A Legal Primer on Clinical Privileging of Advanced Practice Professionals

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A Legal Primer on Clinical Privileging of Advanced Practice Professionals
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Overview of Presentation
• Who are advanced practice professionals (APPs)?
• General considerations to clinical privileging of APPs
• The legal landscape affecting clinical privileging of APPs
  • State practitioner/facility licensure requirements
  • Medicare/Medicaid conditions of participation
  • Health Care Quality and Improvement Act
  • Antitrust considerations
  • Practical takeaways

Who are Advanced Practice Professionals?
• For purposes of this presentation, “advanced practice professional” generally refers to advanced practice nurses, such as nurse practitioners (NPs), and physician assistants (PAs); term could include other providers
• State law generally defines APPs’ scope of practice, supervision/collaboration requirements, and practice setting restrictions
• Substantial percentages of APPs practice in settings with clinical privileging requirements, such as hospitals
General Considerations to Clinical Privileging of APPs

- Potential benefits to greater engagement of APPs in clinically privileged environment
  - Continuity of care
  - Decreased costs
  - Greater patient choice
  - Greater collaboration and education
- Potential roadblocks to engagement of APPs in clinically privileged environment
  - Medical staffs dominated by physician culture
  - Concerns about APPs being “second tier” to physicians
  - Patient expectations

Clinical Privileging of APPs: The Legal Landscape

- A loose patchwork of state and federal laws governs or raises implications for clinical privileging of APPs
- Generally, the law defers to medical staff bylaws and rules to regulate clinical privileging of APPs; thus, these documents take on heightened importance in clinical privileging of APPs

State Practitioner/Facility Licensure Requirements

- In many states, professional practice acts or facility licensure codes address clinical privileging and medical staff membership of APPs
- State law often defers to medical staff bylaws and rules on issue of clinical privileging of APPs
State Practitioner/Facility Licensure Requirements

- Does state law allow facilities and their medical staffs to outright exclude APPs from exercising clinical privileges?
  - No = Oregon (hospitals may refuse to privilege NPs “only upon the same basis that privileges are refused to other medical providers”; see Oregon Revised Statutes § 441.064)
  - Maybe = Texas (“If the governing body of a hospital has adopted a policy of granting clinical privileges to advanced practice nurses or physician assistants, an individual advanced practice nurse or physician assistant who qualifies for privileges under that policy shall be entitled to certain procedural rights…”; see Texas Health & Safety Code § 241.105)

Medicare/Medicaid Conditions of Participation

- To participate in Medicare and Medicaid, hospitals must have a medical staff, which may include “non-physician practitioners” “in accordance with State law, including scope-of-practice laws” (see 42 C.F.R. § 482.22)
- Privileged APPs may perform history and physical
- CoPs still reflect superior role of physicians on medical staff
  - Majority of MEC members must be physicians
  - A physician member must retain “responsibility for organization and conduct of the medical staff”
  - All Medicare patients must be under care of a physician

Health Care Quality and Improvement Act

- Federal Health Care Quality and Improvement Act (HCQIA) gives hospitals and other entities immunity to damages from adverse clinical privileging and other peer review actions if subject of peer review is given certain “due process” rights
- HCQIA also governs reporting to and querying of National Practitioner Data Bank (NPDB)
Health Care Quality and Improvement Act

- HCQIA does not create mandate to privilege APPs; but it also does not provide immunity from damages alleged by APPs regarding clinical privileging actions
- NPDB provisions of HCQIA do apply to APPs, to a limited degree
  - No mandate to report adverse clinical privileging actions against APPs to NPDB
  - However, hospitals that clinically privilege APPs must query NPDB to obtain information on APPs
- State law also may regulate reporting and querying procedures regarding clinical privileging of APPs

Antitrust Considerations

- Sherman Act prohibits contracts or conspiracies “in restraint of trade or commerce”
- Adverse clinical privileging actions often subject of lawsuits brought by physicians alleging hospitals and/or their medical staffs violated Sherman Act
- APPs could potentially sue under Sherman Act to challenge adverse clinical privileging actions or blanket exclusion from medical staff
- Remember: No immunity under HCQIA to damages alleged by APPs

Antitrust Considerations: Case Law Examples

- Nurse Midwifery Associates v. Hibbett
  - Hospital, on recommendation of medical staff, declined to grant clinical privileges to certified nurse midwives (CNMs) except if they fulfilled certain conditions, including the presence of an OB for all deliveries
  - Court noted acts of hostility toward CNMs, as a class of providers, by OB members of hospital’s medical staff
  - Court recognized CNMs as “competitors” to OBs and held that although the hospital could not “conspire” with its own medical staff, individual members of the medical staff could conspire to violate Sherman Act
Antitrust Considerations:
Case Law Examples

- Bhan v. NME Hospitals, Inc.
  - Certified registered nurse anesthetist (CRNA) challenged hospital’s implementation of policy to allow only physicians to provide anesthesia services.
  - Hospital defended policy on grounds that physicians were concerned about liability from supervision of CRNAs, physicians were necessary 24/7 in emergency cases, and physicians were “better trained” than CRNAs.
  - Court sidestepped substantive analysis by ruling that CRNA did not show “substantial” restraint of trade in relevant market.
  - Case leaves open the possibility that hospitals and their medical staffs may selectively privilege classes of APPs without committing antitrust violation.

Practical Takeaways

- Assess medical staff governance “culture”—is it physician-dominated or biased against APPs?
- Consider other hospital and medical staffs’ approach to clinical privileging of APPs.
- Review and revise medical staff bylaws to clarify role of APPs.
- Ensure APPs’ exercise of clinical privileges conforms to state law practice requirements.
- Ensure APPs remain aware of rights and responsibilities that come with clinical privileges.

Questions?
Thank you!

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