NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

MEDICAL STAFF

CREDENTIALS MANUAL

Revised February 2013

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NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO

ARTICLE 2: CREDENTIALS MANUAL **PAGE #**

ARTICLE 2: PROCEDURE FOR CREDENTIALING

2.1. Appointment Process

A. Application for clinical privileges and membership on the medical staff shall be in writing, on a prescribed original form, to the Medical Staff President. The section and/or department chief will be notified by the Medical Staff Office of the applicant's interest in Nationwide Children's Hospital. An application and appropriate documents will be sent to the applicant.

B. It is a requirement for the section or department chief, or their designate to conduct an interview, clinical in nature, of all new applicants for appointment to the medical staff. It will be the responsibility of the section or department chief, or designate to arrange the interview. A permanent record of the interview, signed by the appropriate section or department or designate will be completed and placed in the applicant's credentials file. No applicant will be recommended to the Board of Directors without first participating in an interview.

The information on the application will be verified with the primary sources, whenever possible. A completed application shall document, at a minimum, the following information, if applicable:

1. professional education, training, and specify what portion of training was pediatric;

2. ECFMG number;

3. current and prior affiliations with Hospitals, surgery centers, ambulatory care centers, faculty/teaching appointments; etc.

4. other affiliations, such as private practice; partnerships; corporations; military assignments; government agencies; etc.

5. current and unrestricted Ohio license;

6. out-of-state licenses;

7. Drug Enforcement Agency number;

8. board status;

9. affiliation with all local, state and national professional societies;

10. documentation of professional liability insurance coverage in an amount not less than $1 million per incident and $1 million per annual aggregate. The amount required is determined by the Medical Executive Committee and approved by the Board of Directors;

11. designation of alternative coverage;

12. physical and mental health status;

13. completion of the immunization status questionnaire form;

14. documented completion of annual PPD skin testing requirements (annual Mantoux PPD skin test) unless the practitioner has a history of a prior positive skin test. Those individuals with a prior skin test will have to complete a questionnaire concerning symptoms related to tuberculosis. Failure by the practitioner to comply shall result in immediate suspension of medical staff privileges.

15. department/section assignment and delineation of privileges;

16. evidence of continuing medical education activities as it relates to privileges granted;

17. evidence of current competence to verify the ability to perform the privileges requested, e.g. surgical/procedure/case log;

18. peer references from three practitioners who are knowledgeable about the applicant's training, professional competence and character and who have known the applicant for at least one year (additional letters may be requested at the discretion of the section and/or department chief(s);

19. previously successful or currently pending challenges to any licensure or registration (state or DEA) or the voluntary or involuntary relinquishment of such licensure or registration;

20. voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital;

21. involvement in professional liability actions (pending claims, judgements or settlements); list all carriers used for the last ten years;

22. a review of medicare/medicaid or other federal sanction(s);

23. a review of the AMA Practitioner Masterfile; the AOA Profile Report;

24. a review of incidents reportable to the National Practitioner Data Bank or other central agency; querying the National Practitioner Data Bank is required on all applicants applying for clinical privileges and membership;

25. a recent photograph of the applicant;

26. results of criminal background check;

27. a valid email address;

28. the agreement to abide by the Hospital's policies and rules, the Hospital's corporate integrity plan and standards of conduct, and the Medical Staff's Bylaws and Manuals; and

29. Practitioners in Active Category 2 are required to complete Zero Hero training or other similar training program approved by the Chief Medical Officer within three (3) months of initial appointment unless additional time is granted by the Chief Medical Officer and Medical Staff President. Failure to complete the training in the required time period shall render the practitioner ineligible to continue with his/her Category 2 admit/management privileges. All other practitioners are strongly encouraged to participate in the Zero Hero training.

C. All practitioners for membership and clinical privileges shall at the time of appointment or reappointment, be and remain board certified by the national specialty board applicable to their primary specialty/sub-specialty. A practitioner who is a qualified candidate for board certification at the time of initial appointment shall have five years from the date eligibility was first attained to become board certified.

Board certification is a continuing eligibility requirement for medical staff appointment with or without admitting privileges. Board certification includes initial certification, maintenance of certification and recertification as required by the practitioner's applicable board.

Failure to meet or maintain the eligibility requirement of board certification shall result in automatic termination of membership and clinical privileges on the medical staff. The Board certification requirement will not apply to any practitioner whose application was approved on or prior to July 1, 2005, who was not Board certified on or prior to July 1, 2005, and who has continuously maintained a medical staff appointment in good standing.

D. Any individual who does not satisfy the requirement of Board certification, but is Board eligible or possesses equivalent qualifications, may request that the Board certification requirement be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent.

A request for a waiver shall be submitted to the Credentials Committee for consideration. The individual must supply all information as requested by the Credentials Committee. The Credentials Committee may, in its discretion, consider the specific qualifications of the individual in question, input from the relevant department/section chief(s), the best interests of the Hospital and the patients and families it serves, the application form and other information supplied by the applicant. The individual's specialized expertise to meet a patient care need may also be considered when reviewing a request for a waiver to the Board certification requirements.

The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board of Directors regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges and does not give rise to the right to a hearing. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals. An application will not be submitted to Credentials Committee for consideration of appointment until the Board has determined that a waiver should be granted.

E. Upon receipt of the completed application, the Medical Staff President shall direct the Medical Staff Office to obtain the appropriate documents for review. The information on the application will be verified by the primary source, whenever possible. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information.

F. When collection and verification of materials is accomplished, the Medical Staff Office shall transmit the application and all supporting materials to the appropriate department and/or section chief for recommendation.

G. Applications will not be forwarded through the appointment process until completed properly and unless all verifications have been obtained.

H. All applications must be referred to the appropriate department and/or section chief(s). Surgical section and/or department applications will next be reviewed by the Surgeon-in-Chief followed by the Chief Medical Officer, prior to Credentials Committee submission. All other department and/or section applications will be referred from the department and/or section chiefs to the Chief Medical Officer and then submitted to the Credentials Committee. The department and/or section chiefs and Chief Medical Officer's recommendation for acceptance shall specify the status and clinical privileges recommended and must be forwarded to the Credentials Committee within 75 days of his/her receipt of the completed application and supporting materials.

The Chief Medical Officer may personally interview the applicant before transmitting the written recommendation for acceptance or rejection to the Credentials Committee. The Chief Medical Officer, department and/or section chiefs may stop the appointment process if the applicant refuses a personal interview.

I. The President of the Medical Staff shall transmit the name of the applicant to the Chief Executive Officer and will make any application materials available to the Chief Executive Officer upon his/her request.

J. The Credentials Committee shall cause to be investigated the character, health status, qualifications and standing of the applicant including the review of any adverse professional review actions or other professional sanctions taken or pending, a review of malpractice claims, settlements, awards and criminal background checks. The Credentials Committee shall evaluate these findings and the recommendations of the respective department and/or section chiefs and Chief Medical Officer, shall submit its findings at the next regular meeting of the Medical Executive Committee, or as soon thereafter as possible, recommending that the application be accepted, deferred, or rejected.
A recommendation for acceptance shall specify the status and clinical privileges recommended.

K. Upon receipt of the report of the Credentials Committee, the Medical Executive Committee will determine whether to recommend acceptance, rejection or deferral of the applicant. The Medical Executive Committee has the prerogative to secure additional information from any source prior to making their recommendation. When there is a recommendation for deferral, the Medical Executive Committee shall make a subsequent recommendation for acceptance or rejection of the application.

L. The Medical Executive Committee shall specify the clinical privileges and status of the applicant in the recommendation for approval.

M. If the Credentials Committee recommends to the Medical Executive Committee that the application be rejected, and the Medical Executive Committee concurs, the President of the Medical Staff shall notify the applicant in writing of his/her rejection and right to a hearing before the hearing panel in accordance with Article 1 of these Bylaws. The applicant must submit a written request for a hearing within 30 calendar days of the date upon which the applicant received written notice of such rejection. Upon receipt of the applicant's written request for a hearing the Medical Executive Committee shall forward the application and all supporting materials including the report of the Credentials Committee to the hearing panel in accordance with Article 1 of these Bylaws.

N. If the Credentials Committee recommends that the application be accepted or deferred, the Medical Executive Committee shall determine whether to recommend acceptance, rejection or deferral of the application. The Medical Executive Committee may secure additional information from any source prior to making its recommendation.

In all cases where the Medical Executive Committee recommends that an application be rejected and the Credentials Committee has recommended that such application be accepted or deferred, the President of the Medical Staff shall notify the applicant in writing of his/her rejection and right to a hearing.

Upon the applicant's written request within thirty days of the date upon which the applicant received written notice of such rejection and his/her right to a hearing, the Medical Executive Committee shall forward the application and all supporting materials, including the report of the Credentials Committee, to the hearing panel in accordance with Article 10 of these Bylaws.

No adverse recommendation shall be transmitted to the Board of Directors until the applicant has exercised or has waived his/her right to a hearing.

O. The Medical Executive Committee shall recommend to the Board of Directors those applications it deems acceptable. Recommendation for acceptance or rejection of the applications by the Medical Executive Committee will be transmitted to the Board of Directors or its Executive Committee through the President of the Medical Staff.

P. The Board of Directors or its Executive Committee shall either accept the recommendation of the Medical Executive Committee or if it rejects the recommendation of the Medical Executive Committee it shall enter the reasons for such rejection in its minutes and thereafter shall not act finally on such rejection for at least thirty days. If there is a disagreement between the Board of Directors and Medical Staff's recommendation in relation to clinical privileges of a staff member or applicant, a joint meeting will be called of the Officers of the Board of Directors, the Officers of the Medical Staff, the Credentials Committee chairman, the applicant's department and/or section chief(s), the Chief Medical Officer and Chief Executive Officer before a final decision of the Board of Directors is reached.

Q. Notification of the final decision of the Board of Directors will be sent by the Chief Executive Officer to the department and/or section chief(s), the Chief Medical Officer, to the applicant and other departments as appropriate.

2.2. Reappointment Procedure

A. Any person desiring to maintain clinical privileges and Medical Staff membership must complete a reappointment application packet and submit it to the Medical Staff Office by April 1 of the second year of the reappointment term (with the exception of Emeritus and Retired practitioners). Failure to file the completed reappointment application packet on or before April 1 may result in automatic termination of appointment at the expiration of the appointee's current term.

B. Prior to the December meeting of the Board of Directors, in the second year of the reappointment term, the section and/or department chiefs shall review the status, clinical privileges, demonstrated current competence and performance of Medical Staff members. The review shall include but not be limited to the following:

1. completion of information necessary to update the medical staff file;

2. professional and clinical judgment in the treatment of patients;

3. ethics and conduct;

4. peer recommendation letter from a practitioner that is in the same professional discipline and who has direct professional knowledge of your experience, and who has known you for at least one year;

5. willingness to provide continuous care and supervision to patients, teaching duties, and participation of departmental coverage;

6. attendance at General Staff and department meetings;

7. participation and attendance at committee meetings;

8. board status;

9. affiliation with local, state and national societies;

10. evidence of continuing medical education activities as it relates to privileges granted;

11. evidence of current competence to verify the ability to perform the privileges requested, e.g. surgical/procedure/case log;

12. compliance with these Bylaws, Rules and Regulations, and Manuals in addition to Hospital policies and rules and corporate integrity plan and standards of conduct;

13. timely completion of medical records;

14. cooperation with Hospital personnel and other practitioners;

15. use of the Hospital and general attitude toward patients, the Hospital, and colleagues;

16. participation in continuous quality improvement activities, including the medical review functions;

17. current and unrestricted Ohio license;

18. current and unrestricted Drug Enforcement Agency number;

19. participation in other community activities relating to medicine;

20. return of completed information forms, when required;

21. physical and mental health status;

22. any other criteria which in the opinion of the department and/or section chief (s) is relevant;

23. department and/or section assignment and delineation of privileges;

24. previously successful or currently pending challenges to any licensure or registration (state or DEA) or the voluntary or involuntary relinquishment of such licensure or registration;

25. voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital;

26. involvement in a professional liability action (pending claims, judgments or settlements);

27. documentation of professional liability insurance in an amount not less than $1 million per incident and $1 million per annual aggregate. The amount required is determined by the Medical Executive Committee and approved by the Board of Directors;

28. review of medicare/medicaid or other federal sanction(s);

29. review of incidents reportable to the National Practitioner Data Bank or other central agency; querying the National Practitioner Data Bank is required during reappointment;

30. data contained in the Quality Improvement Profile;

31. documented completion of annual PPD skin testing requirements (annual Mantoux PPD skin test) unless the practitioner has a history of a prior positive skin test. Those individuals with a prior skin test will be required to complete a questionnaire concerning symptoms related to tuberculosis. Failure by the practitioner to comply will result in an automatic suspension of medical staff privileges;

32. results of criminal background check.

C. All practitioners for membership and clinical privileges shall at the time of appointment or reappointment, be and remain board certified by the national specialty board applicable to their primary specialty/sub-specialty. A practitioner who is a qualified candidate for board certification at the time of initial appointment shall have five years from the date eligibility was first attained to become board certified.

Board certification is a continuing eligibility requirement to maintain medical staff appointment with or without privileges. Failure to meet or maintain board certification shall result in automatic termination of membership and clinical privileges on the medical staff. The Board certification requirement shall not apply to any practitioner whose application was approved on or prior to July 1, 2005, who was not Board certified on or prior to July 1 2005, and who has continuously maintained a medical staff appointment in good standing.

D. Any individual who does not satisfy the requirement of Board certification, but is Board eligible or possesses equivalent qualifications, may request that the Board certification requirement be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent.

A request for a waiver shall be submitted to the Credentials Committee for consideration. The individual must supply all information as requested by the Credentials Committee. The Credentials Committee may, in its discretion, consider the specific qualifications of the individual in question, input from the relevant department/section chief(s), the best interests of the Hospital and the patients and families it serves, the application form and other information supplied by the applicant. The individual's specialized expertise to meet a patient care need may also be considered when reviewing a request for a waiver of Board certification

The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board of Directors regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges and does not give rise to the right to a hearing. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

An application will not be submitted to Credentials Committee for consideration of appointment until the Board has determined that a waiver should be granted.

E. The department and/or section chief(s), the Surgeon-in-Chief, if a surgical department and/or section, and the Chief Medical Officer shall thereafter consult and make recommendations to the Credentials Committee which shall evaluate such recommendation on the basis of such criteria, conduct whatever investigation it deems necessary to support its evaluation, and submit its written recommendation as to the status and clinical privileges of the Medical Staff member being considered to the Medical Executive Committee. The recommendation of the Credentials Committee shall be accompanied by the recommendation of the section chief, when appropriate, the department chief, the Surgeon-in-Chief when appropriate, and the Chief Medical Officer.

F. The Medical Executive Committee will review the Credentials Committee recommendations and present their recommendations to the Board of Directors through the President of the Medical Staff. In all instances where non-reappointment or a change for less clinical privileges or staff category is recommended, but not requested by the, staff member, or if a request for promotion is not recommended, the staff member shall be notified by the President of the Medical Staff as to the reasons for such recommendations and that the staff member is entitled to a hearing as specified in the Medical Staff Bylaws.

No adverse recommendation shall be transmitted to the Board of Directors until the staff member has exercised or has waived his/her right to a hearing.

G. No later than their December meeting in the second year of the reappointment term, the Board of Directors will determine reappointment status and clinical privileges of Medical Staff members. Any staff member whose reappointment, category or clinical privileges have changed will be notified by the President of the Medical Staff of such changes.

Staff members who are not reappointed may file a new application for staff membership after one year.

2.3. Change of Staff Category

A. A staff member wishing to change the category of his/her staff appointment must make application in writing to the President of the Medical Staff and must include the reasons for his/her request. The request shall be referred to the Chief Medical Officer and to the appropriate department and/or section chief(s) for his/her recommendation. From that point the procedure outlined under Article 2.1. will be followed.

B. Change in staff appointments can be recommended by the department and/or section chief(s) to the Credentials Committee when appropriate. Normally, these changes will be submitted with the reappointment recommendations. The department and/or section chief(s) will make his/her recommendation in writing to the Credentials Committee after discussion with the staff member concerned, and from that point the procedure outlined under Article 2.2. will be followed.

2.4. Emergency Privileges

A. Members of the Medical Staff

In the case of emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status, shall be expected to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary. When an emergency situation no longer exists, such member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

B. Urgent Intra-Operative Consultation

In the case of an intra-operative emergency, an NCH surgeon may request an emergency consultation from a surgeon who is not a member of the NCH medical staff but who has a current Ohio license and is a member of a medical staff of another Ohio hospital with comparable surgical privileges. An attempt must be made to obtain approval from the Surgeon-in-Chief or his/her designee but this attempt should not delay emergency surgical care. Such emergency privileges shall be limited to the performance of any necessary life-saving or limb-saving procedure(s) that he/she is privileged to perform at another Ohio hospital. When the emergency situation no longer exists, the surgical consultant must request temporary privileges to continue to treat the patient. In the event such temporary privileges are denied or he/she does not desire to request temporary privileges, the patient shall be assigned to an appropriate member of the NCH medical staff.

C. Automatic Review of Emergency Privileges Utilization

Any use of emergency privileges must be reported to the Medical Staff Office within one business day by the responsible NCH physician and will be subject to automatic review by the Medical Staff Officers and the Credentials Committee.

2.5. Disaster Privileges

A. Disaster privileges may be granted to a practitioner who is not a member of the medical staff when the Nationwide Children's Hospital emergency management plan has been activated and Children's is unable to handle immediate patient needs. Disaster privileges are granted for up to thirty (30) days at the discretion of the Chief Executive Officer, or designee, to volunteer practitioners who offer their services while responding to a specific disaster event. Verification of a valid government-issued picture identification in addition to presentation of any of the following will be acceptable identification to obtained disaster privileges:

1. Current pocket license to practice medicine.

2. A current Hospital photo identification card, confirmation by current medical staff member(s) with personal knowledge regarding the practitioner's identity.

3. Name of Hospital where he/she currently have privileges or have recently practiced.

4. Identification that the practitioner is a member of a Disaster Medical Assistance Team or Medical Reserve Corps (MRC) – Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or identification indicating that the practitioner has been granted authority to render patient care in disaster circumstances. Such authority having been granted by a federal, state or municipal entity.

B. The Medical Administrative Specialist, or designee, is required to present to the Medical Staff Office a list of volunteer Practitioner names and if possible, copies of the documents listed above. The granting of disaster privileges shall be done in the same manner as Temporary Privileges, except that primary source verification of licensure and competency may be performed after the situation is under control and as circumstances allow. A primary source verification of licensure shall be conducted as soon as the immediate situation is under control, and is to be completed within seventy-two (72) hours from the time the volunteer practitioner presents to the Hospital. If verification cannot be completed within seventy-two (72) hours (due to, for example, no means of communication or lack of resources), verification shall be performed as soon as possible. A reassessment must be made within seventy-two (72) hours after initial disaster privileges have been granted to determine if there should be a continuation of disaster privileges for that practitioner.

1. If possible, copies should be made of the medical license, photo identification card and driver's license.

2. Attempt to contact the primary facility at which the practitioner has practiced to verify that they are in good standing.

3. Attempt to contact the state medical licensing board to verify license.

4. Attempt to verify professional liability insurance coverage.

C. All practitioners who receive disaster privileges must at all times while at the Hospital wear an identification badge, with photograph, from the facility at which they otherwise hold privileges. If the practitioner does not have such identification, he or she will be issued a badge identifying him or her and designating the practitioner as an emergency provider. The activities of practitioners who receive disaster privileges shall be managed by and under the supervision of the Chief Medical Officer or an appropriate designee. The disaster privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer. A practitioner's privileges, granted under this disaster situation, may be terminated at any time without any reason or cause. Termination of these privileges will not afford the practitioner the right of a hearing process.

2.6. Temporary Privileges

Temporary privileges will only be granted on a case by case basis by the appropriate Hospital leadership as set forth in this section. As permitted by Ohio Law and applicable rules and regulations, including The Joint Commission, temporary privileges may be granted to appropriately licensed practitioners under the following circumstances:

A. To fulfill an important patient care need (without appointment to the medical staff) that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 days. Temporary privileges shall be explicitly curtailed by a date of expiration. Examples would include, but are not limited to:

1. A situation where a practitioner becomes ill or takes a leave of absence and a licensed practitioner would need to cover his/her practice until he/she returns.

2. A specific licensed practitioner has the necessary skills to provide care to a patient(s) that a practitioner currently privileged does not possess.

3. Temporary privileges may be granted provided there is verification of:

   a. Current letter from the practitioner's primary Hospital attesting to his/her character, qualifications and professional standing. The letter is required to be from appropriate medical leadership and include the date of appointment at the primary Hospital.

   b. Copy of valid Ohio license or if out of state/out of county, a special certificate from the Ohio State Medical Board.

   c. Copy of valid DEA certificate, if applicable.

   d. Documentation of current professional liability insurance coverage ($1 million/$1million).

   e. Documentation of current self-query from the National Practitioner Data Bank (allow 10 business days for processing) not applicable for practitioner's practicing outside the United States.

   f. Copy of Annual Tuberculosis Surveillance test.

   g. Completion of Immunization Documentation form.

   h. Board status.

   i. Criminal Background Check

   j. Copy of current curriculum vitae.

B. Examples of temporary privileges that would not be granted would include, but are not limited to the following:

1. The practitioner fails to submit the application packet in a timely manner for processing of his/her application.

2. An applicant that is scheduled to be on-call prior to appointment.

3. Failure of Medical Staff Office personnel to verify performance data and information on the application in a timely manner.

C. Approval Process:

1. Temporary privileges may be granted by the Chief Executive Officer, or an authorized designee, upon recommendation from the section/department chief(s), Chair of the Credentials Committee, Surgeon-in-Chief when applicable, Chief Medical Officer or an authorized designee, or the Medical Staff President or an authorized designee.

2. The section and/or department chief(s) will be responsible for initiating and completing the required form and documentation before recommending temporary privileges. Appropriate forms may be obtained from the Medical Staff Office. The completed form and required documentation shall be forwarded to the Medical Staff Office for processing. The Credentials Committee chair shall review all temporary privileges before they are recommended to the Surgeon-in-Chief when applicable and Chief Medical Officer. After approval by the Surgeon-in-Chief, Chief Medical Officer and the Medical Staff President, temporary privileges may be granted by the Chief Executive Officer to care for the specific patient(s). The time period shall not exceed 120 days.

3. Written notification of temporary privileges will be sent by the Chief Executive Officer to the appropriate department and/or section chief(s), and other Hospital departments, as appropriate.

4. The practitioner will be restricted to the specific delineations for which these temporary privileges are granted. The practitioner will be under the supervision of the section and/or department chief(s) while exercising any type of temporary privileges.

5. Practitioners exercising any type of temporary privileges must agree to abide by the Hospital's policies and rules, and by the Medical Staff Bylaws, Rules and Regulations and Manuals.

6. Temporary privileges may be terminated at any time and for any lawful reason by the Chief Executive Officer or an authorized designee upon recommendation from the respective section and/or department chief(s), Chair of the Credentials Committee, Surgeon-in-Chief when applicable, Chief Medical Officer, or the Medical Staff President.

Termination of temporary privileges may be with or without cause, and may be based on the revocation of the certificate/license from the State Medical/Dental Board of Ohio or on the discovery of any information or the occurrence of any event which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, or for failure to abide by the Medical Staff

Bylaws, Rules and Regulations, and Manuals or any applicable Hospital or Medical Staff policy or procedure.

7. If it is determined that the health of the patient may be endangered by continued treatment by the person exercising temporary privileges, the practitioner's privileges may be terminated by: (1) the Chief Medical Officer or a designee, in consultation with the President of the Medical Staff or a designee; (2) the Physician-in-Chief or a designee, in consultation with the Chief Medical Officer and the President of the Medical Staff or their designees; or (3) the Surgeon-in-Chief or a designee, in consultation with the Chief Medical Officer and the President of the Medical Staff or their designees.

   The Medical Staff President, in consultation with the respective department and/or section department chief(s) and the Chief Medical Officer, shall assign a member of the Medical Staff to assume responsibility for the patient's care until discharged from the Hospital, and he/she shall notify the patient and parents and/or legal guardian of this change.

8. A practitioner who has been granted temporary privileges is not an appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to appointees. A practitioner shall not be entitled to a hearing because the practitioner's request for temporary privileges is refused, in whole or in part, or because all or any portion of such privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

2.7. Telemedicine Privileges

A. Under this Manual, telemedicine is defined as the use of medical information exchanged between an originating site (the site where the patient is located at the time the service is provided) and a distant site (the site where the practitioner providing the professional service is located) through electronic communications for the purpose of providing patient care, treatment, and services at the originating site. For purposes of this Manual, telemedicine does not include services that are strictly interpretative in nature, such as official readings of images or specimens, or consultations in which a practitioner is simply offering advice to a treating practitioner and that typically occur over the phone.

B. The chief of each department and/or section that offers telemedicine services will recommend which clinical services are appropriately delivered via a telemedicine link as is consistent with commonly accepted quality standards.

C. When Nationwide Children's Hospital is acting as the distant site, NCH practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by the authority to write orders, and direct care, treatment, and services) through a telemedicine link are required to be credentialed and privileged by the Nationwide Children's Hospital medical staff and the medical staff of the originating site. Performance of telemedicine services by a Nationwide Children's Hospital practitioner will be evaluated as part of privileging and as part of the reappraisal conducted at the time of reappointment or renewal or revision of clinical privileges.

D. When Nationwide Children's Hospital is the originating site, the practitioner at the distant site must be appropriately credentialed and granted privileges by Nationwide Children's Hospital before the practitioner provides telemedicine services to patients of Nationwide Children's Hospital. A practitioner providing services to Nationwide Children's Hospital's patients from a distant site through a telemedicine link shall be fully credentialed in accordance with the procedures set forth in Article 2: Credentials Manual.

2.8. Leave of Absence (LOA)

A. Request for leave of absence shall be submitted in writing to the Credentials Committee for such period of time as is necessary. A request for an extension may be made to the Credentials Committee. A leave of absence may be granted to medical staff members for any reason deemed appropriate by the Credentials Committee, for a specified period of time.

B. The Credentials Committee may recommend placing a medical staff member on leave of absence status when said member is under medical care or convalescence.

C. A medical staff member on a leave of absence status shall not exercise the privilege of admitting or treating patients in this Hospital during the period of the leave of absence and membership rights and responsibilities shall be inactive. He/she shall be excused from all meetings and from paying medical staff dues during the period of the leave of absence.

D. At least 30 days prior to the termination of the leave of absence, a member wishing to return to his/her previous status from a leave of absence shall submit a summary of relevant activities during the leave of absence to the Credentials Committee. Members returning from a military leave of absence will be required to submit proof of honorable discharge. A member returning from medical leave of absence will be required to submit his/her practitioner's report on his/her health and capability to resume practice. Members returning from an academic leave of absence who request reinstatement of clinical privileges and membership or a change of clinical privileges shall be required to submit evidence of completed training from the appropriate program director.

E. Failure to request reinstatement from an approved leave of absence shall be deemed a voluntary resignation from the medical staff. The Credentials Committee, at their next meeting, may recommend automatic termination of membership and privileges.

F. Leave of absence recommendations (requests for and return from) require the approval of the section and/or department chief(s), the Chief Medical Officer, the Credentials Committee, Medical Executive Committee and the Board of Directors.

G. When a practitioner has experienced a significant illness that has resulted in the inability to practice medicine for longer than three months, the section/department chief should follow this procedure:

1. Ascertain that the practitioner is not taking any medications that would adversely affect the ability of that practitioner to carry out his/her responsibilities as an attending physician.

2. Ascertain that written documentation has been obtained from the practitioner’s managing practitioner certifying that it is safe for the practitioner to fully return to treating patients.

3. The department and/or section chief(s) will then approve or deny the request to return to patient care activities based on all available information and documentation, which may include a direct interview of the returning medical staff member. At the discretion of the section/department chief, outside evaluation or monitoring may be required.

4. Written documentation will then be provided to the Medical Staff Office by the department and/or section chief(s) stating that the provisions of this section have been fulfilled. The documentation will be included in the practitioner's credential file.

5. In the event of an adverse ruling, the practitioner has the right to a hearing in accordance with the Medical Staff Bylaws.

2.9. Resignations and Terminations

A. Resignation from the Medical Staff and the reason for such shall be submitted in writing 30 days in advance of departure to the respective department chief (or designated section chief) and copies made available to the Chief Medical Officer, Medical Staff Office and Health Information Management Department. If the departing practitioner fails to follow the above notification process and fails to complete medical records prior to departure, it will be the responsibility of the department chief (or designated section chief) to complete the medical records on behalf of the departing practitioner. In the event a member of the medical staff is deceased, the responsibility of medical record completion will be assumed by the department chief (or designated section chief).

The name of the practitioner will be immediately removed from the central mailing system. For purpose of information, the resignation will be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board of Directors. The President of the Medical Staff will notify the former member and all appropriate Hospital personnel of the Board of Trustee's acceptance of the resignation.

B. In those cases where a Medical Staff member moved away from the area without submitting a forwarding address or his/her written intentions with regard to his/her Medical Staff appointment, he/she shall be terminated from the Medical Staff after approval by the Credentials Committee, the Medical Executive Committee, and the Board of Directors.

C. If a forwarding address is known, the member will be asked his/her intentions with regard to his/her Medical Staff appointment, and if he/she does not respond within 30 days, his/her name will be submitted to the appropriate committees for approval of termination. The President of the Medical Staff will send the former staff member written notification of the approved termination.

D. Failure to file a completed Reappointment application packet on or before April 1 of the second year of the reappointment term shall result in a termination from staff membership effective December 31 of the same year. Staff members who are not reappointed may file a new application for staff membership after one year.

E. Resignation from or termination of staff membership shall concurrently terminate clinical privileges.

2.10. Reinstatement of Appointment After Resignation

When a member resigns from the Medical Staff and then submits a written request for reinstatement of a previous staff appointment, the request will be processed as an initial application as specified in Article 2.I.

2.11. Medical-Administrative Officer

A. Practitioners, podiatrists, or psychologists employed by the Hospital for medical-administrative duties must be members of the Medical Staff following the same procedure to gain membership as other staff members.

B. Termination of a medical-administrative practitioner's employment shall be subject to a review and a hearing if requested within thirty days as follows:

1. When the reason for the action is determined to involve the individual's medical competence, the Medical Staff shall provide for a review as delineated in these Bylaws, including a hearing pursuant to Article 1. if requested, to formulate a recommendation to the governing body on the action proposed.

2. When the reason for the action is determined to be purely administrative in nature and not involving the individual's medical competence, the matter shall be submitted through the grievance process which may include a hearing by the Hearing Board as specified below:

a. The grievance is to be submitted in writing to the appropriate department and/or section chief(s), or, when appropriate, the Chief Medical Officer. After review of the grievance, the person to whom the grievance was submitted shall respond in writing to the employee within 10 days.

b. If the grievance is not satisfactorily settled at the preceding step, or if the person being terminated is a department chief or above, the individual may request in writing to the President of the Medical Staff that it be considered by a Hearing Board.

c. The provisions for a hearing in Article 1. shall be followed except that the Hearing Board will consist of the Chief Medical Officer, three members of the Medical Executive Committee and three members of the Board of Directors who will be appointed by Chairpersons of the respective bodies. If the Chief Medical Officer is the subject of the grievance, then the President of the Medical Staff shall replace the Chief Medical Officer on the Hearing Board.

d. The decision of the Hearing Board must be made by a majority vote. The Hearing Board will submit its written recommendations to the Medical Executive Committee and the Board of Directors.

e. Within 30 days, notification of the action of the Board of Directors shall be sent by the President of the Medical Staff to the Medical Executive Committee, the appropriate department chief, and to the staff member who requested the hearing.

2.12. Criminal Background Checks

A. Purpose

To promote a safe environment for patients, employees, visitors and the general public by conducting criminal background checks as part of the credentialing process for all medical staff.

B. Procedure

1. A criminal background check (hereafter "background check") shall be performed on practitioners applying for initial appointment and during the recredentialing process. No practitioner will exercise clinical privileges on patients at Nationwide Children's Hospital until all credentialing requirements have been met, including results of a criminal background check.

2. Medical staff will be required to sign a waiver/consent for a background check. Refusal to provide adequate information on the application/reappointment form or to provide consent for the background check will result in no further processing of the initial application or termination from the Medical Staff.

3. The background check process will be initiated by the Medical Staff Office and will not be performed until the signed consent is received by the Medical Staff Office.

4. Background checks will be conducted by a third party vendor who will be instructed to provide results to Medical Staff Office personnel only.

5. If the background check identifies any criminal activity not disclosed on the application/reappointment form, the practitioner will be notified and additional information from the practitioner will be requested. Failure to disclose all previous convictions will be considered falsification of records and will be grounds for immediate termination from the credentialing process.
   If the Medical Staff becomes aware that the practitioner has not completed the application truthfully, he/she will be subject to disciplinary action, including termination.

6. Background check results will be evaluated and processed in accordance with the medical staff procedure for credentialing and will be used for initial credentialing and re-credentialing purposes. The following information will be evaluated to determine what action should be taken:

   (a) Whether the criminal activity occurred recently.
   (b) Number of offenses.
   (c) Nature of each offense.
   (d) Efforts of rehabilitation.
   (e) Seriousness of the matter.
   (f) Relevance of the matter to the practice of medicine.

7. The practitioner may be asked to provide a written response regarding the report(s), asked to meet with the section/department chief(s), asked to meet with the Credentials Committee, and/or may be required to have a fingerprint check. Failure to cooperate will result in no further processing of the initial application or termination from the Medical Staff.

8. Reasonable efforts will be made to ensure that results of criminal background checks are kept confidential as possible with a limited number of individuals authorized to review the results.

9. The practitioner may review the results of the background check by contacting the Medical Staff Office in writing. Practitioners will be permitted access to their own credential's file in the presence of Medical Staff Office personnel. A copy of the report shall be provided to the practitioner upon his/her written request directed to the Medical Staff Office.