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I. INTRODUCTION

The Organized Medical Staff of Carroll Hospital Center supports the hospital's goals of continuous performance improvement, high quality health care, and patient safety. Accordingly, the Medical Staff presents this Quality Plan to define its role in these processes.

The Joint Commission Medical Staff standards state that "The self-governing medical staff provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process." Additionally, "The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners and providing leadership in performance improvement activities within the organization." The bylaws, rules and regulations, privileging criteria, and various other policies of the Carroll Hospital Medical Staff are fully aligned with these Joint Commission standards. This Quality Policy delineates the Medical Staff structure and function, which facilitates achieving these goals, such as the Medical Executive Committee (MEC) and other Medical Staff leadership, relationships with the hospital's governing board, peer review, credentialing and re-credentialing, Ongoing Professional Practice Evaluation (OPPE), and Focused Professional Practice Evaluation (FPPE).

The Medical Staff endorses the Institute of Medicine's six aims for quality in health care, that care is Safe, Timely, Effective, Efficient, Equitable, and Patient-centered. Additionally, the Medical Staff supports Carroll Hospital's vision to "help people maintain the highest attainable level of good health throughout their lives," and their shared values of Service, Performance, Innovation, Respect, Integrity, and Teamwork. Finally, through the processes of OPPE and FPPE, the Medical Staff is committed to maintaining the competency of all practitioners granted privileges according to the following six core competencies, as put forth by the American Council on Graduate Medical Education (ACGME) and the Joint Commission:

- Medical knowledge
- Patient care
- Interpersonal and Communication skills
- Professionalism
- Systems based practice
- Practice-based learning and improvement

II. MEDICAL STAFF CULTURE

The Medical Staff supports physician engagement in Hospital performance improvement, quality, and patient safety activities.

The Medical Staff endorses the following model for supporting physician performance, consisting of successive steps of activity, each building upon the preceding steps:

1. Appoint excellent physicians through the application of solid credentialing and privileging systems.
2. Set and communicate performance expectations around the six core competencies.
3. Measure actual performance, through the use of OPPE and FPPE, as determined by the Medical Staff.
4. Provide periodic performance feedback in a timely and comprehensive manner with the goal of physician self-improvement.
5. Recognize, appreciate and reward exceptional performance.
6. Manage poor performance by applying a series of well-designed and well-executed interventions designed to help physicians develop self-improvement strategies.
7. Take corrective action when appropriate application of all the previous steps have failed to elicit physician self-improvement and his or her poor performance, as defined by the six core competencies, threatens the quality of patient care.

III. MEDICAL STAFF STRUCTURE

Medical Executive Committee (MEC): The primary leadership activity of the Medical Staff is carried out through the Medical Executive Committee (MEC). The function and activity of the MEC is defined and governed by the Medical Staff bylaws.

The MEC has numerous functions, including, but not limited to:

1. Endorsement and/or approval of policies and procedures affecting the care of patients, including various clinical pathways, protocols and order sets.
2. Ensuring that medical staff bylaws, rules and regulations, and privileging/credentialing policies and processes are compliant with current external regulatory and legal requirements.
3. Acting on recommendations of the department chiefs and the credentials committee with regards to credentialing, re-credentialing, and granting membership and/or clinical privileges to eligible providers, and further making recommendations to the governing body of the hospital on these actions.
4. Oversee the activities of the medical staff with regard to the provision of quality patient care and patient safety through its Medical Staff Quality Committee (MSQC).
5. Together with the medical staff quality committee, ensure the ongoing competency of providers to whom clinical privileges have been granted through the use of peer review, OPPE and FPPE.
6. Review and support as necessary various hospital performance improvement and patient safety activities, including but not limited to, performance improvement committee proceedings and recommendations, root cause analyses, failure mode effects analyses, Medication Reconciliation, and Infection Control.

Credentials Committee: This committee reviews data prepared by the Medical Staff Office on individual providers with regards to credentialing of new providers and re-credentialing of current Medical Staff providers, and granting of clinical privileges, established and new. Based upon its review of this data and the recommendation of the clinical Department Chief, the Committee will make a recommendation to the MEC with regards to each provider.

Medical Committee of the Board (MCB): This is the primary quality oversight committee of the Board of Directors of the Hospital. This committee reviews and takes action on all recommendations of the MEC with regard to credentialing, re-credentialing, and clinical privileging. Additionally, the MCB oversees all other quality, risk management, patient safety, and compliance activity of the Hospital, presenting this information to the full Board of Directors as appropriate.

Numerous other Medical Staff committees – such as Pharmacy and Therapeutics Committee among others - perform important performance improvement and peer review activity and report their activities directly to the MEC.

Medical Staff Quality Committee (MSQC): A sub-committee of the MEC with additional ad hoc membership, this committee has the delegated function of overseeing various quality, performance, and patient safety activities of the Medical Staff. This includes evaluation of an individual practitioner's performance through the use of such Peer Review processes as OPPE and FPPE. The Committee also reviews performance data for the Medical Staff in the aggregate to identify various performance trends, and correlate these with Hospital quality and patient safety initiatives. Based on the review of this data, the MSQC will identify opportunities for performance improvement, as well as recognition of exceptional performance, for both individual practitioners and the Medical Staff as a whole, hospital system or nursing practice opportunities and make recommendations to the MEC for endorsement of such activities.

The committee has two review panels, each chaired by an appointed member of the Medical Staff, and reports to the MEC. There is also an ad hoc appeals panel made up of an appeals chair (a member of the MSQC appointed by the President of the Medical Staff; CMO; and at least four others members drawn as available from the panels or other Medical Staff members. The appeals panel meets when a provider disputes the findings of a panel's quality findings.

The MSQC through its subsidiary panels performs case specific peer review, random chart audit peer review, exemplary physician review, departmental aggregate quality review, and review of the hospital quality dashboard.

Peer Review is an activity performed by the Medical Staff to objectively measure, assess, and, where necessary, assign corrective actions to improve performance of individual practitioners, and represents the cornerstone of the Medical Staff's model to assess physician competence and improve performance. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance rather than appraising the quality of care rendered by a group of professionals or by a system.

Basic principles and terms of Peer Review:

1. Confidentiality: The records and proceedings of the Medical Staff quality and peer review functions - electronic, paper or otherwise - whether delineated in this document or the "Quality Policy and Procedure" found elsewhere, or in any way related to peer review or other forms of professional practice evaluation, are privileged and confidential, and protected from discovery pursuant to the federal Health Care Quality Improvement Act (HCQIA) of 1986 and Maryland statutory privilege (Md. Code Ann., Health Occupations, Section 14-501{d}), or other applicable state and federal laws.

a. Peer review proceedings, including individual performance data, documents, and correspondence, are kept in a secure location.
b. Professional practice and performance information is available only to authorized individuals, whether representatives of the Hospital or the Medical Staff.
c. No copies of peer review documents will be created and distributed unless authorized by Hospital management or policy.

2. Specific goals of peer review are to:

a. Monitor and assess the ongoing competence and performance of practitioners who have been granted privileges to provide clinical care to patients at Carroll Hospital.
b. Improve the quality of care provided by individual physicians.
c. Identify and recognize exceptional care provided by individual physicians.
d. Monitor for significant system-wide trends by evaluating aggregate Medical Staff data, and identify opportunities for system-wide performance improvement.
e. Provide necessary data to Medical Staff committees responsible for appointment, re-appointment, and clinical privilege decisions.
f. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

3. A "peer" is a member of the Medical Staff holding clinical privileges and who has expertise in the appropriate subject matter. The level and specificity of subject matter expertise required to provide meaningful evaluation of a practitioner's performance is determined on a case-by-case basis.

4. Reasonable efforts will be made at all times to identify, address, and minimize c*onflict of interest* issues in all peer review proceedings.

5. MSQC may recommend *external* peer review under appropriate circumstances, such as:

a. Litigation – potential for a lawsuit exists.
b. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers, and when conclusions from this review will directly affect a physician's membership or privileges.
c. Lack of internal expertise – when no one on the Medical Staff has adequate expertise in the specialty under review.
d. Irreconcilable *conflict of interest* issues affecting the physician under review and internal reviewers.
e. New technology – when a Medical Staff member requests permission to use new technology or to perform a procedure new to the Hospital and the Medical Staff does not have the necessary subject matter expertise to evaluate adequately the quality of care involved.
f. Other miscellaneous circumstances as deemed appropriate by the MEC.

Core Competencies: The Carroll Hospital Center Medical Staff has adopted the American Council on Graduate Medical Education (ACGME) and Joint Commission *Six Core Competencies* as its framework for all peer review, particularly for OPPE and FPPE:

1. *Medical Knowledge*: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

2. *Patient Care*: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, for the prevention of illness, for the treatment of disease, and at the end of life.

3. *Interpersonal and Communication Skills*: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

4. *Professionalism*: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

5. *Systems-Based Practice*: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

6. *Practice-Based Learning and Improvement*: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

IV. CASE-SPECIFIC PEER REVIEW: This consists of individual chart review to determine the appropriateness of care in an individual case.

1. Procedure:

   a. Cases are reviewed by the MSQC screening committee, composed of a panel chair, the CMO, Director of Quality, and Department of Quality Staff. Cases are referred primarily by the provider core competency tables jointly developed by the department chiefs and MSQC. Cases may also be referred in case of patient death, payer request, provider request, patient request, or administration recommendation (sentinel event or near miss is identified during concurrent or retrospective review, or an unusual individual case or clinical pattern of care is identified during a quality review.

   b. The MSQC screening committee will determine whether there is sufficient concern for the case to proceed to a full panel hearing based on attribution of responsibility, amount of evidence, and whether the issue is a system or personal concern. The screening panel tabulates the number of cases received, those vetted for a full review, and the reasons why each is screened as appropriate or inappropriate for further review. Criteria for review will be reviewed annually by the MSQC committee, CMO, and department chiefs. The tabulations and the criteria are available to all MSQC members, department chiefs, MEC, the board of directors, and the administration.

   c. Cases are then assigned to a panel member(s) with sufficient familiarity with the specialty or procedure under review. This panel member is the ‘manager’ of the case

and will do an in-depth investigation of the medical record, literature, and may ask questions of the staff or providers involved. The manager will summarize the case, their findings, a conclusion, and a recommendation—both in writing at in-person at the panel meeting.

d. MSQC panels. There shall be two panels—each consisting of the following voting members: panel chair, CMO, and at least 10 active medical staff members. Every effort will be made to ensure diversity of specialties in panel composition as well as diversity in age and gender as well as diversity in employment: independent providers, contractors, and employees. Panels will each meet once a month—staggered by two weeks between panels A and B so as to allow for quick response and processing of cases. Panels will review cases as below, review department quality metrics (each department reviewed twice annually), and will review the hospital quality dashboard in an effort to gain full understanding of the elements of quality in the hospital and how best to direct and guide physician behavior toward that end.

e. All members of the panel will read the case before the meeting so that they can progress directly to debating the findings, conclusion, and recommendation. The quality department will assemble all pertinent findings and supplemental data and will distribute such to the panel members with a reasonable time for review.

f. The committee will obtain input from the physician(s) involved in the case, either before or after the committee meets. Follow up questions are addressed to the physician(s) as appropriate. In all cases, the physician(s) will be notified in writing before a panel reviews a case concerning them.

g. For all case reviews, the committee's findings and recommendations are summarized on the standardized Medical Staff Quality Committee minutes, which provides the committee's rating of the overall care provided by the physician(s) and makes recommendations for further action or follow up as appropriate, among other findings. Findings and action plans are voted upon by simple majority vote.

h. Overall patient care provided by the physician is rated

i. In all cases, appropriate feedback is given to the physician, including both the need for performance improvement as well as recognition of exceptional performance when identified. The department chief, section chief, or CMO will assign corrective action if any and will report back to MSQC the results of such action.

j. Hearings of the panels will be reported by a panel chair to MEC and the Medical Committee of the Board.

k. Appeals Panel. There shall be an ad hoc appeals panel made up of the CMO, a panel chair, and at least four members of the MSQC committee or other Medical Staff members. Any physician appealing a decision made by a panel has the right to appear in person before the appeals panel and give further explanation in the matter at hand. The finding of the appeals panel is final.

l. Ad hoc emergency review panels may be convened at the discretion of the CMO or the CMO's designee when a case is of great urgency and a finding must be returned in a

short time. The ad hoc emergency review panel is constituted in the same manner as the appeals panel. Despite the desire for celerity, the full due process will be followed.

V. MEDICAL STAFF EDUCATIONAL ACTIVITIES

The Continuing Medical Education (CME) Program of LifeBridge Health/Carroll Hospital Center is dedicated to providing high-quality educational activities for physician and other healthcare providers to enhance outcomes in patients cared for in our institutions, community and region. Activities are designed to maintain, develop or advance physicians' knowledge and skills in the art and science of medicine. It is expected that the learning that occurs will result in continuous improvement in the quality of the health and treatment outcomes of our patients.

Our CME activities address a broad range of topics including specialty and subspecialty clinical updates, review of best practices, quality improvement and patient safety training, professionalism, cultural competency, ethics and state, national and professional society CME requirements.

The Medical Staff recognizes, supports, and participates in CME as vital to its commitment to continuous performance improvement and maintenance of clinical competence consistent with the ACGME six Core Competencies.

The LifeBridge Health CME program monitors and evaluates all CME learning activities.

VI. PRACTICE EVALUATION

1. Ongoing Professional Practice Evaluation (OPPE): This is the routine measurement and evaluation of current competency for current Medical Staff members. OPPE includes individual cases identified through screening criteria or referred from adverse events as described above. However, the main focus of OPPE is performance measurement using review, rate, and rule indicators.

   OPPE has two goals: First, to obtain data for as many of the six core competencies as practicable of the core competencies, and to make the evaluation of physician performance timelier so that the organization identifies performance trends of current Medical Staff members on an ongoing basis, not just at re-appointment every two years. The second goal of OPPE is to provide opportunities to improve individual physician performance prior to the re-appointment decision. Accordingly, use of a systematic and timely physician competency report, or *Physician Performance Report (PPR)*, is a key component to the Medical Staff's OPPE process. Key features of the *PPR* are:

   a. The *PPR* is populated with individual physician performance data collected from various sources around the six core competencies previously detailed.

   b. Performance is presented relative to defined *indicators, which are subject to review and approval,* by the Medical Staff through the MEC. These indicators are chosen because they are measurable, relevant to physician practice, attributable to an individual physician with reasonable reliability and accuracy, and related to an important specialty-specific or general medical staff competency or expectation based on the six core competencies. Generally, such indicators are of 3 types:

1) Review indicator: identifies a significant event or situation, which requires analysis by the appropriate peer review committee to assess the effectiveness and appropriateness of the care provided. Generally, a review indicator measures relatively broad outcomes that may or may not relate to physician performance; it should flag a case for detailed chart analysis when the actual (or potential) outcome for the patient is serious and too complex to be understood by measuring how frequently such outcomes occur.

2) Rule indicator: represents a general rule, standard, generally recognized professional guideline, or accepted practice of medicine where individual variation does not directly cause adverse patient outcomes; ideally, there should always be compliance, although rare or isolated deviations usually represent only a minor problem. Occurrence of a rule event generates an automatic report of findings to the physician, thereby providing immediate feedback with the hope that the physician will self-correct. A target number of events should be set for each rule indicator based on the criticality of the rule to determine whether further follow-up is needed.

3) Rate indicator: identifies cases or events that are aggregated for statistical analysis, and thereby measure the number of events that have occurred compared to number of opportunities for that event to occur. Thus, a rate indicator has a numerator and denominator and can be expressed as a percentage, frequency, average, rank or ratio. They can measure both processes and outcomes. A target range should be established for each rate indicator based on benchmark data or internal targets. Feedback to individual physicians regarding their rate indicators is provided on a regular basis.

c. In selecting specific indicators for the *PPR*, the following attributes should be specified:

1) Indicator name
2) Performance dimension
3) Competency (department/specialty-specific or general medical staff)
4) Indicator type (review, rule, or rate)
5) Physician specific attribution (yes or no)
6) Acceptable and excellence targets
7) Target source
8) External and internal benchmarks, if any.

d. At a minimum, the *PPR* contains the following elements:

1) Activity and volume data (admissions, consults, procedures, etc.)
2) Performance indicators organized by core competency
3) Indicator type (review, rule, or rate)
4) Physician data for each indicator
5) Excellent and acceptable performance targets
6) Internal and/or external benchmarks, if available
7) Color-coded rating indicating which of the three "zones" of performance into which that indicator falls.

e. The *PPR* is provided to each physician at 6-month intervals and not just at the time of re-appointment. The intent is to allow the physician to use the feedback data to self-improve performance.

2. Focused Professional Practice Evaluation (FPPE): This is the establishment of current competency when the Medical Staff lacks information regarding the performance of physicians who hold or are requesting clinical privileges. This generally occurs under three circumstances:

   a. Initially requested privileges of new Medical Staff or Allied Health members.

   b. For current Medical Staff or Allied Health members requesting new privileges/procedures (the practitioner has not yet performed the procedure for which he or she seeks privileges).

   c. For current Medical Staff or Allied Health members with identified competency concerns generated from peer review or OPPE (there is a concern regarding an existing privileged practitioner's current competency that may affect their ability to provide safe, high-quality patient care).

   The first two circumstances are generally addressed through a process broadly known as *proctoring*. The third circumstance, regarding a pattern or trend of performance that causes concern, or a specific event, which calls into question the competency of a practitioner, involves obtaining more data or examining current data to better understand a potential pattern or issue. FPPE is therefore used when the Medical Staff questions if a privileged practitioner (new to the Medical Staff or an established member in whom an event or OPPE has raised a clinical care concern) is competent to consistently provide safe, high-quality care. FPPE is not an investigation as defined in the bylaws, but may trigger one if the action plan developed so dictates.

   Proctoring: The Medical Staff has adopted a newer definition of proctoring as proposed by Marder, Smith and Sagan as follows: "*Proctoring is a process that allows for the focused evaluation of current physician competency in carrying out actual clinical care and takes both cognitive and procedural abilities into account*." Unlike the classical definition, this does not necessarily require active observation of clinical activity. Accordingly, proctoring can take several forms:

   a. *Prospective* – the proctor previews the care to be administered to a patient.
   b. *Concurrent* – the proctor observes clinical care (cognitive or procedural) being administered in real time.
   c. *Retrospective* – the proctor reviews the care given to the patient after it has been administered; this most often takes the form of chart review for process and outcome indicators of competence.
   d. Discussions with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

   Initially requested privileges of new Medical Staff members: For initially requested privileges for new members, the Chief or his/her designee, shall review a minimum of five admissions and/or procedures (or more at the discretion of the Chief). Cases/procedures

reviewed will include a sampling of the type of privileges requested as determined by the Chief. Documentation of the FPPE review will be documented on the FPPE Physician Review form.

Initially requested privileges of new Allied Health members: For initially requested privileges for new Allied Health members, the Chief of his/her designee, shall review a minimum of 20 patient encounters as described in the FPPE Guidelines for PAs, NPs or CRNAs. Cases reviewed will include a sampling of the type of privileges requested as determined by the Chief. Documentation of the FPPE review will be documented on the FPPE Allied Health Review form.

New privilege/procedure for current Medical Staff members: For existing medical staff members requesting to add a new privilege/procedure, the Chief or his/her designee, shall review a minimum of three cases. Documentation of the FPPE review will be documented on the FPPE Physician Review form.

As part of its FPPE process, the Medical staff can use all forms of proctoring as deemed appropriate. FPPE of a practitioner may be initiated, at the discretion of the clinical Department Chief, Vice President of Medical Affairs, the MEC, or MSQC, in response to a number of circumstances, including, but not limited to:

a. Following a sentinel event or near miss with the potential for major or permanent injury or death.
b. An unusual individual case or clinical pattern of care as identified by OPPE or other peer review process such as case review.
c. After an individual case review with or without an adverse outcome.
d. When indicator thresholds are exceeded within a given time period which may be established from time to time by the MEC and/or the MSQC.

Identified competency concerns for current Medical Staff or Allied Health members: The Chief or his/her designee will determine the number of cases and the type of proctoring necessary.

FPPE may result in an action plan for performance improvement, which will be monitored by the clinical Department Chief, who will provide an update report on the status of the action plan to the MEC and/or MSQC periodically until such time as deemed appropriate.

At the conclusion of the FPPE, the Chief will make a determination whether the Medical Staff or Allied Health member has successfully completed the evaluation. This determination will be transmitted to the Credentials Committee, Medical Executive Committee and the Board of Directors for final approval.

3. Low Volume/No Volume Providers: It is recognized that a number of physicians have a low or no volume of clinical activity at Carroll Hospital Center. The Medical Staff acknowledges that the process of OPPE for these providers is extremely problematic and challenging, if at all possible. These physicians fall into one of two categories:

   a. Physicians who have an active inpatient clinical practice at other hospitals and utilize Carroll Hospital Center infrequently or rarely, such as for group practice coverage.

Therefore, adequate volume of performance data is not available. For these practitioners, the Medical Staff leadership (Credentials Committee, MSQC or MEC) may accept the results of OPPE from those other institutions for review as evidence of performance and competency. The Medical Staff leadership reserves the right to decide if the nature and volume of this external data is adequate for this purpose.

b. Physicians who have transitioned to an outpatient or office-based practice, and who have no inpatient clinical activity at any hospital. For those physicians, the Medical Staff privilege of "*Refer and Follow*" or "non-clinical" has been created which grants the practitioner Medical Staff membership but no clinical privileges – he or she may visit their patients in the hospital and review their medical records, but may not examine, write orders, or otherwise treat a patient, nor document in the patients' medical records. Since these physicians do not have clinical privileges, OPPE and FPPE by the Medical Staff are not required.

VII. DISRUPTIVE PHYSICIAN BEHAVIOR

Disruptive behavior is an act, or pattern of actions, by an individual which adversely affects a health care team to the degree it may impede the team's ability to deliver quality patient care. The Medical Staff recognizes that disruptive behavior on the part of any member of the health care team (physician or other licensed independent practitioner, nurse, aide, technician, etc.) discourages a collaborative team approach, and is an impediment to quality and safe patient care. Disruptive conduct can take many forms including but not limited to the following:

1. Non-constructive criticism addressed to its recipient in such a way as to intimidate, undermine confidence, or impute stupidity, bad motives, or incompetence.
2. Verbal or physical abuse, including foul language and rude conduct, of such significant character that no person of reasonable sensitivity should be expected to tolerate.
3. Sexual harassment of employees, colleagues, or patients.
4. Words or deeds which affect the ability of others to get their jobs done, or impinge on their right to go about their own business free of burdensome harassment or unreasonable interference.
5. Attacks leveled at employees or colleagues which are personal and irrelevant, or go beyond the bounds of fair professional conduct.
6. Impertinent and inappropriate comments written on patient medical records or other official documents.
7. Behavior, verbal or otherwise, which is intimidating to other members of the health care team in such a way as to prevent or discourage them from actively participating in and contributing to appropriate patient care and patient safety, including, but not limited to, potential or actual patient care occurrences which may affect patient safety.
8. Intentional and/or repetitive non-compliance with recognized Hospital or Medical Staff policies, regulations, by-laws, etc.

In accordance with Joint Commission standards, the Medical Staff recognizes that disruptive behavior on the part of its members is not consistent with its values or those of Carroll Hospital Center or with the core competency of Professionalism. To that end, the Medical Staff takes documented and validated incidents of disruptive physician behavior seriously and has developed a policy on dealing with such incidents (see Hospital policy entitled "*Medical Staff Code of Conduct*" for a full description). Incidents of disruptive behavior by a given practitioner which have been

determined to be credible and validated following appropriate investigation will be tracked and trended for patterns, and this will be made available to the Medical Staff Office at the time of re-credentialing. Additional actions may be taken as appropriate in accordance with current policy on code of conduct in accordance with the Medical Staff Bylaws.