, misgendering, slurs, foul language/profanity, shouting, rudeness, micro/macro-aggressions, repetitive sarcasm, or cynicism, and threats of violence, retribution, litigation, or financial harm

- Criticizing medical staff, hospital staff, housestaff, or students in front of others while in the workplace or in front of patients
- Shaming others for negative outcomes and/or medical errors
- Physically or verbally slandering or threatening other physicians or health care professionals
- Physical contact or actions with another individual that are reasonably felt by others to represent threats or intimidation. This includes throwing instruments, charts or other items
- Sexual harassment, including gender harassment (sexist hostility, crude behavior), unwanted sexual attention (unwelcome verbal or physical sexual advances), sexual coercion (when favorable professional or educational treatment is conditioned on sexual activity), and sexual assault
- Romantic, sexual, or intimate physical relationship with any current patient, or former patients if the former patient is under the age of 18. This extends to key third parties such as spouses, children, or parents of current patients.
- Romantic, sexual, or intimate physical relationship with any current trainees or anyone you manage.
- Engage in racial or ethnic discrimination, including stereotypical statements, racist jokes, slurs, mockery/teasing/making fun of someone's clothing, relationships, socioeconomic status, property or physical appearance, and humiliation of accents or gestures.
- Structuring opportunity and/or assigning value based on the social interpretation of how one looks or behaves, that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities

Guidelines for Clinical Practice

- Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation or clinical service
- Respond to patient and staff requests promptly and appropriately
- Respect patient confidentiality and privacy at all times; follow all regulations for the release of information
- Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, etc.)
- Seek and obtain appropriate consultation
- Arrange for appropriate coverage when not available
- Do one's best to provide the best effective and efficient care
- Prepare and maintain medical records within established time frames
- Disclose potential conflicts of interest and resolve the conflict in the best interest of the patient
- When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- Adhere to the policy on "Interactions between the SoM, SHC, LPCH and the Pharmaceutical, Biotech, Medical Device, and Hospital and Research Equipment and Supplies Industries"
    - For faculty, housestaff and medical students, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies
    - For non-faculty medical staff, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies when on-site at the SoM, SHC or LPCH, or affiliated hospital

Guidelines for Relationship with Hospital and Community

- Abide by all rules, regulations, policies and bylaws of the SHC and LPCH
- Address dissatisfaction with policies through appropriate channels
- Serve on Hospital and Medical Staff committees
- Assist in the identification of colleagues who may be professionally impaired or disruptive
- Maintain professional skills and knowledge and participate in continuing medical education
- Refrain from fraudulent scientific practices
- Accurately present data derived from research

- Request appropriate approval from the Institutional Review Board (IRB) prior to human research activities and abide by all laws and regulations applying to these activities
- Follow and obey the law of the land and refrain from unlawful activity at all times.
- Physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.
- Cooperate with legal professionals, including Hospital legal counsel, unless such cooperation is prohibited by law
- Participate in clinical outcome reviews, quality assurance procedures, and quality improvement programs
- Hold in the strictest confidence all information pertaining to peer review, quality assurance, and quality improvement
- Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential hospital information

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Complied from: The Disruptive Physician, Peter Moskowitz, M.D.
American Academy of Physical Medicine & Rehabilitation Code of Conduct
SHC/LPCH Policy on Code of Conduct and Principles of Compliance

LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD

Medical Staff Code of Professional Behavior
Acknowledgement of Receipt

As a member of the Medical Staff at Stanford Hospital and Clinics and/or Lucile Packard children's Hospital, I have received and reviewed the *Code of Professional Behavior of Medical Staff and Physicians-in-Training Policy* for the Medical Staff of Lucile Packard Children's Hospital Stanford, including Appendix A: Medical Staff Code of Professional Behavior. To the best of my knowledge, I have complied with the *Code of Professional Behavior of Medical Staff and Physicians-in-Training*, and I will use my best efforts to comply with the Code on an on-going basis.

I have read, understand, and agree to abide by this Policy

Signature:_____

Print Name:_____

Date:_____

Please sign, date and return this acknowledgement page along your application packet.

APPENDIX B

Evaluation of Severity for Physician Behavioral Incidents

Severity Level Definitions	*Service Chief notification and actions*	*VPMA/AVPMA notification and actions*
1= Minor • Self-corrected after feedback • Unintended • "Stressful" situation • In front of staff • In front of family • Behavior undermines Culture of Safety	• Standard referral letter to Service Chief • Service Chief to obtain feedback from physician involved (via written communication, phone call or in person) and determine action • Service Chief to return completed and signed form to PPE team *Response Timeframe:* • 1st notice- 2 weeks to respond • 2nd notice- 2 week to respond **Escalation**: if no response after 2nd notice or one month (whichever comes first), send to CMO/ACMO or designee for follow-up	• CMO/ACMO or designee notification via monthly behavior report as an FYI **Escalation**: follow-up with non-responsive Service Chiefs after 2nd notice Refer to "Description of Levels of Intervention and Escalation for Management of Physician Behavioral Incidents" grid for intervention description. Correlates with Level 1 of intervention.
2= Moderate • Second event in 6 months • Impact on patient care due to intimidation/disrespect • Impact on staff due to intimidation/disrespect	• Standard referral letter to Service Chief • Send past events to Service Chief as reference, if applicable • Service Chief to obtain feedback from physician involved, in conjunction with physician leader (e.g. – President of Medical Staff, CMO, or designees), via written communication, phone call or in	• CMO/ACMO notification in real time to manage escalation. **Escalation**: follow-up with non-responsive Service Chiefs after 2nd notice Refer to "Description of Levels of Intervention and Escalation for Management of Physician Behavioral Incidents" grid for intervention description. Correlates with

	person and determine actions • Service Chief to return completed and signed form to PPE team	Level 2 of intervention.
	Response timeframe: • 1st notice- 2 weeks to respond • 2nd notice- 2 week to respond **Escalation**: if no response after 2nd notice or one month (whichever comes first), send to CMO/ACMO	
3= Severe • Staff/Patient harm • Total of 3 or more incidents in 2 years • Verbally/physically threatening • Egregious behavior (ex.- throwing instrument)	• Referral to Service Chief with notice of severity • Inform Service Chief, event needs to be addressed in conjunction with CMO/ACMO and President of the Medical Staff • Service Chief to obtain feedback from physician involved, in conjunction with physician leader (e.g. President of Medical Staff, CMO, or designees), via formal communication (in person) and determine actions	• Immediate notice to CMO/ACMO via email (or text) • CMO/ACMO or designees meet with Service Chief and physician involved **Escalation**: Reports to MEC based on intervention grid in Physician Behavior Escalation and Intervention Process

	• Actions to be taken together, Service Chief, President of Medical Staff, CMO, ACMO or designee • CMO/ACMO to return completed and signed form to PPE team	
	Response timeframe: • Service Chief, President of Medical Staff, CMO, and ACMO or designee to develop plan for intervention within 2 weeks. Extension of 2 weeks, if needed. • Service Chief to discuss plan with physician involved within 2 weeks. • Immediate evaluation regarding medical staff suspension will be considered by CMO and President of Medical Staff. • Extension of up to 8 weeks (60 days), if needed. • Service Chiefs to have full plan in place by 8 weeks.	

APPENDIX C

Physician Behavior Escalation and Intervention Process

Level of Intervention	Type of Event	Intervention	Referrals	Documentation	Notification of incident and intervention	Escalation to next level
Level 1 (minor severity level) "Cup of coffee – collegial intervention"	Initial occurrence of validated behavioral incident	Collegial discussion between service chief and/or other **medical staff leader** (The following are considered medical staff leaders: Chief Medical Officer (CMO), ACMO (or designee), and President of Medical Staff)	Optional Help Center or similar resources at physician's discretion Option for facilitated discussion with person toward whom the unprofessional behavior was directed	Brief summary in Confidential Behavioral Incident Database, anonymized report to CFP	Chairs, Medical Staff leadership, Service chief	Two or more additional complaints within 2 year period following intervention
	PARS referral	Collegial discussion between PARS trained physician messenger and physician	Optional Help Center or similar resources at physician's discretion	Brief summary in Confidential Behavioral Incident Database, anonymized report to CFP	Chairs, medical staff leadership, Service Chief	Lack of significant decrease in complaints after X year

Level of Intervention	Type of Event	Intervention	Referrals	Documentation	Notification of incident and intervention	Escalation to next level
Level 2 (moderate severity level)	Repeated validated behavioral incidents or escalation from level 1 Initial occurrence of validated major behavioral incident	1) Meeting between the physician, Service Chief and at least 2 other Medical Staff Leaders 2) Progress report every 6 months or more frequently as needed to Service Chief and Medical Staff Leaders involved 3) Consider formal referral to MEC: Focused Professional Practice Evaluation, or other actions.	Optional or required depending on issues: -Performance Improvement Plan -Counseling referral -Course in risk management -Course in improving communication skills -Assignment of mentor or coach - Other measures, as deemed appropriate -Referral to Well Being Committee	Summary of intervention and recommendations, performance improvement plan in Confidential Behavioral Incident Database, OPPE report in Credentials file Option provided to physician to place written response to incident and report in medical staff file	Chairs, medical staff leadership, Service Chief.	Two or more additional behavioral incidents or one major behavioral incident within a 2 year period following intervention
	PARS escalation from level 1	As above	As above	As above	As above	Lack of significant decrease in complaints after X year

Level of Intervention	Type of Event	Intervention	Referrals	Documentation	Notification of incident and intervention	Escalation to next level
Level 3 (Severe)	Escalation from Level 2: Total of 3 or more incidents or one major behavioral incident within a 2 year period initial occurrence of validated egregious behavioral incident	Review and validation by Service Chief and at least 2 other Medical Staff Leaders Formation of Medical Staff ad hoc Subcommittee to determine interventions and recommendations to MEC Formal report to LPCH Medical Executive Committee (MEC) for consideration of action. Examples include: Suspension of privileges, commissioning a Focused Professional Practice Evaluation, Performance Improvement Plan, or other actions in accordance with Medical Staff ByLaws.	Dependent on outcome of MEC determination. Potential Actions may include: -Counseling referral -Course in risk management -Course in improving communication skills -Assignment of mentor or coach -Referral to Wellbeing Committee -FPPE with Performance Improvement Plan	Summary of intervention and recommendations, MEC determination in Confidential Behavioral Incident Database, OPPE report, and other documentation as required by Medical Staff ByLaws, including Medical Staff Credentialing file. Option provided to physician to place written response to incident and report in Medical Staff file	Chairs, Medical Staff leadership, Service chief and/or Chair of Department, MEC members, others as required in ByLaws depending on action taken. Medical Staff credentialing file	Continued incidents will be referred to MEC for additional consideration of action
	PARS escalation from Level 2	As above	As above	As above	As above	As above

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

APPENDIX D

Professional Practice Evaluation Program
Performance Improvement Plan

Department/Division: _____
MD Name: _____

Date PIP initiated: _____
Expected Completion Date: _____

1. Areas of Concern this PIP will address (related to review of specific events, cases, other issues):

2. Performance Improvement Goals: Goals should address the areas of concern

1.	
2.	
3.	
4.	
etc	

3. Implementation: How will the goals be accomplished? (See attachment for action options/examples)

Goal	Action	How to Accomplish	Responsible Person(s) to monitor	Updates (Frequency determined by Monitoring and Evaluation Section below)
#				**Provide progress in this domain, include any specific courses or tasks completed. Identify whether on target, delayed and why (barriers, additional support needed, concerns about progress, etc).**
				Update #1 (date) Update #2 (date)

				Update #3 (date)…
				Update #1 (date) Update #2 (date) Update #3 (date)…
				Update #1 (date) Update #2 (date) Update #3 (date)…
				Update #1 (date) Update #2 (date) Update #3 (date)…

4. Monitoring and Evaluation Schedule

Monitoring Meetings	Responsible Person(s)	Frequency (weekly, monthly, quarterly)	Comments or concerns
Service Chief or Delegate			
Update of implementation progress to Medical Staff Leadership (usually q3 months)			
Other as needed (please specify)			

Physician Acknowledgment: Standards the physician is expected to follow in order to meet goals/accomplish actions.

1.	
2.	
3.	
4.	

Physician Name: _____

Physician Signature: _____**Date:** _____

Service Chief Name: _____

Service Chief Signature: _____**Date:** _____

Medical Staff Leadership Name: _____

Medical Staff Leadership Signature: _____ **Date:** _____

Medical Staff Leadership Name: _____

Medical Staff Leadership Signature: _____**Date:** _____

Medical Staff Leadership Name: _____

Medical Staff Leadership Signature: _____**Date:** _____

Date PIP completed: _____

Final Disposition can be included here or separate document