AHP Conundrum: To Privilege or Not to Privilege?

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We Will Discuss…

- Why must Advanced Practice AHPs be privileged?
- CMS and Joint Commission requirements related to what AHPs must be credentialed
- Considerations related to developing privileges for Advanced Practice AHPs
  - What about job descriptions, collaborative agreements, standardized procedures, protocols, etc.
  - Application of privileging principles to AHPs.
- Where to find information for privilege development
- Developing methods of assessing competency
- Additional credentialing issues

What is an Advanced Practice AHP?

Definitions are important!

- Old term: “AHPs” which meant, in many organizations, the healthcare professionals who were not employees of the organization.
  - Other terms used in addition to AHP:
    - specified professional personnel
    - mid-level providers
    - dependent practitioners
    - medical associates and/or assistants

- New term: Advanced Practice AHP means those healthcare professionals that are determined to require the credentialing and/or privileging process. It doesn’t matter whether they are employed by the organization or not.
Definitions are Important…

• An Advanced Practice AHP would typically NOT include the following:
  – Physician employed scrub techs
  – Physician employed dental assistants
  – Physician employed RNs

• Don’t use this term:
  – Independent AHP

  if the services provided by the AHP are subject to some type of supervision

Determining What Healthcare Professionals Must be Credentialed and/or Privileged
CMS Requirements

Basic Requirements

- AHPs who provide a “medical level of care” must be credentialed and privileged through the Medical Staff process.
  - Generally applicable to physician assistants and advanced practice registered nurses, but can also include other types of AHPs.
Medicare Conditions of Participation

• The governing body must: §482.12(a)(1)
  – Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;
  – Practitioners, both physicians and non-physicians, may be granted privileges to practice at the hospital by the governing body for practice activities authorized within their State scope of practice without being appointed a member of the medical staff.

Medicare Conditions of Participation

§482.51(a)(4)
• If the hospital utilizes RN First Assistants, surgical PA, or other non-MD/DO surgical assistants, the hospital must establish criteria, qualifications and a credentialing process to grant specific privileges to individual practitioners based on each individual practitioner’s compliance with the privileging/credentialing criteria and in accordance with Federal and State laws and regulations. This would include surgical services tasks conducted by these practitioners while under the supervision of an MD/DO.

• When practitioners whose scope of practice for conducting surgical procedures requires the direct supervision of an MD/DO surgeon, the term “supervision” would mean the supervising MD/DO surgeon is present in the same room, working with the same patient.
CMS Supervision

- **Types of Supervision**
  - **General Supervision** means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure or provision of the services.
  - **Direct Supervision** means the physician must be present in the office suite or on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
  - **Personal Supervision** means a physician must be in the room during the performance of the procedure.

Joint Commission Requirements
Human Resources Standards

- **Standard HR.01.02.05** (EP #10)
  - Physician assistants and advanced practice registered nurses who practice within the hospital are credentialed, privileged, and re-privileged through the medical staff process or an equivalent process.
  - (Scored as a 3 Direct Impact Requirements Apply)

Medical Staff – Credentialing and Privileging Standards

- Those who provide “medical level of care” must use the medical staff process for credentialing and privileging, making all MS standards applicable (including recommendation by the organized medical staff and approval by the governing body, OPPE, and FPPE).
  - APRNs should request privileges only for those responsibilities involving medical level of care and not those responsibilities already allowed under the RN scope of practice
  - APRNs and PAs who provide “medical level of care” must be credentialed and privileged through the Medical Staff standards process
  - APRNs and PAs who do not provide “medical level of care” can utilize the human resources “equivalent” process – HR.01.02.05, EPs 10-15

*Source: Standards Booster Pak for FPPE/OPPE – Jan/2011*
Deciding What AHPs to Credential and/or Privilege

- **CMS**
  - AHPs that provide a “medical level of care”
    - Usually includes PAs and APRNs
  - RNFAQs
  - ???

- **Method for Privileging**
  - Medical Staff process
Deciding What AHPs to Credential and/or Privilege

- **Joint Commission**
  - Any AHP that functions as an LIP
  - PAs (must provide a medical level of care)
  - APRNs (must provide a medical level of care)
  - Other non-LIPs who provide a medical level of care

- **Method(s)**
  - Medical staff privileging process
  - There is no “equivalent” process for practitioners who provide a medical level of care

Why is Development of AHPs Privileges Difficult?

- **Nursing Practice Acts limit what licensed nurses can do – and they are state-specific**
  - Physicians are usually licensed to “practice medicine and surgery” in each state – and hospitals decide what they may/may not do within the organization
  - This means that you need to have an individual with expertise in your state’s practice acts (relevant to nursing) involved with your privileging approach

- **There are few limitations or definition of what PAs can do – but there are some and these are also state-specific**
Why is Development of AHPs Privileges Difficult?

- PAs and APRNs overlap into the “practice of medicine” (which is why they must have privileges)

Why is Development of AHPs Privileges Difficult?

- PAs and APRNs are evolving professions impacted by
  - Shortage of physicians in many areas (and this will continue into the future) and access to care issues
  - Lower costs
  - Advocacy of professional organizations
  - Demand for services: many physicians/medical groups want to employ and use PAs and APRNs
Evolving Professions: Radiologist Assistant

- The radiologist assistant is identified (by the American College of Radiology) as an "advanced-level radiologic technologist who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the diagnostic imaging environment." As conceived, the radiologist assistant will not interpret radiological examinations nor transmit observations other than to the supervising radiologist.

Radiologist Assistant, cont.

- In addition to radiologist-supervised patient assessment and management, the radiologist assistant would perform selected exams, including:
  - Obtaining consent for and injecting agents that facilitate or enable diagnostic imaging
  - Obtaining clinical history from patient or medical record
  - Performing pre- and post-procedure evaluation of patients undergoing invasive procedures
  - Assisting radiologists with invasive procedures
  - Performing fluoroscopy for non-invasive procedures with the radiologist providing direct supervision of the service
  - Monitoring and tailoring selected exams under direct supervision (e.g., IVU, CT urogram, GI studies, VCIG and retrograde urethrograms)
  - Communicating the reports of the radiologist's findings to the referring physician or an appropriate representative with appropriate documentation
  - Providing naso-enteric and oro-enteric feeding tube placement in uncomplicated patients
  - Performing selected peripheral venous diagnostic procedures
Evolving Professions: Anesthesiologist Assistant

- An Anesthesiologist Assistant (AA) is a healthcare professional trained extensively in the delivery of safe and high quality anesthesia care, as well as advanced patient monitoring techniques. As nonphysician anesthetists, AAs work under the direction of licensed anesthesiologists to implement anesthesia care plans. An AA may not practice outside the field of anesthesia or apart from the supervision of an anesthesiologist.

Anesthesiologist Assistant, cont.

- The scope of AA clinical practice is generally the same as that of nurse anesthetists on the Anesthesia Care Team. Specifically, the local scope of practice of AAs is usually defined by
  - the medically directing anesthesiologist,
  - the hospital credentialing body,
  - the state's board of medicine
  - any applicable state statute or regulation.
  - States may also require a practice agreement between the sponsoring anesthesiologist and the AAs who are medically directed.
Anesthesiologist Assistant, cont.

• The specific privileges of AAs may differ according to local practice. State law or board of medicine regulations or guidelines may further define the privileges of AAs.

• The constant ingredient no matter what the local variation is that AAs always practice under the medical direction of a qualified anesthesiologist.

Evolving Professions: Pharmacists/MMT

• The evolution of the pharmacist away from the scope of “pharmaceutical care” towards an advanced scope of practice that encompasses patient-centered care and medication therapy management (MMT) is fairly recent. This advanced scope typically requires specialty training that goes beyond a professional degree and current licensure examination requirements and therefore raises the question of whether to privilege pharmacists who perform MMT.
Pharmacists/MMT, cont.

- There are currently no specific privileging requirements for pharmacists from the Center for Medicare and Medicaid Services (CMS) or accrediting bodies (e.g. The Joint Commission, DNV, NCQA, HFAP). Licensed independent practitioners (LIPs) must be privileged (as defined by state law and the organization). Most organizations do not currently define pharmacists as LIPs. Other practitioners may be privileged at the discretion of the organization. This discretionary judgment is typically based upon industry standards, risk management practices, and compliance interpretation. Organizations need to determine the scope of practice for pharmacists including whether or not to privilege and their classification. State specific requirements and the organization’s internal requirements for credentialing and privileging of any allied health practitioner will also influence this decision. In addition, specific recommendations regarding privileging criteria are an organization or facility specific function.

Considerations Related to Developing Privileges for AP AHPs

- Find out what they do (currently) or what services the organization wants to let them provide

  ✓ The decision about what Advanced Practice AHPs will be allowed to do in the hospital setting must not be solely decided by physicians due to anti-trust issues

- Research community standards

- For APRNs - Differentiate between nursing services provided (those services that may be provided by an RN) vs. those services that are comparable with services provided by physicians (“medical acts” as defined by CMS)
Considerations Related to Developing Privileges

• Important!
  ✓ Just because an Advanced Practice AHP is licensed by the State to provide a service doesn’t mean that an organization is required to allow the AHP to provide that service. However, there is some evolving case law in some States that is worth keeping an eye on.

• Remember that physicians are routinely licensed to practice medicine and surgery – it is the hospital that determines specifically what services a physician will be permitted to provide within the hospital based upon
  ✓ Services the hospital provides
  ✓ Established qualifications/criteria based on licensure, education, training, health, current competency, etc.

Considerations Related to Developing Privileges

• The delineation of privileges for an Advanced Practice AHP (PAs and APRNs) – or any healthcare professional granted clinical privileges – must be the source of information for services the Advanced Practice AHP can provide
  ✓ Job descriptions for employed Advanced Practice AHPs should “point” to the privilege delineation
  ✓ The permission to function under standardized procedures or protocols (if present) should be linked to granted privileges
  ✓ Privilege delineations “trump” standardized care arrangements or collaborative agreements
Why is this Important?

• If someone needs to find out what an Advanced Practice AHP can do, they shouldn’t have to look at multiple documents
  ✓ If we want to find out what a radiologist can do, we look at his/her privilege delineation form – not his/her contract – or his/her job description
  ✓ We look at the contract to develop the privilege delineation form

Where to Find Information for Development of Privileges

• APRNS
  ✓ Start with the Colorado State Board of Nursing Website

• APRNs include:
  – CNS (Clinical Nurse Specialist)
  – CNM (Certified Nurse Midwife)
  – CRNA (Certified Registered Nurse Anesthetist)
  – NP (Nurse Practitioner)
Information for Privileges...

Examples of Recognized APRN Specialties

- Nurse Anesthetist
- Certified Nurse Midwife
- Acute Care Nurse Practitioner
- Adult Nurse Practitioner
- Family Nurse Practitioner
- Gerontological Nurse Practitioner
- Oncology Clinical Nurse Specialist
- Pediatric Nurse Practitioner
- School Nurse Practitioner
- Women’s Health Care Nurse Practitioner
- Adult Psychiatric and Mental Health Nursing Clinical Specialist
- Child and Adolescent Psychiatric and Mental Health Nursing Clinical Specialist
- Community Health Nursing Clinical Specialist
- Gerontological Nursing Clinical Specialist
- Home Health Clinical Specialist
- Adult Health Clinical Specialist (formerly known as ‘Medical – Surgical Nursing’)
- Maternal Child Clinical Specialist
- Clinical Nurse Specialist in Acute and Critical Care - Adult
- Clinical Nurse Specialist in Acute and Critical Care - Pediatric
- Clinical Nurse Specialist in Acute and Critical Care - Neonatal
- Adult Psychiatric and Mental Health Nurse Practitioner
- Family Psychiatric and Mental Health Nurse Practitioner
- Clinical Nurse Specialist in Pediatric Nursing

Where to Find Information for Development of Privileges

Physician Assistant Authority Varies by State

- In Colorado: Colorado Medical Board

- Physician Assistants (PAs) are persons who have completed a graduate training program in health care. PAs are licensed by the Medical Board and work under the supervision of a physician. The Medical Board rules allow PAs to perform any medical function delegated to them by the supervising physician including full prescribing privileges.

Requirements for licensure as a physician assistant include:

- Graduation from an NCCPA-approved physician assistant program
- Verified practice history
- Passage of the NCCPA National Board Exam
- Verification of Federation of State Medical Boards disciplinary history
Do I Need a Separate Privilege Form for Each Specialty?

- Either style can be used. It will depend upon the variety of specialties found in your organization and other factors.
- The multi-specialty privilege form (see sample)
  - Cluster 1 – Usual and customary privileges common to all specialties
  - Cluster 2 – Dedicated subspecialty clusters with privileges “exclusive” to that cluster.
    - Assists in assuring that subspecialty related services are exclusive to a specific specialty(s) and are supervised by physicians who work in that specialty.
- The specialty-specific privilege form (see sample)

Development of Privileges

- In Summary – Perform Research:
  - ✓ Find out what services Advanced Practice AHPs are licensed to provide (and any requirements related to provision of those services, such as collaborative agreements, specific identification of supervising physician, standard care arrangements, etc.)
  - ✓ What qualifications Advanced Practice AHPs must meet in order to provide services from a statutory perspective
  - ✓ Qualifications that Advanced Practice AHPs must meet in order to be certified
  - ✓ Find out (when possible) what services Advanced Practice AHPs are qualified/competent to provide because of a specific certification
Development of Privileges

- Determine your organization’s “intent” related to Advanced Practice AHPs practice
  - What is the scope of services that your organization wants to allow each category of Advanced Practice AHPs to provide
- Make sure that the privilege delineation form is the authoritative source for the services Advanced Practice AHPs are permitted to provide
- Use essentially same privileging format for Advanced Practice AHPs that is used for LIPs (i.e., don’t use a laundry list for AP AHPS if you use core privileges for LIPs)

- Remember that privileges must be criteria-based
- Many Advanced Practice AHPs provide services only in the outpatient setting. We often find that privileges have not been delineated in these areas.
  - Privileges must be delineated in all areas that are subject to the accreditation process
  - However, privileges do not have to be “site specific” unless an AP AHP is only permitted to provide services in a specific site (for example, if an NP is permitted to perform an HP, the organization does not need to specify where the HP may be performed)
Privileging Advanced Practice AHPs

• **Same process that is used for LIPs applies to Advanced Practice AHPs**
  ✓ Joint Commission credentialing and privileging standards are applicable
    • Data collected via application form (education, training, history, etc.)
    • What is verified/how should be the same (as applicable) as what is verified for LIPs
      – Peer references
    • Evaluation and decision-making route often varies by the addition of an AHP Committee (i.e., Interdisciplinary Practice Committee) layer

Privileging Issues

• **Many Advanced Practice AHPs are employed by the healthcare organization that must also privilege them**
  ✓ Employment and credentialing/privileging processes must be coordinated
  ✓ Privileges cannot be exercised until they have been granted
    • Standards related to temporary privileges are applicable to Advanced Practice AHPs
      - Pending application or urgent patient care/service need
Privileging Issues

• **Supervision Requirements**
  – Must be explicitly defined
  – Must be monitored

Privileging Issues

• **Must determine methods for “fair hearing and appeals”**
  – Organizations will need to consider this section carefully. Issues to be considered:
    • The Joint Commission medical staff standards permit a different right of hearing and appeal for individuals that are members of the medical staff versus those who are not members but privileged by the medical staff. However, the right of hearing and appeal must be a two-step process.
Privileging Issues

• Some medical staff organizations provide the same right of hearing and appeal to Advanced Practice AHPs, while others choose to provide a less extensive process. Factors to consider in making this determination:
  - Will the outcome be reported to the National Practitioner Data Bank?
  - Are there state-specific laws or regulations impacting the right to a hearing and appeal?
  - Will employees of the organization be provided the employee grievance process and an additional hearing/appeal through the medical staff?
  - Are there employment contracts, union contracts, or other agreements that affect these rights?

Privileging Issues

• It is recommended these factors be carefully weighed and discussed with legal counsel to determine the best course for the organization.
Privileging Issues

• Development of competency reports is often problematic
  ✓ Lack of clinical activity information
  ✓ Past (total) reliance on endorsement of employing/supervising physician

• Must establish competency reports that relate to privileges granted
  – Electronic medical records usually yield clinical activity and other indicator reporting as a byproduct of care
  – If your medical records are not yet electronic you will need to work with your medical records department to modify abstracting practices OR require that AP AHPs periodically provide you with a “log” of their activities.
    • You could provide them with a clinical activity summary of their supervising physician(s) and they could indicate the cases in which they were involved

Competence Assessment Plan

• What will this include?
  – FPPE – how will competency of initially granted privileges be validated?
    • Proctoring
      – prospective/concurrent/retrospective
    • Discussions with other individuals involved in the care of the patient
      – Consultants, nursing, etc.
    • Monitoring clinical practice patterns
    • External review
  – OPPE – method for ongoing evaluation of competency
    • Frequency – same as for members of the medical staff/others with clinical privileges
    • Content – depends upon privileges granted
    • Methods – same as methods used for initially validate competency
    • Tip: Use AP AHPs to determine methods and content of OPPE reports
Tip #1

Don’t credential/privilege AHPs unless it is required (by CMS/TJC) OR unless the services provided by the AHP category are determined to be complex and therefore a privileging process is warranted.

Tip #2

Don’t charge AP AHPs medical staff dues. They are not members of the medical staff organization. Charging them dues may lead them to believe that they have “rights” and a status that they actually don’t have.
Tip #3

Develop a good working relationship with the Director/VP of Human Resources. You’ll need to collaborate if there are employed AHPs in your organization that must also be privileged.

Tip #4

A simpler “authorization” process (not a more complex credentialing/privileging process) should be established for AHPs that do not require credentialing/privileging. This authorization process should be implemented by Human Resources (as opposed to the Medical Staff Services Department).
Tip #5

Don’t allow non-employed AHPs to provide services that they would not be eligible to provide if they were employed by your organization.

Tip #6

Recognize that the Medical Staff Services Department cannot resolve in a vacuum all issues related to non-employed health care professionals. There are organizational issues that need to be addressed by a high-level group of individuals from the organization (including a representative from the Medical Staff Services Department).
Tip #7

Don’t accept an application from an AHP in a new category before your organization has determined if that category will even be permitted to provide services. Develop the category first (including the privilege form or job description) before accepting any applications.

Tip #8

Have written policies and procedures for addressing adding new AHP categories. The first issue that should be addressed is whether there is a community and organizational need to provide the services the new category wants to provide. And – can the services be provided by healthcare professionals already credentialed?
Tip #9

It is not your job to figure out how to accommodate the physician's wife who wants to act as a scrub tech for her husband (even if he is the Chief of Staff) when she doesn't meet organization requirements. Rules are meant to be followed and education/training standards have been established for a rational reason.

Tip #10

Remember that while peer recommendations are required (by the Joint Commission) for healthcare professionals who are privileged, that all peer recommendations don’t have to come from peers. Valuable recommendations may come from physicians and other healthcare professionals who have worked closely with the individual who needs the peer recommendations.
Tip #11

When reappointing AHPs, the supervisor of the area in which the AHP is providing services may be a good source of information about the AHPs’ competency (example – the ER supervisor for a PA who works in the emergency department).

Tip #12

Incorporate privileged AHPs into established systems – such as peer review. When a case is reviewed that involves an AHP, the group performing the peer review should pay attention to requirements/rules related to how the AHP provides services (for example – was the history and physical that was written by the PA confirmed by the attending physician prior to the patient going to surgery?).
Tip #13

State specifically in policy (and potentially on the privilege delineation form itself) how supervision of an AHP will occur.

Tip #14

Enlist the assistance of AHPs in development of methods to evaluate competence. The nursing members of the AHP Committee or Interdisciplinary Practice Committee should be a good source of information (otherwise, why should they be on the committee?)

Additionally – this type of committee is often chaired by a representative of nursing, rather than a physician.
Tip #15

Make sure that documents specify those healthcare professionals that the medical staff organization is responsible to credential and privilege. Just because a healthcare professional is providing services within an organization and is not an employee of the organization, doesn’t necessarily make that person the responsibility of the medical staff organization.

Tip #16

The employment of AHPs that are required to be privileged, must be contingent upon their ability to be granted clinical privileges.
Tip #17

Remember that NPDB queries are required when granting privileges – therefore, queries are required for all privileged AHPs.

Tip #18

Issue AHPs name badges that identify them and their type of license (PA, NP, etc.) – and make it a rule that they are to wear their name badge when they are providing services in your organization.
And Finally…

Remember that credentialing and privileging of AHPs is a work in process. We can be certain that CMS and the Joint Commission will continue to refine the standards related to these issues.

In the meantime, we should:

- apply common sense and be ready to defend our decisions
- remember that protecting patients is a primary goal of what we should do
- protect the reputation of our organizations

Q&A