Privileges v. scopes of practice: How to handle AHPs

It's a question that challenges hospitals and other health care organizations across the country:

How should we authorize our AHPs to provide care—through clinical privileges or a job description?

While it might seem like a simple “either/or” question at first glance, determining how to authorize AHP care requires serious consideration of credentialing practices, state and federal regulations, and accrediting body standards. Hospitals must take a hard look at which types of AHPs currently work in the facility, their scopes of practice, and their independence levels to make sound decisions. Hospitals also must follow (and amend, if necessary) medical staff policies and procedures for authorizing AHP care.

“It’s not necessarily a simple project,” says Carol Cairns, CMCS, CPCS, president of PRO-CON, Morris, IL. “It will take some work to figure out how to handle various AHPs, especially if you don’t have specific policies and

JCAHO gives nod to temporary privileges at reappointment

The JCAHO issued another clarification to the temporary privileges standard found in its standards manual for hospitals (MS.5.14.4), ambulatory care (HR.7.2), behavioral health care (HR.4), managed behavioral health care (HR.7), and long-term care (HR.7).

This clarification, released March 15, explains that it is acceptable to grant temporary privileges at reappointment as well as at initial appointment, as long as they’re used to meet an urgent patient-care need rather than to remedy administrative delays. The new language appears in the last three paragraphs of the clarification.

But industry experts warn that the clarification does not spell out whether it’s acceptable to grant temporary privileges at reappointment when a clean, verified reappointment awaits medical executive committee (MEC) and governing body approval.

JCAHO breaks its silence
Prior to March 15, it remained unclear whether JCAHO standards allowed for temporary privileges at reappointment as well as at initial appointment. But the new language states that if a
Procedures already in place. And no two organizations will handle it the same way—each must decide which method makes the most sense.

Don’t confuse credentialing with privileging. JCAHO standards require health care organizations to credential all individuals who practice within a hospital. The extent of the credentials verification and approval process, however, depends on the role of the individual in question.

Therefore, the human resources department, the medical staff office, or the ambulatory clinic may conduct credentials verification, depending on the practitioner, explains Cairns.

Remember: Credentialing is the verification of a practitioner’s professional qualifications to provide patient care (e.g., education, training, experience), whereas privileging is the delineation of which clinical tasks he or she may carry out.

Consider ‘privileges’ as a practitioner’s ticket to practice, says Cairns. "Too often, ‘credentialing’ and ‘privileging’ are used interchangeably, leading to a lot of confusion." Hospitals must credential all practitioners in some way, but only medical staff members and other designated practitioners may hold privileges.

Who must be credentialed?
With this clarification in mind, it becomes clear that hospitals must credential the following individuals:

- All employees with patient contact
- Medical staff members and those privileged through the medical staff structure
- AHPs who work as solo practitioners or are employed or under contract with a medical staff member
- Contract employees who undergo credentialing through the institution or contract service
- Medical device representatives allowed into the operating room

Simply put, any individual allowed to access patients must undergo some type of credentialing, says Cairns. The level of medical and legal risk to the patient and the organization usually determines the extent of credentialing.

For example, a sales representative for a new medical device wouldn’t undergo the same process as a physician member of the medical staff. Organizations must outline in a policy the credentialing processes for each of the above-listed practitioner groups.

Who must be privileged?
To evaluate whether an AHP should undergo privileging via the medical staff structure, organizations must consider the JCAHO’s requirements. The Comprehensive Accreditation Manual for Hospitals states the following:

"All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital must have delineated clinical privileges, whether or not they are medical staff members." (MS.5.14)

Remember, in order for a practitioner to hold privileges, he or she must be permitted by law and by the hospital to practice independently. "Both of those criteria must be met," explains JCAHO spokesperson Mark Forst neger.

Some organizations and AHPs believe that since the state authorizes their profession to function independently, the hospital must do so as well. On the contrary, organizations have the right to limit a practitioner’s provision of care, regardless of what’s allowed under state law.

So, if the state authorizes the practitioner to practice independently, the hospital is not bound to do so as well. The governing body holds the responsibility to evaluate the organization’s scope of services and determine which practitioners may practice and what level of supervision it will permit. The hospital doesn’t have to grant these individuals clinical privileges; a scope of practice or job description would suffice.
“The nurse practitioners at our facility caused us to take another look at our AHP privileging policy,” says Marijo DeMott, coordinator of medical staff services at St. Alexius Medical Center, Bismark, ND. “They currently work under contract and are supervised by a physician, but they want to practice independently because North Dakota law allows it.”

But if the state and hospital consider the practitioner a licensed independent practitioner (LIP) and he or she practices without supervision, then the hospital should credential and privilege him or her through the medical staff process, Cairns says.

‘Indirect supervision’ not synonymous with ‘LIP’

But don’t automatically conclude that if a practitioner isn’t directly supervised, then he or she must be an LIP.

“Direct supervision may be one criterion to determine level of independence, but use it cautiously,” warns Cairns. For example, no state currently considers a registered nurse (RN) an LIP, but many RNs perform a significant amount of their work in the hospital without direct supervision.

Often organizations fail to define what they mean by “supervision,” leaving the AHP, his or her supervising or employing physician, and other hospital personnel confused about the organization’s expectations.

**Tip:** Consider writing into your bylaws and rules and regulations clear definitions of the various supervision levels at your facility. Cairns suggests (see sample definitions below). This clarity should not only prevent misunderstandings and potential conflicts, but also establish expectations to maximize patient safety and minimize legal risk.

Who must hold a scope or job description?

Practitioners whom the hospital doesn’t permit to function independently must obtain authorization to provide patient care using a “ticket” other than clinical privileges. Terms used for this type of “ticket” include scope of practice, scope of care, job description, specified services, practice parameters, practice prerogatives, and duties.

Since hospitals are not required to grant privileges to this practitioner category, they don’t have to authorize provision of care through the medical staff channel, either. The human resources

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**Levels of AHP supervision**

<table>
<thead>
<tr>
<th>Supervision Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Direct</td>
<td>Physician must be physically present to observe the AHP</td>
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<tr>
<td>Indirect</td>
<td>Physician must be physically present in hospital and immediately available to the AHP</td>
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<tr>
<td>Available</td>
<td>Physician must be able to be physically present at the hospital in ___ minutes OR Physician must be available by telephone within ___ minutes</td>
</tr>
<tr>
<td>Protocol supervision</td>
<td>AHP carries out tasks that are specifically defined in standardized protocol or procedure, which has been approved by the board, after input by the medical executive committee. In this case, the necessity for using independent judgment is diminished, since the protocols define when to perform a particular task—and in many protocols, what tasks to perform under what situations.</td>
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department may assume this responsibility.

“Our human resource department currently handles our contracted AHPs,” says DeMott, “but they [human resources] would like the medical staff office to take over. I think medical staff services might have better credentialing skills, but taking on all of these additional AHPs would add a significant burden on us.”

“Again, since there is no requirement to credential dependent AHPs through medical staff channels, each hospital is free to specify the most efficient route to fulfill this responsibility,” notes Cairns.

Update your policies and procedures
As organizations rethink and redesign their approach to authorizing AHP care, they should

• collaborate with others within the institution
• seek the most effective and cost-efficient route without compromising quality of care
• involve all stakeholders for a successful outcome

“Our director of human resources, director of nursing, chief executive officer, medical staff coordinator, medical executive committee [MEC], and credentials committee are involved in looking at this issue at St. Alexius,” says DeMott.

If your organization decides an AHP should receive privileges through the medical staff mechanism, then your medical staff bylaws, rules and regulations, and related polices and procedures should outline the credentialing/privileging process. Evaluate whether any portion of the bylaws, rules and regulations, and related polices would or should change.

“For example,” says Cairns, “if an AHP were privileged through the medical staff structure, would this change the current wording in medical staff bylaws or related manuals regarding fair hearing and appeal rights?”

On the other hand, if your hospital determines the AHP will not function independently, develop an administrative policy with input and perhaps even approval from the medical staff.

Appoint a special task force
In the first stages of policy development, Cairns recommends appointing a small allied health task force. This task force would draft a preliminary document for input and consideration by larger groups. Representation should include the medical staff, hospital administration, human resources, medical staff services, and perhaps an AHP.

The task force would research the subject, consider the needs and capabilities of the hospital, and recommend a draft document. It may then seek approval from larger groups such as the senior management team, the credentials committee or MEC, and ultimately the governing body.

Tip: “Have the task force develop a broad policy that outlines your hospital’s guiding principles regarding all AHPs,” recommends Cairns (see excerpt of sample policy on p. 5). “From then on, develop a template to follow for each specific allied health discipline authorized to provide care.”

The content of a general AHP policy may include statements/sections on the following:

• Policy intent statement
• Scope of practitioners covered
• Applicant qualifications
• Application process
• Relationship of the AHP with the institution/medical staff
• Expectations of professional ethics and conduct
• Suspension, modification, or termination of permission to provide care

Editor’s note: For extensive information about developing an AHP credentialing process, look for HCPro’s forthcoming book, Guidelines for Credentialing AHPs: Challenges and Opportunities, by Carol Cairns, CMSC, CPCS, and Beverly Pybus, CMSC. In addition to offering practical, how-to advice for tackling this project, this book contains more than 20 sample policies, as well as sample scopes of practice for 24 different allied health disciplines. Call 800/650-6787 for more information.
FORREST GENERAL HOSPITAL
POLICY FOR DEPENDENT ALLIED HEALTH PRACTITIONERS
(EXCERPT)

SECTION 1. GENERAL
The board of trustees, hereinafter referred to as the “board,” permits certain types of practitioners to provide patient care services without appointment to the medical staff. Such practitioners must be qualified by academic and clinical or other training to practice in a clinical or supportive role in providing services. All individuals will provide services only under supervision of a member of the active medical staff or Forrest General Hospital’s designee. These practitioners may provide services only as permitted by this institution, in keeping with all applicable rules, policies, and procedures of Forrest General Hospital, and as stipulated by the individual practitioner’s license and the laws of the state of Mississippi. This policy does not apply to Forrest General Hospital employees.

SECTION 2. STATEMENT OF POLICY FOR PRACTITIONERS
A. Categories of allied health practitioners may include the following:

1. Audiologists
2. Clinical perfusionists
3. Licensed professional counselors
4. Marriage and family therapists
5. Nurse anesthetists
6. Nurse practitioners
7. Occupational therapists
8. Physical therapists
9. RN first assistants
10. Social workers
11. Speech pathologists
12. Clinical research coordinators
13. Radiation therapists
14. NIDCAP practitioners
15. Special educator practitioners
16. Optometrists
17. Child life specialists
18. Radiation physicists
19. Physician assistants

B. All dependent allied health practitioners must work under the appropriate supervision (and when applicable, i.e., nurse anesthetists and clinical perfusionists, as established by the department) of a physician with appropriate clinical privileges at Forrest General Hospital.

C. Each dependent allied health practitioner must have a scope of practice approved by the sponsoring physician and the appropriate medical staff department chairperson and/or designee. The scope of practice must specify the scope of job requirements and education/training requirements.

D. Dependent allied health practitioners shall provide evidence of professional liability insurance in an amount of at least $1,000,000/$1,000,000.

E. Each dependent allied health practitioner will be on probation for six months. During this time, the practitioner’s performance will be evaluated. The competency of the practitioner will be assessed by the sponsoring physician and the medical staff department chairperson and/or designee. If the evaluation is below standard, the practitioner’s services shall be terminated.

F. Dependent allied health practitioners will undergo continued assessment of competency and ability to perform their jobs. The competency of the dependent allied health practitioner will be assessed by the sponsoring physician and medical staff department chairperson and/or designee and documented on an annual evaluation form, including patient age-specific competency.

G. This policy is effective February 1, 1999. Prior to this date, dependent allied health practitioners were credentialed in accordance with the medical staff bylaws and rules and regulations. After this date, all new dependent allied health practitioners and those whose privileges have previously been processed through medical staff procedures shall be subject to this policy.

H. The staff development committee will be responsible for giving a recommendation to the board for consideration of a new category upon request or documented need. The board’s decision will be final.

Source: Forrest General Hospital, Hattiesburg, MS. Excerpt reprinted with permission.
Temporary privileges

licensed independent practitioner (LIP) fails to provide his or her reappointment information on time or the credentialing staff fails to verify and process that information on time, the LIP must “cease to provide care in the facility until the reappointment process is completed.”

“Never before has the JCAHO come out and said that you must let a physician’s privileges lapse when administrative delays hold up the reappointment process,” says Richard Thompson, MD, president of Thompson, Mohr & Associates, Palm Harbor, FL. “I think a lot of organizations have understood that to be the case, but now it’s in writing.”

Okay to grant when patient health at stake

The latest clarification states that facilities may grant temporary privileges at reappointment if keeping an LIP from continuing his or her practice would result in a significant patient-care problem. “This move gives organizations a lot more flexibility,” notes Steve Bryant, practice director of accreditation and regulatory compliance services with The Greeley Company, a division of HCPro, Marblehead, MA. “In the past, the JCAHO indicated that it didn’t want temporary privileges to occur at reappointment at all.”

Tip: To comply, Bryant advises writing into your medical staff rules and regulations what exactly constitutes an urgent patient-care need. List the criteria and follow them consistently to determine whether a situation warrants temporary privileges.

An acceptable example of an urgent situation, according to the JCAHO clarification, includes a hospital with only one cardiovascular surgeon on its medical staff. If he or she couldn’t continue to practice, no one else in the facility would possess the necessary skills to care for cardiovascular patients.

“Another example of an urgent situation could involve a busy internist—the busiest internist at the hospital—who cares for a large number of patients,” adds Bryant. “If this internist were removed because of reappointment delays, it would cause a significant disruption in patient care, even if there are other internists on staff.”

Clean reapplications: The controversy continues

But what about granting temporary privileges when a reapplication is clean, fully verified, and awaits final approval by the MEC and governing body? JCAHO surveyors and medical staff consultants alike vary on this issue, often leading to confusion in the field.

“There’s no question that the clarification says it’s okay to grant temporary privileges for clean initial applications waiting on board and MEC approval, but it doesn’t come out and say the same for reapplications,” explains Carol Cairns, CMSC, CPCS, president of PRO-CON, Morris, IL.

Bryant advises that organizations grant temporary privileges at reappointment as seldom as possible. “When you do, be sure to clearly explain why and justify it with an urgent clinical need,” he says.

Editor’s note: To read the JCAHO’s clarification, go to www.jcaho.org/standard/clarif/stanclar_frm.html.
Could you please explain the “board qualified” terminology that many bylaws contain but the American Board of Medical Specialties (ABMS) doesn’t recognize?

Most specialty boards stopped using the terms “board qualified” or “board eligible” long ago. Boards and hospitals alike misused these terms to the point where they no longer carried any significance. Specialty boards now generally provide information about a physician’s board status and indicate whether he or she is board certified, is eligible to take the exam, has taken a specific portion of the exam, or has no board status at all.

Hospitals and their medical staffs should stop relying on the terms “board eligible” and “board qualified.” Medical staff rules and regulations or specialty board policies should clearly indicate the institution’s expectations regarding an individual’s board status. Furthermore, hospitals should verify information on a physician’s application or reapplication by contacting the specialty board directly, or by relying on information in the American Medical Association’s Physician Masterfile, the American Osteopathic Association’s Physician Profile, or the ABMS’ Directory of Board-Certified Medical Specialists or CertiFACTS service.

What guidelines should we follow when we receive requests for credentialing information about a physician or resident who formerly practiced at our facility? Should we complete the form the other organization sends, or should we develop a form of our own?

Generally, a physician or administrator should feel free to provide any information requested by another hospital regarding a physician who previously served on the medical staff. If you provide information in response to a formal request—and it’s accompanied by a release form signed by the physician in question—you can rest assured that it will be used for credentialing purposes, and the respondent won’t be dragged into any subsequent legal entanglements.

According to health care attorneys, multiple protections exist for organizations or individuals providing information to peer review entities such as hospitals, managed care organizations, or multispecialty group practices. Many states have laws that protect such information. Require the practitioner in question to sign a release form that authorizes the institution to provide information. This form also should include a clause that says the individual or institution will not be sued after responding to such requests.

Additionally, the Healthcare Quality Improvement Act of 1996 provides immunity from lawsuits to individuals or organizations that provide peer review information—as long as whoever provides it does not know the information to be false.

I recommend that hospitals and physicians respond candidly and thoroughly to any questions concerning physicians who once served (or still serve) as members of their medical staff. It is not necessary for you to design your own response form; just make certain that you only provide information in response to specific requests. For further information on this issue, I suggest that you consult a qualified health care attorney.

How do you address older practitioners who refuse to retire, considering the Americans with Disabilities Act and other pertinent state and federal laws?

In general, hospitals shouldn’t concern themselves with the Americans with Disabilities Act with regard to medical staff and privileging issues. After all, the primary consideration in any credentialing process is patient safety. The hospital should use well-designed policies and procedures that permit the credentials committee to investigate and evaluate performance more frequently once practitioners reach a certain age. If a physician suffers from diminishing physical or mental capacities because of age, injury, illness, etc., the credentials committee should make sure such limitations do not compromise patient care.

Credentialing concerns
With Hugh Greeley, chair of The Greeley Company, a division of HCPro, Marblehead, MA
Points of privilege

Idaho opts out of CRNA supervision rule
Idaho became the third state to opt out of the Centers for Medicare & Medicaid Services’ (CMS) rule that requires certified registered nurse anesthetists to care for Medicare patients under physician supervision. Idaho Governor Dirk Kempthorne informed CMS of this decision on March 14, stating that it “is in the best interests of Idaho’s citizens, rural communities, and hospitals,” according to an American Association of Nurse Anesthetists press release. Go to www.aana.com/press/2002/031502.asp to read the full release.

Supervising doc held liable for residents’ care
The Ohio Supreme Court recently ruled that a supervising physician could be held liable for malpractice even if he or she never directly treated the patient in question, says Health Care Daily Report.

The case (Lownsbury v. VanBuren) involved a patient who sued a physician for allegedly failing to adequately supervise obstetrics/gynecology residents. According to the lawsuit, improper supervision led to poor prenatal care administered by the residents, which in turn resulted in permanent brain damage to the plaintiff’s infant daughter.

MA medical board seeks disciplinary power
The Massachusetts Board of Registration in Medicine recently asked the Massachusetts legislature to make it easier to discipline “bad” physicians and to report a wider range of physician data on its consumer Web site, reported the Boston Globe.

The board currently must prove “gross negligence” to discipline a physician for a single act of malpractice. Instead of abiding by such legal standards, the board sought the authority to discipline physicians based on its own judgment. It also wanted subpoena power to use in its investigations.

In addition, the board asked to keep a larger portion of the money it collects from physicians’ licensing fees in order to hire more investigators and a Web master to run the board’s Web site.

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