UNIVERSITY OF CALIFORNIA
SAN FRANCISCO HEALTH MEDICAL STAFF

CREDENTIALING
AND
PERFORMANCE PLAN

Approved on 07/28/2026 by the Medical Staff
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DEFINITIONS

Unless otherwise stated, the definitions that apply to the terms set forth in this Credentialing and Performance Plan are the same definitions set forth in the Medical Staff Bylaws.

ARTICLE 14. MEMBERSHIP AND CLINICAL PRIVILEGES

14.1 Eligibility and Qualifications of Membership

a. Eligibility

Membership on the Medical Staff and/or granting of clinical privileges shall be extended only to professionally competent physicians, oral and maxillofacial surgeons, clinical psychologists, podiatrists, and dentists who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws, Plans, Rules and Regulations, Medical Staff Policies and applicable Medical Center Policies. Appointment to the Medical Staff shall confer on the Member only such privileges and prerogatives as have been recommended by the Medical Staff and granted by the Governance Advisory Council in accordance with the Bylaws and this Plan. Only physicians (MD, MBBS, MBChB, and DO) with the appropriate admitting privilege(s) are permitted to admit patients.

b. Credentialing

Applications for membership to the Medical Staff shall be evaluated by the Credentials Committee as detailed below. In addition, the Medical Staff may enter into arrangements with System Members to assist it in credentialing activities. This may include, without limitation, relying on information in other System Members' credentials and peer review files in evaluating applications for appointment and reappointment and in utilizing the other System Members' medical or professional staff support resources to process or assist in processing applications for appointment and reappointment.

14.2 General Requirements for Physician Members

a. Physician Members of the Medical Staff must be licensed or otherwise certified to practice in the State of California or be specifically exempt from such requirements.

b. Physician Members of the Medical Staff must have an intact Federal DEA number or furnishing license if prescribing controlled substances.

c. Physicians who are applying for initial appointment and new privileges or reappointment and renewal of privileges must meet the following requirements:

i. Completion of residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Oral and Maxillofacial Surgery (ABOMS) (or verifiable equivalent non-U.S. training) that includes complete training in the specialty or subspecialty for which the physician or oral and maxillofacial surgeon is applying for credentials, and

ii. Current American Board of Medical Specialties (ABMS) certification and recertification or Canadian or international equivalent certification and

recertification if applicable in the specialty that the applicant will practice (as applicable to the privileges requested) and when endorsed by the Department Chair;

iii. Physicians and oral and maxillofacial surgeons with a time-limited board certification or Certificate of Added Qualification (CAQ) are required to maintain current board certification, if available, and/or CAQ within the specialty for which they primarily practice. In fields in which there is general training followed by subspecialty training, physicians may retain basic privileges in their general field if they maintain active board certification in their subspecialty.

Or

iv. Entry into the examination process of the appropriate specialty board. The physician or oral and maxillofacial surgeon must be board certified within a reasonable time as determined by the specialty board in which the practitioner is currently practicing. An applicant to the Medical Staff who is within one (1) year of completing the appropriate ACGME/ABMS accredited training program is expected to enter the examination process at the time of application to ensure compliance with the board certification requirements in the time frame required. When a physician or oral and maxillofacial surgeon is required to become board certified within a time specified by their specialty board, the termination of the physician's or oral and maxillofacial surgeon's privileges and membership on the Medical Staff because of their failure to become board certified as required by this Section, shall not entitle the practitioner to the hearing and appellate review rights provided for in the Fair Hearing Plan. It is the responsibility of the applicant and reapplicant to demonstrate evidence of board certification and re-certification as applicable or requested by the Medical Staff.

14.3 General Requirements for Non-Physician Members

a. Dentists and podiatrists must be licensed or otherwise certified to practice in the State of California or be specifically exempt from such requirements.

b. Dentists and podiatrists must have a Federal DEA number and furnishing license if prescribing controlled substances.

c. Board certification

i. Dentists who practice in the inpatient setting must hold current board certification in their subspecialty, or be eligible to sit for the certifying examination and attain board certification within a reasonable time as determined by the board in which the dentist is currently practicing. General practice dentists who practice solely in general dentistry at the Medical Center are exempt from this requirement.

ii. Podiatrists must hold current board certification by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine, or be eligible to sit for the certifying examination and attain board certification within a reasonable time as determined by the specialty board in which the podiatrist is currently practicing.

d. Clinical psychologists must hold an earned doctorate degree in psychology that meets the California Board of Psychology requirements and have completed the required California Board of Psychology supervised professional experience requirements and hold a valid and unsuspended license to practice clinical psychology issued by the California Board of Psychology.

14.4 Requirements for Medical Staff and Advanced Practice Providers

a. Physicians, oral and maxillofacial surgeons, clinical psychologists, podiatrists, dentists, and Advanced Practice Providers must document their current general competencies including but not limited to their experience, background, training, physical and mental health status, and their ability to provide their patients with competent care at the level of quality determined by the Medical Staff.

b. Physicians, oral and maxillofacial surgeons, clinical psychologists, podiatrists, dentists, and Advanced Practice Providers must also document their adherence to the ethics of their profession, including refraining from fee splitting or other inducements relating to patient referral. The division of fees is prohibited and will be cause for exclusion or removal from the Medical Staff.

c. No individual who is currently excluded or has voluntarily opted out from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible for UCSF Health Medical Staff membership and/or privileges, except Members of the Teaching Only staff category.

d. Membership and/or privileges shall not be denied on the basis of race, color, national origin, religion, sex, age, veteran status, ancestry, marital status, citizenship, sexual orientation or gender identity or the types of procedures (e.g. abortions) or the types of patients (e.g. Medicaid) in which the clinician specializes, when allowed by the state to practice independently and approved by the Executive Medical Board and the Governance Advisory Council.

e. Appointment to the faculty of the UCSF School of Medicine or School of Dentistry shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. To qualify for appointment or reappointment to the Medical Staff, an applicant or Member must hold a faculty appointment at the UCSF School of Medicine, be a member of the Faculty Practice Organization, be a member of the UCSF Medical Group, be a member or of practice through the UCSF Health Medical Foundation, or hold a contractual relationship with UCSF Health.

f. Neither appointment to the Medical Staff nor the granting of privileges to perform specific procedures shall confer entitlement to unrestricted use of the facilities of the Medical Center or the resources thereof. Allocation of resources, including, but not limited to, patient beds and operating room time, shall be subject to administrative allocation pursuant to procedures established by authority of the Chief Medical Officer of the Medical Center in consultation with the President of the Medical Staff.

g. Unless provided by UCSF, each Medical Staff Member or Advanced Practice Provider granted privileges at the Medical Center shall maintain current professional liability insurance in not less than the minimum amounts required, and with an insurance carrier acceptable to the University, and provide evidence satisfactory to the Credentials Committee of conforming coverage. It is the responsibility of the Member or Advanced Practice Provider to verify coverage and to promptly advise the Office of Medical Affairs and Governance of any lapses in coverage.

Membership for persons functioning partially in an administrative capacity shall be neither extended nor withdrawn based solely on administrative appointment but shall be subject to the same terms of appointment and termination as otherwise provided in the Bylaws and this Plan.

14.5 Waiver of Qualifications

Insofar as is consistent with applicable laws, the Governance Advisory Council has the discretion to deem an applicant to have satisfied a qualification, upon a favorable recommendation of the Department Chair, Credentials Committee, and Executive Medical Board, if it determines that the applicant has demonstrated they have substantially comparable qualifications and that the waiver is necessary to serve the best interests of the patients and the Medical Center. There is no obligation to grant any waiver, and applicants have no right to have a waiver considered or granted. An applicant who is denied a waiver or consideration of a waiver is not entitled to any hearing and appellate review rights provided for in the Fair Hearing Plan.

14.6 General Responsibilities of Membership

a. Members must provide for continuous care and attend to patients at the Medical Center according to the principles established in the Bylaws, Plans, Rules and Regulations, and Policies of the Medical Staff and Medical Center.

b. Members agree to know, comply with, and be bound by the Medical Staff Bylaws, Plans, Rules and Regulations, and Policies of the Medical Staff and the Medical Center.

c. Only Members of the Medical Staff with relevant clinical privileges shall be authorized to independently manage treatment of patients at the Medical Center.

d. Except as otherwise approved by the Executive Medical Board, each Medical Staff Member is expected to participate in the training of students and other trainees, develop and maintain teaching skills essential to effective functioning in contact with students and other trainees, and to perform their responsibilities in such a way as to serve as an exemplary role model for the students and for the teaching programs of the Medical Center.

e. Physicians supervising Advanced Practice Providers are expected to provide such supervision in accordance with the applicable parameters for Advanced Practice Provider supervision.

f. All Members are responsible for timely completion of medical records, including documentation of medical histories and physical examinations, as more fully described in the Bylaws, Rules and Regulations, and Policies of the Medical Staff and Medical Center.

g. Members must comply with the Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA) and all privacy related policies of the Medical Center and otherwise keep confidential, as required by law, all protected patient information, medical information, and medical records.

h. When the patient's written informed consent is required, Members are responsible for obtaining the patient's informed consent in the manner outlined in the Medical Center Policies and the Medical Staff Rules and Regulations.

i. Members must participate in and properly discharge all responsibilities of the Medical Staff, including but not limited to cooperation and participation in peer review activities in a confidential manner.

j. Each Member is expected to assist with quality improvement, peer review activities, ad hoc committee participation and fair hearing participation, utilization management, Ongoing and Focused Professional Practice Evaluations and related monitoring activities, and in discharging such other functions as may be reasonably required from time to time.

k. A Member is required to advise the Office of Medical Affairs and Governance and the Member's Department Chair in writing within 14 days of any of the following occurrences:

    i. Delisting, exclusion, suspension, or change in status of the Member's participating provider status in a federal or state health care program or private health plan, or the pendency of any investigation relating to the Member's participation in these programs;

    ii. Any of the following actions taken by a governmental entity, licensing board, or certifying board: the initiation of an investigation, the filing of an accusation or amended accusation, issuance of a decision or settlement,

imposition of discipline, or any change in status of their professional license or board certification.

iii. Any arrests, criminal charges, and/or criminal convictions, including pleas of no contest;

iv. Receipt of notice from Office for the Prevention of Harassment and Discrimination of a complaint alleging sexual harassment or misconduct;

v. Any adverse action to Medical Staff membership and/or privileges or employment by another health care facility or peer review body;

vi. Loss, suspension, or restriction of a DEA certificate; Entry of a final judgment or settlement of a professional liability case (other than dismissal).

14.7 Categories of Membership

The categories of Membership for the Medical Staff are set forth in Article 3 of the Medical Staff Bylaws and are incorporated herein by reference.

a. The categories are:

i. Attending Staff

ii. Affiliate Staff

iii. Courtesy Staff

iv. Clinical Partner

v. Teaching Only Staff

vi. Courtesy-Associate Staff

14.8 Standard of Conduct of Medical Staff Members and Privilege Holders

In addition to the Medical Center and Medical Staff policies regarding professional conduct, Members and privilege holders are expected to adhere to the Medical Staff Standards of Conduct, including but not limited to the following:

a. <u>General</u>

i. Medical Staff Members are expected to fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior as defined by the Executive Medical Board, consistent with UC policies, and Medical Staff Policies. The Medical Staff is committed to supporting a culture and environment that values safety, integrity, honesty and fair dealing with each other and all

staff, and to promoting a caring environment for patients, employees, and visitors.

ii. All Members play a part in the ultimate mission of delivering quality patient care. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or to comply with Plans, Rules, Regulations, Policies and Procedures of the Medical Staff, and/or the policies of the Department or the Medical Center, constitute disruptive behavior.

iii. In assessing whether particular circumstances are affecting quality patient care or Medical Center operations, the assessment need not be limited to care of specific patients, or to direct impact on patient safety. Rather, it is understood that quality patient care embraces, in addition to medical outcome, matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third-party payors) as necessary to effect payment for care, ongoing professional cooperation with healthcare team members, and general patient satisfaction with services rendered.

b. Conduct Guidelines

i. Upon receiving Medical Staff Membership, with or without clinical privileges, the Member shall comply with the common goals of all Members to endeavor to maintain quality of patient care and appropriate professional conduct in compliance with this Plan, the Medical Staff Code of Conduct, and the UCSF Medical Center Professional Code of Conduct Policy 1.02.22.

ii. Members are expected to behave in a professional manner at all times and with all people, patients, professional peers, Medical Center staff, visitors, and others in and affiliated with the Medical Center. Behavior that adversely affects or could be reasonably expected to adversely affect patient care or safety, public safety, or the operations or reputation of the Medical Center or its personnel is unprofessional. Examples of such unprofessional conduct include but are not limited to: unethical or dishonest behavior, non-compliance with coding and billing documentation rules and policies, negative public commentary or criticism of Medical Center staff or another Practitioner where such criticism can be heard by others (for example, in an elevator or hospital corridor), disregard of generally recognized authority and lines of professional interaction and communication within the Medical Center, not working collaboratively with others, working or serving on call while under the influence of alcohol or drugs, and deliberate physical, visual, or verbal intimidation or challenge.

iii. Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the Medical Staff shall be cooperative and

respectful in their dealings with other persons in and affiliated with the Medical Center.

iv. Concerns, complaints, or grievances regarding a Member should be aired constructively and shall be brought to the attention of the most directly-responsible individual or body, such as the responsible Chief of Clinical Service, Department Chair, responsible committee chair, President of the Medical Staff or the Chief Medical Officer through written notification, verbal notification, or an incident report. The Executive Medical Board may establish a formal process for handling concerns, complaints, or grievances.

v. Neither the Medical Staff, its Members, committees, officers, leaders, Governance Advisory Council, nor any employee or agent of the Medical Center shall discriminate or retaliate against any person because that person has done any of the following:

(1) Presented a complaint, concern, or grievance as noted above to a Member of the Medical Staff, Department, or to an entity or agency responsible for evaluation, accreditation, or regulatory oversight of the Medical Center or to any other governmental agency.

(2) Initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the Medical Center that is carried out by a governmental agency or by an entity or agency responsible for evaluation, accreditation, or regulatory oversight of the Medical Center or the Medical Staff.

(3) Any Member who is suspected of or has retaliated against any person will be subject to investigation, discipline, and corrective action, including loss of membership and privileges.

vi. Members must cooperate and adhere to the policies of the Medical Center and the Bylaws, Plans, Rules and Regulations, and Medical Staff Policies.

vii. Members of the Medical Staff shall not engage in conduct that is harassing, offensive, or disruptive, whether written, oral, or behavioral.

viii. It is the affirmative responsibility of all Members who hear, see, or are otherwise made aware of concerning behavior or actions of other Members or Medical Center personnel to promptly report such behavior or concerns in the manner as described in Section 14.8.b.iv of this Plan. Failure to report may result in corrective action when patient safety is at risk.

c. The Executive Medical Board may promulgate Rules and Regulations and/or Policies implementing the purposes of this Article, which may include, but are not limited to, specific conduct guidelines for professionalism, procedures for investigating and addressing incidents of perceived misconduct, and remedial

measures including, when necessary, disciplinary action. Although generally an attempt to resolve matters is made through counseling and opportunity to correct the behavior, in appropriate circumstances corrective action such as restriction, summary suspension, or termination of Medical Staff membership and/or privileges will be taken or recommended.

14.9 Advanced Practice Providers

a. Definition

Only Advanced Practice Providers and Allied Health Professionals in approved categories (see Credentialing Policy and Procedures in the Rules and Regulations) who are employed or contracted by the Medical Center, School of Medicine, or UCSF Medical Group are eligible to apply for the APP/AHP Staff category. Applications (initial and reappointment) shall be submitted and processed in the same manner as the processes used for Members of the Medical Staff, unless otherwise specified in the Credentialing Policy and Procedures. Appointment to the APP/AHP Staff category is automatically terminated if the employment service contract is terminated.

b. General Requirement for APPs/AHPs

i. All APPs and AHPs must be licensed or otherwise certified to practice in the State of California.

ii. All APPs and AHPs must have a Federal DEA number and furnishing license if prescribing controlled substances.

iii. Prerogatives and Responsibilities: APPs and AHPs shall provide services pursuant to approved standardized procedures, practice agreements, and/or job descriptions delineated by the assigned Department and granted by Governance Advisory Council through the Committee on Interdisciplinary Practice and Executive Medical Board. Supervision requirements for APPs and AHPs shall be specifically defined on any applicable standardized procedures, practice agreements, privilege forms, and/or job descriptions. APPs and AHPs are not Members of the Medical Staff and are not eligible to hold office or vote but may participate in the activities of the Medical Staff and may be appointed to committees with voting rights if specified at the time of committee appointment. No APP or AHP may be the admitting provider of record. Upon appointment and to the extent approved by the Committee on Interdisciplinary Practice, Credentials Committee, Executive Medical Board, and Governance Advisory Council, APPs and AHPs shall be expected to:

(1) Meet the qualifications and perform responsibilities outlined in their respective privilege forms, standardized procedures, practice agreements, and/or job descriptions;

(2) Exercise independent judgment within their approved areas of competence, clinical privileges, applicable standardized procedures, and practice agreements, provided that a physician who is a current Member in good standing of the Attending Medical Staff must retain the ultimate responsibility for the patient's care;

(3) Participate directly in the management of patients;

(4) Write orders as permitted by scope of practice;

(5) Record reports and progress notes on patient charts;

(6) Perform consultations upon request; and

(7) Adhere to all requirements of the Medical Staff Bylaws, Plans, Rules, Regulations, and Policies as may reasonably be construed to apply in the context of the limited role and scope of services of the APP/AHP.

c. Corrective Action

Employed APPs and AHPs are subject to corrective action processes pursuant to Medical Center Human Resources policies and procedures. Contracted APPs and AHPs are subject to corrective action processes described within the terms of their service contract. Notwithstanding the foregoing, clinical privileges exercised by APPs and AHPs are subject to oversight by the Medical Staff. Performance concerns or problems with clinical care not believed to be sufficiently resolved through the foregoing policies, procedures, and/or service contract provisions may result in clinical privileges restriction, suspension or termination by the Committee on Interdisciplinary Practice or the Executive Medical Board, subject to the following:

i. Prior to restriction, suspension, or termination of clinical privileges, the affected APP or AHP must be given notice of the proposed action and afforded an opportunity to present written or verbal response to the President of the Medical Staff (or designee), who shall be authorized to make a final recommendation on behalf of the Medical Staff, which thereafter will be submitted to the Governance Advisory Council for final action.

ii. This Article shall not be deemed to afford an APP or AHP a right to a hearing pursuant to this Plan, the Fair Hearing Plan, or the Medical Staff Bylaws.

ARTICLE 15. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

15.1 Application

A separate credentials file shall be maintained for each applicant for Medical Staff membership or clinical privileges. Each application for Staff appointment, reappointment, and/or clinical privileges shall be in the format requested by the Office of Medical Affairs and Governance, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, they shall be provided an application form when they are deemed eligible to apply, and shall also be given access to these Medical Staff Bylaws, Plans, Rules, Regulations, Policies, and applicable Medical Center policies. At least four (4) months prior to expiration of the current term of membership and/or clinical privileges, the individual will be sent a notice of the impending expiration and a link to an application for reappointment and/or renewal of privileges.

a. Failure to Meet Basic Requirements

An applicant who does not meet the basic requirements as outlined in this Plan, the Bylaws, and/or related Policies and Procedures is ineligible to apply for membership or clinical privileges, and the application will not be accepted for review. If it is determined during the processing that an applicant does not meet all the basic qualifications, the review of the application will be discontinued. An applicant who does not meet the basic requirements is not entitled to the procedural rights set forth in the Fair Hearing Plan.

An applicant or Member is not entitled to the hearing rights under the Fair Hearing Plan if their membership and/or privileges are denied, restricted or terminated or their Medical Staff category is changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws, Plans, Rules, Regulations, and Policies.

b. Failure to File Reappointment Application

Failure to file a complete application for reappointment in sufficient time for the application to be fully processed prior to expiration of the Member's current appointment will result in the expiration of membership and/or privileges at the end of the current term without any procedural rights in the Fair Hearing Plan.

15.2 Burden on Applicant

It is the applicant's/reapplicant's responsibility to tender a complete application/reapplication for membership and/or privileges. It is the applicant's/reapplicant's responsibility to keep current all information contained in the most recent application/reapplication and to promptly inform the Office of Medical Affairs and Governance in writing of any change in circumstance or new information, including but not limited to changes in the status of or discipline against a professional license, the filing of criminal charges, and the filing of professional liability claims. The burden on

applicants for appointment, reappointment, and/or other clinical privileges is set forth in the Medical Staff Bylaws and incorporated herein. See Section 4.3 of the Medical Staff Bylaws.

15.3 Complete Application

A completed application must include an accurate and complete and updated disclosure by the applicant with regard to the following queries as may be amended from time to time:

a. Whether the applicant's professional license or controlled substance registration (DEA, state or local) in any jurisdiction has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;

b. Whether the applicant has had any involuntary termination of Medical Staff membership or employment, or involuntary limitation, reduction, restriction, admonition, loss, or denial of clinical privileges at another health facility, or has voluntarily resigned or agreed to limitations on practice while under investigation or to avoid an investigation at another health facility or employer;

c. Whether the applicant has been notified of or involved in a professional liability action, including any final judgments or settlements involving the applicant;

d. Whether the applicant has ever been charged with or convicted of any crime, other than a minor traffic violation, or whether any such action is pending;

e. A statement from the applicant that their physical and mental health status is such that they are currently able to competently and safely perform the clinical privileges being requested;

f. A statement from the applicant that they have had access to and read the current Medical Staff Bylaws, Plans, Rules, Regulations, and Policies, including the Code of Conduct and Conflict of Interest Policy, and agrees to be bound by them, including any future Bylaws, Plans, Rules, Regulations and Policies that may be duly adopted;

g. A statement from the applicant consenting to the release and inspection of all records or other documents that may be material to an evaluation of their professional qualifications, including information bearing upon clinical competency, and all health information and medical records necessary to verify the applicant's physical or mental health status; and

h. A statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background or evaluating and making judgments regarding such qualifications or background.

A completed application must also include the following attestations by the applicant:

i. The applicant consents to undergo any physical or mental health evaluations required by the Medical Staff President and provide the results thereof as necessary to enable a full assessment of the applicant's fitness for duty. Failure to comply with a required evaluation will result in the application being deemed incomplete.

j. The applicant agrees that the Medical Center and the Medical Staff may obtain and share information with a representative or agent of the UCSF Medical Center, UCSF School of Medicine, the UCSF Medical Group, and the Peninsula Outpatient Center, including information obtained from other sources, and they release each person and each entity who received information and each person and each entity who disclosed information from any and all liability, including any claims of violations of any federal or state laws or regulations, including those laws forbidding restraint of trade that may arise from the sharing of information. By virtue of applying for membership and/or privileges, the applicant agrees that the Medical Center and the Medical Staff may seek information from other sources regarding involuntary limitation of privileges, voluntary limitations or resignations while under or to avoid an investigation, or loss of licensure elsewhere. The applicant also agrees that UCSF Medical Center, UCSF School of Medicine, the UCSF Medical Group, and the Peninsula Outpatient Center may act upon such information.

k. By applying for privileges and/or membership, the applicant pledges to provide continuous care to their patients and to arrange for coverage by an appropriate alternative provider to ensure continuity of care.

l. By applying for privileges and/or membership, the applicant pledges to keep patient information confidential.

m. By applying for privileges and/or membership, the applicant pledges to abide by peer review confidentiality, participate in peer review activities, and cooperate in investigations as requested.

n. By applying or reapplying for privileges and/or membership, while the application is pending the applicant pledges to update the Office of Medical Affairs and Governance of any changes to the information provided in the application, including but not limited to any criminal charges, receipt of complaints or allegations of sexual misconduct, changes in licensure status, loss or suspension of DEA certificate, exclusion from federal, state, or private health care programs, adverse action against medical staff membership, privileges, or employment elsewhere, or the filing of any accusation against a professional license.

15.4 Verification Process

a. Upon the receipt of a complete application, the Office of Medical Affairs and Governance shall arrange to verify the qualifications and obtain supporting information relative to the application. The Office of Medical Affairs and

Governance shall consult primary sources of information about the applicant's credentials, where feasible.

b. The Office of Medical Affairs and Governance shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed to the satisfaction of the Office of Medical Affairs and Governance; meaning that all information has been provided and verified, as defined in this Plan. The Credentialing Policy and Procedure shall identify all information that will be verified.

15.5 Application Processing

After verification is accomplished and the application is fully complete, unless review or processing is deferred for later consideration by the Executive Medical Board, it shall be reviewed and processed as follows:

a. Department and Division Review

As to all new applications for appointment to the Medical Staff and requests for new privileges, the Office of Medical Affairs and Governance will make available the application and all supporting materials to the Chair of each Department and/or Chief of each Division in which the applicant seeks privileges and request a documented evaluation and recommendations as to the Staff category (in the case of applicants for Staff membership), the Department and Division to be assigned, the clinical privileges to be granted, and any concerns regarding the applicant or clinical privileges requested. Following evaluation by the Department Chair and/or Division Chief (or designees), the recommendations will be transmitted to the Credentials Committee. The time frame for completion of the Department/Division recommendation(s) is within thirty (30) days of receipt of a complete application.

As to applications for reappointment to the Medical Staff and requests for renewal of privileges that raise no concerns (as detailed in the Medical Staff Organization Credentialing Policy and Procedure), the Office of Medical Affairs and Governance will present a list of these reapplicants to the Department Chair and/or Division Chief prior to forwarding the applications to the Credentials Committee. No formal recommendation from the Department Chair or Division Chief is required; however the Department Chair and/or Division Chief may, in their discretion, review any application and supporting materials and make a recommendation for consideration by the Credentials Committee.

As to applications for reappointment to the Medical Staff and requests for renewal of privileges that raise concerns (as detailed in the Medical Staff Organization Credentialing Policy and Procedure), the Office of Medical Affairs and Governance will make available the application and all supporting materials to the relevant Department Chairs and Division Chiefs along with a request an evaluation and recommendations. In the event that the reapplicant is the Department Chair, the Medical Staff President will designate an alternate to make the evaluation and

recommendations. Following evaluation by the Department Chair and Division Chief (or designees), the recommendations will be transmitted to the Credentials Committee. The time frame for completion of the Department/Division recommendation(s) is within thirty (30) days of receipt of a complete application.

b. Credentials Committee Report

The Credentials Committee will review the application, supporting materials, the recommendation of the Department Chair and/or Division Chief (or designees), if any, and any such other available information as may be relevant to the applicant's qualifications. The Credentials Committee may on its own or by delegation undertake an interview of the applicant. The Credentials Committee must prepare a written report with recommendations for the Executive Medical Board as to appointment and Staff category (in the case of applicants for Staff membership), the Department and Division to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons must be stated. The time frame for completion of the Credentials Committee action is the next regular meeting of the committee following receipt of the Department's and/or Division's recommendation, if any, to be within thirty (30) days, unless the Credentials Committee requests additional information.

c. Executive Medical Board Recommendation

The Executive Medical Board will review the reports and recommendations from the Department Chair and/or Division Chief (or designees) and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. As soon as practicable, the Executive Medical Board will prepare a written report with recommendations for the Governance Advisory Council as to appointment, Staff category, and clinical privileges. In the event there are any adverse recommendations, the reasons must be stated. Where applicable, the Governance Advisory Council will consider the reports and recommendations at its next regular meeting or as soon as practicable.

d. Effect of Executive Medical Board Recommendation

i. Deferral: The Executive Medical Board may defer making a recommendation to enable further evaluation and follow up. A decision by the Executive Medical Board to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. Unless the application is withdrawn, the deferral must be followed with a subsequent favorable or adverse recommendation. The Executive Medical Board may delegate the responsibility for further consideration to the Credentials Committee or Department Chair as deemed appropriate.

ii. Favorable Recommendation: When the recommendation is completely favorable, the application will be forwarded promptly to the Governance Advisory Council for action.

iii. Adverse Recommendation: If the recommendation of the Executive Medical Board is adverse as defined in the Fair Hearing Plan, the President of the Medical Staff shall promptly notify the applicant. Such notice shall contain the information prescribed in the Fair Hearing Plan. In such case, the applicant shall be entitled to procedural rights provided in the Fair Hearing Plan and the recommendation will not be transmitted to the Governance Advisory Council until after the applicant has exercised or waived such rights.

e. Governance Advisory Council

i. Deferral: The Governance Advisory Council may defer making a recommendation to enable further evaluation and follow-up. A decision to defer the application for further consideration shall state the reasons for deferral, provide direction for further investigation, and state time limits for such further investigation. As soon as practical after the deferral, such decision to defer the application shall be followed with a subsequent favorable or adverse recommendation. The Governance Advisory Council may delegate the responsibility for further consideration to the Executive Medical Board or Credentials Committee as deemed appropriate.

ii. Unless subject to the provisions of the hearing and appellate review provisions in the Fair Hearing Plan, the Governance Advisory Council shall act on the application no later than the second regularly scheduled meeting following receipt of the recommendation from the Executive Medical Board. Action shall be taken within sixty (60) days after receiving a recommendation from the Executive Medical Board.

iii. Favorable Recommendation from Executive Medical Board: If the Governance Advisory Council adopts the recommendation of the Executive Medical Board, the Executive Medical Board recommendation shall become the final action.

If the Governance Advisory Council does not adopt the recommendation of the Executive Medical Board, the matter will be referred back to the Executive Medical Board with instructions for further review and recommendation along with a time frame for responding to the Governance Advisory Council, or the Governance Advisory Council may take unilateral action. If the Governance Advisory Council takes unilateral action, it must advise the Executive Medical Board of its action. If the matter is referred back to the Executive Medical Board, the Executive Medical Board shall review the matter and forward its recommendation to the Governance Advisory Council. If the Executive Medical Board's subsequent

recommendation remains favorable and the Governance Advisory Council adopts the recommendation, the recommendation becomes the final action.

If the Governance Advisory Council ultimately does not adopt a favorable recommendation from the Executive Medical Board, the Governance Advisory Council or designee must promptly send written notice to the applicant containing the information prescribed in the Fair Hearing Plan. In such case, the applicant shall be entitled to a hearing and appellate review rights if provided in the Fair Hearing Plan, and the adverse decision of the Governance Advisory Council shall not become final until after the applicant has exercised or waived such rights. At its next regular meeting, after all the applicant's applicable hearing and appellate review rights under the Fair Hearing Plan have been exhausted or waived, the Governance Advisory Council shall take final action.

iv. Unfavorable recommendation from Executive Medical Board: An unfavorable recommendation from the Executive Medical Board will not be forwarded to the Governance Advisory Council until the applicant has either waived or exhausted the procedural rights provided in Fair Hearing Plan.

v. All decisions to appoint must include a delineation of clinical privileges, the designation of a Staff category and clinical department, and any applicable conditions placed on the appointment or clinical privileges. The applicant will be notified within thirty (30) days of the Governance Advisory Council's decision.

vi. Subject to any applicable provisions of the Fair Hearing Plan, notice of the Governance Advisory Council's final decision will be given in writing by the President of the Medical Staff to the applicant. In the event hearing rights are triggered, provisions detailed in the Fair Hearing Plan govern notice of the Governance Advisory Council's final decision.

15.6 Term of Appointment and Reappointment

a. Appointments and reappointments to UCSF Health Medical Staff shall be effective on approval by the Governance Advisory Council, and corresponding privileges shall extend for a period of no more than two (2) years. Providers in network affiliated clinical settings may be appointed and reappointed for a period of no more than three (3) years.

b. Initial appointments or the granting of new privileges shall be subjected to Focused Professional Practice Evaluation for a period of up to twelve (12) months, and extensions may be considered as indicated.

15.7 Waiting Period for Reapplication after Adverse Action or Withdrawal of Application Following Adverse Recommendation

A waiting period of forty-eight (48) months to reapply for membership and/or privileges applies to the following applicants or former Members:

a. An applicant who received a final adverse decision regarding appointment, reappointment, or renewal of Medical Staff membership and/or privileges;

b. An applicant who withdrew their application for membership or request for privileges following an adverse recommendation by the Credentials Committee, Executive Medical Board, and/or Governance Advisory Council;

c. A former Member or privilege holder who received a final adverse decision resulting in termination of Medical Staff membership and/or privileges;

d. A former Member or privilege holder who voluntarily accepted termination of membership and/or privileges;

e. A former Member or privilege holder who resigned from the Medical Staff and/or relinquished privileges while an investigation was pending;

f. A current Member or privilege holder who received a final adverse decision resulting in termination or restriction of one or more privileges; or

g. A current Member or privilege holder who received a final adverse decision resulting in denial of their request for additional privileges for a medical disciplinary cause or reason.

h. Duration of Waiting Period for Reapplication

Ordinarily, the waiting period for reapplication shall be forty-eight (48) months, however, for applicants or Members whose adverse action included a specified period or conditions of retraining or additional experience, the Executive Medical Board may exercise its discretion to allow earlier or later reapplication upon completion of the specified conditions. Similarly, the Executive Medical Board may exercise its discretion, with approval of the Governance Advisory Council, to waive the forty-eight (48) month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application. A decision by the Executive Medical Board or Governance Advisory Council to deny a waiver of the forty-eight month waiting period does not give rise to procedural rights under the Fair Hearing Plan.

i. Definition of Adverse Action

An action is considered adverse only if it is based on the type of occurrences that might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to professional competence or professional

conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move) or to maintain professional liability insurance (which can be cured by obtaining the insurance).

j. Date When the Action Becomes Final

The action is considered final on the latest date on which the application and/or request for privileges was withdrawn, a Member's resignation became effective, or upon completion of: (a) all Medical Staff and Medical Center fair hearings and internal appeals; and (b) all judicial proceedings pertinent to the action.

k. Reapplication Following Waiting Period

After the waiting period, the Member or applicant may reapply for Medical Staff membership and/or privileges. The application will be processed like an initial application or request, plus the applicant or Member must document that the basis for the adverse action no longer exists, that they have corrected any problems that prompted the adverse action, and/or they have complied with any specific training or other conditions that were imposed.

15.8 Objections to Actions or Procedures Relating to Appointment or Reappointment

In the event an applicant or Member has any objection to any action taken, or procedures followed by the Medical Center, the Medical Staff, or any individual in connection with the consideration of their application for appointment or reappointment, such individual must promptly convey the objection in writing, along with the reasons therefor, to the Office of Medical Affairs and Governance to permit timely consideration of the objection and to afford an opportunity to address the objection, as appropriate.

15.9 Leave of Absence for Members and Privilege Holders

a. Members must request a leave of absence for any anticipated leave that exceeds six (6) months. For elective leave, the Member is expected to submit this request at least 30 days prior to the anticipated start of the leave. Members must request the leave of absence from their Department Chair, which must be approved by the Credentials Committee and the Executive Medical Board. The request for a leave of absence must state the reason for the leave and the specific period of time, which may not exceed one (1) year. Prior to commencing a leave of absence, the Member must work with the Division Chief and clinical coordinator(s) to assign patient care responsibilities to colleagues with like clinical privileges, including assigning in-basket messages, providing appropriate hand-offs regarding active patient care issues, and ensuring patients are scheduled appropriately for follow-up visits. All outstanding medical record documentation/reports must be completed prior to start of the leave. In the instance of non-elective leave (such as emergent medical leave for physician or family member), this responsibility will fall to the Division Chief. During the period of leave, the Member shall not exercise privileges at the Medical Center, and membership rights and responsibilities shall be inactive. A leave of absence, regardless of its duration, may also be requested by the member's

Department Chair in an effort to align it with any leave requested for the Member's employment and/or faculty appointment. If the Member's term of appointment ends during the leave and the Member does not submit a completed application for reappointment as required by these Bylaws, the Member's Medical Staff membership and privileges will lapse at the end of the current term.

b. At least thirty (30) days prior to termination of the leave (not including a sabbatical), or at any earlier time, the Member may request reinstatement of their privileges and prerogatives by submitting a request to the Department Chair, who shall promptly forward the request, along with the Chair's recommendation, to the Credentials Committee and to the Executive Medical Board via the Office of Medical Affairs and Governance. The Member must submit a written summary of relevant clinical activities during the leave. The Executive Medical Board, upon receipt of the request, will forward its recommendation as to whether to approve the request for reinstatement to the Governance Advisory Council. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the requirements for reappointment review and may require proof of physical and mental health necessary to return or exercise the duties and privileges requested. Denial of a request for reinstatement from leave does not give rise to the procedural rights in the Fair Hearing Plan and Bylaws unless the reason for non-reinstatement constitutes a medical disciplinary cause or reason as defined in California Business and Professions Code Section 805.

ARTICLE 16. EVALUATION AND MONITORING

16.1 General Overview of Evaluation and Monitoring

a. Routine evaluation and monitoring activities are conducted to assist the Medical Staff and Clinical Departments in assessing qualifications and performance of applicants, members of the Medical Staff, and Advanced Practice Providers. These activities consist of a variety of quality improvement activities, including but not limited to Focused Professional Practice Evaluations (FPPE), as further described in Section 16.3 of this Plan, Ongoing Professional Practice Evaluations (OPPE), as further described in Section 16.2 of this Plan, and regular and systematic review of all reported issues or incidents involving members of the Medical Staff or Advanced Practice Providers exercising clinical privileges.

b. Insofar as feasible, these activities should strive to produce detailed, current, accurate, objective and evidence-based information about the Medical Staff member or Advanced Practice Providers. This information should be integrated into the general quality improvement and continuing education activities of the Clinical Departments. Specific information about the Medical Staff Member or Advanced Practice Provider should be reviewed on an ongoing basis and considered in making decisions regarding the need for improvement, counseling, and/or corrective action at any time, as well as in making decisions regarding appointment, and renewal of privileges. Without limiting the foregoing, the President of the Medical Staff and Chief Medical Officer are to be promptly apprised of incident reports that involve significant patient care issues, patient safety, or conduct that undermines a culture of safety.

c. OPPE and FPPE activities are to be conducted in a manner to preserve confidentiality established by applicable law and Medical Center and Medical Staff policy.

d. Routine FPPEs are performed at the time of initial appointment and are not disciplinary, whereas for-cause FPPEs are performed in response to concerns raised regarding the Member's or Advanced Practice Provider's clinical practice or professional conduct. OPPE activities are not medical disciplinary actions and do not give rise to procedural rights described in the Fair Hearing Plan. However, where circumstances warrant, some of the same evaluation tools (such as proctoring or mandatory consultation) may be imposed as part of a medical disciplinary action, and in those cases only, procedural rights may apply if the measure imposed constitutes grounds for a hearing in the Fair Hearing Plan.

e. Information for Focused and Ongoing Practice Evaluations may be acquired through a variety of methods as deemed appropriate by the Department Chair, including but not limited to:

    i. Periodic random chart review

ii. Concurrent or retrospective review of selected charts

iii. Direct observation

iv. Proctoring (as further described below)

v. Simulation

vi. Quality and Safety Dashboard data

vii. Monitoring of diagnostic and treatment techniques and/or clinical practice patterns

viii. Departmental Quality Review process

ix. Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel

x. External peer review

xi. Continuing Medical Education

xii. Patient satisfaction data

xiii. Professional liability experience

xiv. Incident Reports

xv. Anonymous or Confidential Complaints

xvi. Compliance/Non-compliance with Medical Staff Bylaws and Rules and Regulations

xvii. Compliance/Non-compliance with Medical Center Policies and Procedures

16.2 Ongoing Professional Practice Evaluation (OPPE)

a. Ongoing evaluations of each Member or Advanced Practice Provider's professional performance will be conducted pursuant to the Medical Staff OPPE policy. Individual Departments will monitor and review clinical data, trends, and outliers through the electronic Ongoing Professional Practice Evaluation (eOPPE) system per the Medical Staff OPPE policy. This process not only allows any potential performance problems to be identified and resolved as soon as possible, but also fosters a more efficient, evidence-based privilege renewal process.

b. The eOPPE system allows the organization to identify professional practice trends that impact quality of care and patient safety. Such identification may require

intervention by the responsible Department Chair, Committee Chair, or officers of the Medical Staff.

c. If during the course of the OPPE there is uncertainty regarding the Member or Advanced Practice Professional's professional performance, including professional conduct, further evaluation (i.e., for-cause FPPE) or referral for formal investigation and/or corrective action will be implemented, as appropriate under the circumstances.

16.3 Focused Professional Practice Evaluation (FPPE)

a. Initial FPPE

Except as otherwise determined by the Department Chair, FPPE for new Members and Advanced Practice Providers exercising new privileges will generally be conducted in accordance with standards and procedures defined in the FPPE policy and will be documented on each Department's delineated clinical privileges form. FPPE should begin with the applicant's first admission or performance of the newly requested privilege. Each Department/Division will determine the number of cases or charts to be reviewed as part of initial FPPE. While initial FPPE should be completed within twelve (12) months, the time may be extended at the discretion of the Department Chair, if indicated. It is the Member's or Advanced Practice Provider's responsibility to obtain an extension. The inability to obtain an extension will be deemed a voluntary relinquishment of the privilege(s) and will not give rise to procedural rights described in the Fair Hearing Plan. While proctoring is the most common form of FPPE used in these circumstances, the Departments and Department Chairs are authorized to implement other methods for evaluation as deemed appropriate under the circumstances pursuant to the Medical Staff FPPE policy. In addition, at the discretion of the Department Chair, Members and Advanced Practice Providers may be required to undergo FPPE as a condition of renewal of privileges under appropriate circumstances, such as when a Member or Advanced Practice Provider requests renewal of a privilege that has been performed so infrequently that it is difficult to assess current competence in that area.

b. For-Cause FPPE

FPPE processes are used to evaluate, for a time-limited period, a Member's or Advanced Practice Provider's professional performance to include quality of care, patient safety, and professional behavior. The Medical Staff may supplement this Plan with policies that further define the general circumstances when and how a for-cause FPPE will occur. An FPPE may also be implemented whenever the responsible Department Chair, Credentials Committee, Executive Medical Board, or Physician Review Board determines that additional information is needed to assess a Member's or Advanced Practice Provider's competence. An FPPE under this Section should be imposed for such period (or number of cases) as is reasonably necessary to enable an appropriate assessment.

c. Completion of FPPE

An FPPE will be deemed successfully completed when the Member or Advanced Practice Provider completes the required number of cases or other criteria established by the FPPE plan within the time frame established in the Bylaws or as required by the Department Chair or other initiating person or committee, and the individual's performance is determined to have met the standard of care or other applicable requirements of the Department and Medical Center.

d. Failure to Complete FPPE

i. If the Member or Advanced Practice Provider undergoing initial FPPE fails to complete the required number of cases within the time frame established by the Department, the individual will be deemed to have voluntarily resigned from the Medical Staff and/or relinquished the relevant clinical privileges, unless the Department Chair, in their discretion, extends the time to complete initial FPPE, subject to the approval of the Executive Medical Board. In this circumstance, the Member or Advanced Practice Provider is not entitled to procedural rights described in the Fair Hearing Plan. The Department Chair also has the discretion to extend initial FPPE when the individual's performance raises concerns and further observation is needed.

ii. If the Member or Advanced Practice Provider completes the necessary volume of cases or meets other criteria established by the FPPE plan, but fails to perform satisfactorily during FPPE, the Department Chair must forward a report to the Credentials Committee and Executive Medical Board recommending that the Member's or Advanced Practice Provider's privileges be terminated.

16.4 Sharing of Peer Review Information Within Affiliated Networks

The Medical Staff may enter into arrangements with other system medical staffs, integrated networks, or clinical affiliates to assist it in peer review evaluation and monitoring activities. This may include, without limitation, relying on information in other health systems' credentials and peer review files, and utilizing the other health systems' medical or professional staff support resources to conduct or assist in conducting peer review activities.