LANGLEY PORTER PSYCHIATRIC HOSPITAL
UNIVERSITY OF CALIFORNIA SAN FRANCISCO MEDICAL STAFF

CREDENTIALING AND PERFORMANCE PLAN

Approved on _02/09/2023__by the Medical Staff Executive Committee
Approved on _03/02/2023__ by Governance Advisory Council

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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

14.1.1 Eligibility.

Membership of the Medical Staff and/or granting of clinical privileges shall be extended only to professionally competent physicians, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws, Plans, Rules and Regulations, Medical Staff Policies and applicable LPPH 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.

14.1.2 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 UCSF Health System Members' credentials and peer review files in evaluating applications for appointment and reappointment and in utilizing the other UCSF Health 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

14.2.1 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.

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

14.2.3 Physicians who are seeking new membership/privileges or reappointment of the same must meet the following requirements:

14.2.3.1 Completion of residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) (or verifiable equivalent non-U.S. training) that includes complete training in the specialty or subspecialty for which the physician is applying for credentials, and

14.2.3.2 Current 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), when endorsed by the Department Chair;

14.2.3.3 Physicians with a time-limited board certification or 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

14.2.3.4 Entry into the examination process of the appropriate specialty board. The physician 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 is required to become board certified within a time specified by his/her specialty board, the termination of the physician's privileges and membership on the Medical Staff because of his or her failure to become board certified as required by this Section, shall not entitle a physician to the procedural 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.

14.2.3.5 Exceptions: Exceptions to the requirement for board certification and CAQ must be substantiated by documented appropriate medical education and training, relevant experience, outstanding reputation, and additional evidence of current competency that is endorsed by the Department Chair and presented, in writing, for the MSEC's consideration through the Credentials Committee. In certain exceptional circumstances, providers may be approved/granted membership/privileges by the Governance Advisory Council.

14.3 General Requirements for Non-Physician Members

14.3.1 Non-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.

14.3.2 Non-Physician Members of the Medical Staff must have a Federal DEA number and furnishing license if prescribing controlled substances.

14.4 Requirements for Medical Staff and Non-Physician Members

14.4.1 Physicians, clinical psychologists, 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.

14.4.2 Physicians, clinical psychologists, 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.

14.4.3 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 LPPH Medical Staff membership and privileges.

14.4.4 Membership 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 physician, clinical psychologist, or other professionals specialize, when allowed by the state to practice independently and approved by the MSEC and the Governance Advisory Council.

14.4.5 Appointment to the faculty of the School of Medicine, University of California, San Francisco, shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. Absence of a faculty appointment shall not disqualify a person from Medical Staff membership; however, except as otherwise provided with respect to temporary or visiting privileges, absence of Medical Staff membership will disqualify a person from providing patient care services at LPPH.

14.4.6 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 LPPH or the resources thereof. Allocation of resources, including,

but not limited to, patient beds, shall be subject to administrative allocation pursuant to procedures established by authority of the Chief Medical Officer of LPPH in consultation with the President of the Medical Staff.

14.4.7 Unless provided through UCSF, each Medical Staff Member granted privileges at LPPH 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 and Risk Management of conforming coverage. It is the Member's responsibility to verify coverage and to promptly advise the Office of Medical Staff Affairs and Governance and Risk Management of any lapses in coverage.

14.4.8 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 recommendation of the MSEC, if it determines that the applicant has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and LPPH. Waivers are not granted on a permanent basis, rather, requests for waiver are reviewed at each time the applicant/Member applies/reapplies for privileges. There is no obligation to grant any waiver, and applicants have no right to have a waiver considered and/or granted. An applicant who is denied waiver or consideration of a waiver shall not be entitled to any procedural hearing and appellate review rights provided for in the Fair Hearing Plan.

14.6 Administrative and Contract Individuals

14.6.1 Contractors Who Have Clinical Duties.

An individual with whom LPPH contracts to provide services that involve clinical privileges must be a Member of the Medical Staff, achieving his/her status by the procedures described in this Plan. Unless a contract or agreement executed after this provision is adopted provides otherwise, or unless otherwise required by law, those clinical privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of the Fair Hearing Plan, upon termination or expiration of such individual's contract or agreement with LPPH. In the event there is a conflict between the Bylaws, this Plan, and such contract with the Member, the contract terms shall prevail.

14.6.2 Subcontractors.

Members who contract with LPPH may lose any clinical privileges and/or Membership granted pursuant to an exclusive or semi-exclusive arrangement if their relationship with the contracting individual or entity is terminated, or LPPH and the contracting individual's or entity's agreement or exclusive relationship is terminated.

14.7 General Responsibilities of Membership

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

14.7.2 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 LPPH.

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

14.7.4 Except as otherwise approved by the Medical Staff Executive Committee (MSEC), 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 his/her responsibilities in such a way as to serve as an exemplary role model for the students and for the teaching programs of LPPH.

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

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

14.7.7 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 LPPH and UCSF Health, and otherwise keep confidential, as required by law, all protected patient information, medical and mental health information and medical records.

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

14.7.9 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.

14.7.10 Without limiting the obligations of each Member to comply with the Medical Staff Bylaws, Plans, Rules and Regulations and Policies of the Medical Staff and LPPH, each Member is expected to maintain all qualifications, participate in and cooperate with the Medical Staff in promptly advising the Office of Medical Staff Affairs and Governance in writing of any changes to the information provided on the Member's last application/reapplication for membership/privileges. 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.

14.7.11 Reappointment and continuation of privileges are subject to at least biennial review, and ongoing monitoring is performed at least every six (6) months, and may be based upon criteria that include, but are not limited to quality of patient care, quality of teaching, professional conduct and proper utilization of LPPH resources.

14.8 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.

14.8.1 The categories are:

14.8.1.1 Attending Staff

14.8.1.2 Courtesy Staff

14.8.1.3 Teaching Only Staff

14.8.1.4 Courtesy Associate Staff

14.9 Standard of Conduct of Medical Staff Members:

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

14.9.1 General.

14.9.1.1 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 MSEC, 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.

14.9.1.2 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 reasonable Plans, Rules, Regulations, Policies and Procedures of the Medical Staff, and/or the policies of the Department, LPPH, may be found to constitute disruptive behavior.

14.9.1.3 In assessing whether particular circumstances are affecting quality patient care or LPPH 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.

14.9.2 Conduct Guidelines.

14.9.2.1 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, and the UCSF Code of Conduct and Principles of Compliance.

14.9.2.2 Members are expected to behave in a professional manner at all times and with all people, patients, professional peers, LPPH staff, visitors, and others in and affiliated with LPPH. Behavior that adversely affects or could be reasonably expected to adversely affect patient care or safety, public safety, or the operations or reputation of LPPH 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 LPPH 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 LPPH, not working collaboratively with others, working/or on call duty while under the influence of alcohol or drugs, and deliberate physical, visual, or verbal intimidation or challenge.

14.9.2.3 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 LPPH.

14.9.2.4 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 MSEC may establish a formal process for handling concerns, complaints or grievances.

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

14.9.2.5.1 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 LPPH or to any other governmental agency.

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

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

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

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

14.9.2.8 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 LPPH personnel to promptly report such behavior or concerns in the manner as described in section 14.9.2.4 of this Plan. Failure to report may result in corrective action when patient safety is at risk.

14.9.3 The MSEC 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 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.

14.10 Advanced Practice Providers (APPs):

14.10.1 Definition.

Only APPs in approved categories (see Credentialing Policy and Procedures in the Rules and Regulations) who are employed or contracted by LPPH are eligible to apply for Advanced Practice Provider 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 Advanced Practice Provider Staff category is automatically terminated if the employment service contract is terminated.

14.10.2 General Requirement for Advanced Practice Providers.

14.10.2.1 All Advanced Practice Providers must be licensed or otherwise certified to practice in the State of California.

14.10.2.2 All Advanced Practice Providers must have a Federal DEA number and furnishing license if prescribing controlled substances.

14.10.2.3 Prerogatives and Responsibilities: Advanced Practice Providers shall provide services pursuant to approved standardized procedures and/or job descriptions delineated by the assigned Department and granted by Governance Advisory Council through the Committee on Interdisciplinary Practice (CIDP) and MSEC. Supervision requirements shall be specifically defined on any applicable Standardized Procedures, Nurse Practitioner Privilege Forms and/or job descriptions. APPs 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 may be the admitting provider of record. Upon appointment and to the extent approved by the Committee on Interdisciplinary Practice (CIDP), MSEC and Governance Advisory Council, Advanced Practice Providers shall be expected to:

14.10.2.3.1 Meet the qualifications and perform responsibilities outlined in their respective privilege forms, Standardized Procedures, Practice Agreements, and/or job descriptions;

14.10.2.3.2 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 Active Medical Staff shall retain the ultimate responsibility for the patient's care;

14.10.2.3.3 Participate directly in the management of patients;

14.10.2.3.4 Write orders as permitted by scope of practice;

14.10.2.3.5 Record reports and progress notes on patient charts;

14.10.2.3.6 Perform consultations upon request; and

14.10.2.3.7 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 Advanced Practice Provider.

14.10.3 Corrective Action.

Employed Advanced Practice Providers are subject to corrective action processes pursuant to UCSF Health Human Resources policies and procedures. Contracted Advanced Practice Providers are subject to corrective action processes described within the terms of their service contract. Notwithstanding the foregoing, clinical privileges exercised by Advanced Practice Providers 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 CIDP or MSEC, subject to the following:

14.10.3.1 Prior to restriction, suspension or termination of clinical privileges of an Advanced Practice Provider, the affected Advanced Practice Provider shall 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 his/her designee), who shall be authorized to take final action on behalf of the Medical Staff.

14.10.3.2 This Article shall not be deemed to afford an Advanced Practice Provider 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 Staff, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given access to the Medical Staff Bylaws, Plans, Rules, Regulations, Policies, and applicable LPPH policies. At least four (4) months prior to expiration of the current term of membership and/or clinical privileges, the individual should be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges.

15.1.1 Failure to Meet Basic Requirements.

An applicant who does not meet the basic requirements as outlined in this Plan, the Bylaws and related Policies and Procedures is ineligible to apply for membership or APP status, and the application shall 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 shall 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 but may submit comments and request for reconsideration of the specific requirements which adversely affected such applicant. Those comments and requests shall be reviewed by the MSEC and Governance Advisory Council, which shall have sole discretion to decide whether to consider any changes in the basic requirements or to grant a waiver as allowed by this Plan or the Bylaws.

15.1.2 Failure to File Reappointment Application.

Failure without good cause to file a complete application for reappointment at least forty-five (45) days prior to expiration of his/her current appointment shall result in the automatic termination of membership, privileges or standardized procedures of the Member or APP at the end of the current appointment. The Member or APP shall be deemed to have resigned and the Member or APP shall not be entitled to the procedural hearing and appellate review rights provided for in the Fair Hearing Plan.

15.2 Burden on Applicant

It is the applicant's/Member's responsibility to tender a complete application/reapplication for membership and privileges. It is the applicant's/Member'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 upon any change in circumstance including but not limited to status or discipline of professional license, criminal charges, and claims of professional wrongdoing or malpractice. The burden on applicants for appointment, reappointment, and/or other clinical privileges is set forth in the Medical Staff Bylaws and incorporated herein. See the Medical Staff Bylaws for "Burden on Applicant."

15.3 Complete Application

The Complete Application form shall include accurate and complete and updated disclosure by the applicant with regard to the following queries as may be amended from time to time:

15.3.1 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;

15.3.2 Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, restriction, admonition, loss, or denial of clinical privileges at another Hospital;

15.3.3 Whether the applicant has had any notification of, or any involvement in a professional liability action, including any final judgments or settlements involving the applicant;

15.3.4 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;

15.3.5 A statement from the applicant that his/her physical and mental health status is such that he/she is currently able to competently and safely perform the clinical privileges that he/she is requesting;

15.3.6 A statement from the applicant that he/she has had access to and read the current Medical Staff Bylaws, Plans, Rules, Regulations, and Policies, including the UCSF 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;

15.3.7 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 his/her 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

15.3.8 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.

The Complete Application form shall also include the following attestations by the applicant:

15.3.9 The applicant consents to and cooperate with any required physical or mental health evaluations and provide the results thereof as necessary to enable a full assessment of the applicant's fitness for duty. Noncooperation may result in denial of the application for failure to satisfy his/her burden of producing adequate information for proper evaluation of qualifications;

15.3.10 The applicant agrees that LPPH and the Medical Staff may obtain and share information with a representative or agent of LPPH, UCSF School of Medicine, and the UCSF Medical Group, including information obtained from other sources, and he/she releases 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, Applicant agrees that LPPH and the Medical Staff may seek information from other sources regarding voluntary or involuntary limitation of privileges or loss of licensure elsewhere. Applicant also agrees that LPPH, UCSF School of Medicine, and the UCSF Medical Group may act upon such information.

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

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

15.3.13 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.

15.3.14 By applying for privileges and/or membership, the applicant pledges to inform the Medical Staff of conflicts of interest as they arise, and any changes to his/her basic qualifications for membership, including but not limited to any and all criminal charges despite plea or pending appeal, complaints of sexual misconduct, changes in licensure status, or threatened discipline of professional license.

15.4 Verification Process

15.4.1 Upon the receipt of a Complete Application form, 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 Staff Affairs and Governance shall consult primary sources of information about the applicant's credentials, where feasible. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, internet) information when the means of transmittal is directly from the primary source to LPPH and the verification is documented. If the primary source has designated another organization as its agent in providing information to verify credentials, LPPH may use this other organization as the designated equivalent source.

15.4.2 The Office of Medical Staff 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 Staff 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 MSEC, it shall be reviewed and processed as follows:

15.5.1 Department Report.

The Office of Medical Staff Affairs and Governance shall make available the application and all supporting materials to the Chair of each Department in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category (in the case of applicants for Staff membership), the Department to be assigned, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested. In the event that the applicant is the Department Chair, the President of the Staff shall designate an alternate to make the evaluation and recommendations. Following the Department Chair's/designee's evaluation and

recommendations, the report shall then be transmitted to the Credentials Committee. The time frame for completion of the Department report(s) shall be within thirty (30) days of receipt of a complete application.

15.5.2 Credentials Committee Report.

The Credentials Committee shall review the application, supporting materials, the report of the Department Chair 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 regarding the information obtained from the applicant or another source. The Credentials Committee shall prepare a written report with recommendations for the MSEC as to Medical Staff appointment and Medical Staff category (in the case of applicants for Staff membership), the Department 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 shall be stated. The time frame for completion of the Credentials Committee action shall be at the next regular meeting of the committee following receipt of the Department report, to be within thirty (30) days, unless the Credentials Committee requests additional information.

15.5.3 Medical Staff Executive Committee Recommendation.

The MSEC shall receive the reports and recommendations from the Department Chair and the Credentials Committee, and any such other available information as may be relevant to the applicant's qualifications. As soon as practicable, the MSEC shall prepare a written report with recommendations for the Governance Advisory Council as to Staff appointment and Staff category. In the event there are any adverse recommendations, the reasons shall be stated. The Governance Advisory Council shall consider the reports and recommendations at its next regular meeting or as soon as practicable.

15.5.4 Effect of Medical Staff Executive Committee Recommendation.

15.5.4.1 Deferral: The MSEC may defer making a recommendation for up to sixty (60) days where the deferral is not solely for the purpose of causing delay. A decision by the MSEC 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 shall be followed with a subsequent favorable or adverse recommendation. The MSEC may delegate the responsibility for further consideration to the Credentials Committee or Department Chair as deemed appropriate.

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

15.5.4.3 Adverse Recommendation: If the recommendation of the MSEC 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, if entitled to hearing rights because of peer review actions reported under Business & Professions Code Section 805, the applicant shall be entitled to procedural rights provided in the Fair Hearing Plan and the recommendation need not be transmitted to the Governance Advisory Council until after the applicant has exercised or waived such rights.

15.5.5 Governance Advisory Council.

15.5.5.1 Deferral: The Governance Advisory Council may defer making a recommendation for up to sixty (60) days where the deferral is not solely for the purpose of causing delay. 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 Medical Staff Executive Committee (MSEC) or Credentials Committee as deemed appropriate.

15.5.5.2 Unless subject to the provisions of the procedural 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 MSEC. Action shall be taken within sixty (60) days after receiving a recommendation from the MSEC.

15.5.5.3 Favorable Recommendation: If the Governance Advisory Council adopts the recommendation of the MSEC, the MSEC recommendation shall become final.

15.5.5.4 Adverse Recommendation: If the Governance Advisory Council does not adopt the recommendation of the MSEC, the matter is referred back to the MSEC with instructions for further review and recommendation, and 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 so advise the MSEC of its action, and such action becomes final. If the matter is referred back to the MSEC, the MSEC shall review the matter and shall

forward its recommendation to the Governance Advisory Council. If the Governance Advisory Council adopts the recommendation, the recommendation becomes final.

15.5.5.5 If the action of the Governance Advisory Council is adverse to the applicant, the President of the Medical Staff or designee shall promptly send written notice to the applicant. If applicable, such notice shall contain the information prescribed in the Fair Hearing Plan. In such case, if applicable, the applicant shall be entitled to procedural hearings 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 procedural hearing and appellate review rights under the Fair Hearing Plan have been exhausted or waived, the Governance Advisory Council shall take final action.

15.5.5.6 All decisions to appoint shall 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 shall be so notified within thirty (30) days of the Governance Advisory Council's decision.

15.5.5.7 Subject to any applicable provisions of the Fair Hearing Plan, notice of the Governance Advisory Council's final decision shall be given in writing by the President of the Medical Staff to the applicant. In the event a hearing and/or appeal are triggered, provisions detailed in the Fair Hearing Plan shall govern notice of the Governance Advisory Council's final decision.

15.6 Term of Appointment and Reappointment

15.6.1 Appointments and reappointments to LPPH 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, depending upon the membership category.

15.6.2 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 Application after Adverse Action

A waiting period of twenty-four (24) months to apply for membership and/or privileges shall apply to the following applicant or Member:

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

Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Credentials Committee, MSEC or Governance Advisory Council.

15.7.2 A former Member who has received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or

Voluntary accepted termination or other adverse recommendation or action upon his/her membership and/or privileges; or

Resigned from the Medical Staff or relinquished privileges while an investigation was pending.

15.7.3 A current Member who has received a final adverse decision resulting in Restriction of his or her privilege(s); or

Denial of his or her request for additional privileges for a medical disciplinary cause or reason.

15.7.4 Duration and Commencement Date of Waiting Period for Reapplication.

15.7.4.1 Ordinarily, the waiting period for reapplication shall be twenty-four (24) months, however, for applicants or Members whose adverse action included a specified period or conditions of retraining or additional experience, the MSEC may exercise its discretion to allow earlier or later reapplication upon completion of the specified conditions. Similarly, the MSEC may exercise its discretion, with approval of Governance Advisory Council, to waive the twenty-four (24) month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application.

15.7.4.2 An action is considered adverse only if it is based on the type of occurrences which 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 professional liability insurance (which can be cured by obtaining the insurance).

15.7.5 Date When the Action Becomes Final.

15.7.5.1 The action is considered final on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon completion of (a) all Medical Staff and LPPH fair hearings and

internal appeal and (b) all judicial proceedings pertinent to the action served within two (2) years after the completion of the LPPH proceedings.

15.7.6 Waiting Period and Effect of the Waiting Period.

15.7.6.1 Unless otherwise determined by the Credentials Committee, there is a waiting period of no less than twenty-four (24) months and no more than forty-eight (48) months for reapplication following unprocessed incomplete application, withdrawal of application pending investigation, resignation of Membership pending or following investigation, or completion of all proceedings pertaining to corrective action and completion of fair hearing and attendant appeal. After the waiting period, the Member or applicant may reapply. The application will be processed like an initial application or request, plus the Member or applicant shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

15.8 Objections to Actions Relating to Appointment or Reappointment of Membership

In the event any applicant or Practitioner has any objection to any action taken or procedures followed by LPPH, the LPPH Medical Staff, UCSF Health, or any individual, Hearing Panel/Arbitrator or committee with regard to the consideration of any application for appointment or reappointment, any investigation, any corrective action, any hearing, or other action, the applicant or Practitioner shall immediately state such objection and the reasons for the objection to the individual or body concerned in writing, or verbally if the objection arises during any recorded proceedings, in order to permit the body before whom the matter is pending to address the objection and take any corrective action deemed appropriate. The failure to give such notice of any objection shall be deemed to be a waiver of any such objection and consent to the procedures being followed or action being taken.

15.9 Exceptions to Hearing Rights

In instances of denial of an application for failure to meet the minimum qualifications, Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California professional license to practice medicine, clinical psychology; or to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under the Medical Staff Bylaws, Plans or Rules and Regulations); or to maintain professional liability insurance as required by the Medical Staff Bylaws, Plans or Rules and Regulations; or to meet any of the other basic standards specified in this Plan or the Bylaws, or failure to

file an accurate and complete application to the satisfaction of the Credentials Committee.

15.10 Leave of Absence for Members

15.10.1 Members must request a leave of absence for any anticipated leave that exceeds three (3) months. Members must request the leave of absence from their Department Chair, which must be approved by the Credentials Committee and the MSEC. The request for a leave of absence must state the reason for the leave and the specific period of time requested which may not exceed one (1) year. During the period of leave, the Member shall not exercise privileges at LPPH, and membership rights and responsibilities shall be inactive. The time period for consideration of reappointment shall be stayed during the leave of absence. 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.

15.10.2 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 his or her privileges and prerogatives by submitting a request to the Department Chair who shall promptly forward the request to the Credentials Committee and to the MSEC via the Office of Medical Staff Affairs and Governance. The Member shall submit a written summary of his or her relevant clinical activities during the leave. The MSEC, upon receipt of the request, shall recommend to Governance Advisory Council whether to approve the Member's request for reinstatement of privileges and prerogatives. 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 competent physical and mental health necessary to return or exercise the duties and privileges requested. Failure to achieve a requested reinstatement does not give rise to procedural rights, as stated in the Fair Hearing Plan and Bylaws unless the reason for non-reinstatement is 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

16.1.1 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 APPs. These activities consist of a variety of quality improvement activities, including but not limited to Focused Professional Practice Evaluations (FPPE), as further described in Article 16.3 of this Plan, Ongoing Professional Practice Evaluations (OPPE), as further described in Article 16.2 of this Plan, and regular and systematic review of all reported issues or incidents involving members of the Medical Staff or APPs exercising clinical privileges.

16.1.2 Insofar as feasible, these activities should strive to produce detailed, current, accurate, objective and evidence-based information about the Medical Staff member or APP. 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 APP 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 appointment and reappointment decisions. Without limiting the foregoing, the President of the Medical Staff and CMO are to be promptly apprised of incident reports that involve significant patient care issues, patient safety or conduct that undermines a culture of safety.

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

16.1.4 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 clinical practice or professional conduct, which may be considered disciplinary and may give rise to hearing rights under the Fair Hearing Plan. 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 a reportable event as further described in the Fair Hearing Plan and California Business and Professions Code Section 805.

16.1.5 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:

16.1.5.1 Periodic random chart review

16.1.5.2 Concurrent or retrospective review of selected charts

16.1.5.3 Direct observation

16.1.5.4 Proctoring (as further described below)

16.1.5.5 Simulation

16.1.5.6 Quality and Safety Dashboard data

16.1.5.7 Monitoring of diagnostic and treatment techniques and/or clinical practice patterns

16.1.5.8 Departmental Quality Review process

16.1.5.9 Discussion with other individuals involved in the care of each patient

16.1.5.10 External peer review

16.1.5.11 Continuing Medical Education

16.1.5.12 Patient satisfaction data

16.1.5.13 Professional liability experience

16.1.5.14 Incident Reports

16.1.5.15 Anonymous or Confidential Complaints

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

16.1.5.17 Compliance/Non-compliance with LPPH Policies and Procedures

16.2 Ongoing Professional Practice Evaluation (OPPE)

16.2.1 Ongoing evaluations of each Member or APP's professional performance will be conducted pursuant to the Medical Staff Ongoing Professional Practice Evaluation 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.

16.2.2 The eOPPE allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the responsible Chief of Clinical Service, Department Chair, Committee Chair, or officers of the Medical Staff.

16.2.3 If during the course of the Ongoing Professional Practice Evaluation there is uncertainty regarding the Member or APP's professional performance, including professional conduct, further evaluation (i.e., FPPE) or referral for formal investigation and/or corrective action should be implemented, as appropriate under the circumstances.

16.3 Focused Professional Practice Evaluation (FPPE)

16.3.1 Initial and New Privileges.

Except as otherwise determined by the Department Chair, FPPE for new applicants and Members 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 for privileging. While FPPE for new applicants should be completed within twelve (12) months, if indicated, the time may be extended at the discretion of the Department Chair. It is the Member's responsibility to obtain an extension. The inability to obtain an extension will be deemed the applicant or Member's 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 evaluating as deemed appropriate under the circumstances pursuant to the Medical Staff Focused Professional Practice Evaluation policy. In addition, Members may be required to undergo FPPE as a condition of renewal of privileges (for example, when a Member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area).

16.3.2 Specific Professional Performance.

FPPE processes are used to observe and evaluate, for a time-limited period, a Practitioner's professional performance to include quality of care, patient safety and professional behavior. The Medical Staff may supplement this Plan, with Policies, for approval by the MSEC and Governance Advisory Council, that will further define the general circumstances when and how a FPPE will occur. FPPE may also be implemented whenever the responsible Department Chair, Credentials Committee, MSEC, or Physician Review Board determines that additional information is needed to assess a Member's

competence. FPPE is not normally imposed as a form of discipline but rather to assess competency. It should be imposed for such period (or number of cases) as is reasonably necessary to enable such assessment. During FPPE, the Member must demonstrate that he/she is qualified to exercise the privileges that were granted and/or requested.

16.3.3 Completion of FPPE.

FPPE shall be deemed successfully completed when the Practitioner 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 Practitioner's professional performance met the standard of care or other applicable requirements of the Department and LPPH.

16.3.4 Failure to Satisfactorily Complete FPPE.

If a Practitioner completes the necessary volume of cases or meets other criteria established by the FPPE plan, but fails to perform satisfactorily during FPPE, he or she may voluntarily withdraw the privilege or request a review by the Credentials Committee.

16.4 Sharing of Peer Review Information Within UCSF Medical Staffs

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