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Privileged Versus Non-Privileged

Which Practitioners
Should Be Privileged?

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Many healthcare organizations continue to struggle with the issue of which practitioners should-or must-be privileged via the medical staff process. This is not a simple issue and is further complicated by the fact that there is a lot of “folklore” about what is required in this area to be in compliance with regulatory and accreditation requirements.

Note: It is important to note this document is devoted to a discussion of privileging (i.e., which clinical disciplines should be privileged and the authorization to provide medical care). This document is not about which clinical disciplines should be afforded the rights of medical staff membership.

STEP 1: DEFINE YOUR TERMS

First of all, make sure everyone in your organization is on the same page with the terms you are using and what they mean. The term “allied health practitioners” applies to a broad range of practitioners and means different things to different people. In an effort to provide guidance for the field regarding terminology, for several years now The Greeley Company has utilized the term *non-physician healthcare professionals* to identify this broad range of practitioners. We utilize the term *advanced practice professionals (APP)* for physician assistants (PA) and advanced practice registered nurses (APRNs) (i.e., certified nurse-midwives, nurse practitioners, clinical nurse specialists, and nurse anesthetists). We utilize the term *clinical assistants (CA)* to apply to all other types of individuals providing clinical services to patients who do not need to be granted privileges to perform their clinical duties.

Secondly, recognize that another important term to define is *licensed independent practitioners (LIP)*. LIPs are individuals who function without supervision or direction and provide a **medical level of care**¹.

Practitioners who are generally privileged as LIPs are physicians (MDs, DOs), dentists, and podiatrists. Many organizations also include clinical psychologists in this group. Each organization must define the practitioners classified as LIPs. The first step in defining LIPs is a review of the state licensing laws to determine if the licensing standards impact the specific disciplines to be included in this definition.

STEP 2: PRIVILEGE ALL LIPS

Healthcare organizations are required to privilege all LIPs through the medical staff privileging process.

STEP 3: CONSIDER PAs AND APRNs

PAs and APRNs who are providing a *medical level of care* and/or perform surgical procedures must be privileged. APRNs are defined by the boards of registered nursing in most states as including the following disciplines: CNMs (certified nurse midwives), CNSs² (clinical nurse specialists), CRNAs (certified registered nurse anesthetists), and

¹ The Joint Commission – Standards BoosterPak™ for FPPE/OPPE January 2011: Definition of medical level of care, “involves making medical diagnosis and medical treatment decisions” (e.g., skills and tasks routinely performed by physicians – diagnosing, admitting, managing, treating, and discharging patients).

² In many organizations, the role of a CNS is one of an educator, consultant, researcher with a goal toward improved outcomes and quality. CNSs should only be privileged if they are providing direct patient care.

NPs (nurse practitioners). It should be noted that the elements related to the privileging process must be applied regardless of whether the PAs and APRNs are employed by the organization. For example, some NPs may enter the organization via an employment relationship with a physician; others may be employed by the organization. Both groups need to be privileged, the same way that a physician employed or under contract with the hospital (e.g., radiology) must still be privileged in order to be able to provide clinical services.

STEP 4: CONSIDER OTHER PRACTITIONERS

In addition to PAs and APRNs, there may be additional non-physician healthcare professionals who would warrant privileging according to the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) or who the organized medical staff believes should be privileged.

CMS's CoPs require privileging for any practitioner who provides a medical level of care. Additionally, the CoPs state in the surgical services section §482.51 (a) (4) that "hospitals must specify surgical privileges for each practitioner that performs surgical tasks." Further, "if the hospital utilizes RNFAs, surgical PAs, or other non MD/DO surgical assistants, then the organization must establish qualifications, criteria, and a credentialing process to grant specific privileges...Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines."

Therefore, hospitals should evaluate and identify any individuals such as RNFAs or surgical assistants/surgical technicians who are performing surgical procedures e.g., suturing, performing hemostasis, ligation, manipulating internal tissue to determine whether it is necessary to privilege these individuals through the medical staff privileging process **for these specific tasks.**

Beyond these regulatory requirements, the deciding factor for the organized medical staff as to whether or not to privilege an individual should be based upon the complexity of services that are to be provided; it should not be based on how the healthcare professional entered the organization or because of undue pressure to privilege. The CMS' CoPs are permissive rather than prescriptive regarding certain clinical disciplines such as those referenced in the Interpretive Guidelines §482.12 (a)(l) i.e., anesthesiologist's assistants, registered dietitians or nutrition professionals, physical therapists, occupational therapists, speech language therapists, and pharmacists. When credentials committees and medical staff leaders are presented with the question as to whether or not these non-physician healthcare practitioners require privileging they should base their decision on the complexity of the care, treatment, and services that are to be provided. If a medical level of care or surgical service is not applicable, organizations should educate their medical staff leaders that a more effective way to assess competency is through a human resource or contract process.

Another factor to consider is that the resources associated with privileging are far greater than those associated with an authorization process. Thus, the privileging process should be reserved for only those practitioners who provide a "medical level of care" due to the complexity and costs of privileging vs. an authorization process as defined in Step 4.

Once the initial privileging process is complete, the non-physician healthcare professionals granted privileges follow the same path as a privileged physician. The same expectations regarding competence assessment or

periodic appraisal apply (e.g., focused professional practice evaluation [FPPE] and ongoing professional practice evaluation [OPPE] for Joint Commission and HFAP accredited facilities). These expectations are a frequent obstacle for medical staff organizations and hospitals. Over the past few years, medical staff organizations have dedicated significant effort to designing and implementing ongoing performance monitoring for physicians. However, less attention has been paid to evaluating the competence of non-physician healthcare professionals granted privileges even though the same standards apply. Involving these practitioners in the development of measurement standards and adequately resourcing the function is the key to moving forward quickly and effectively.

STEP 5: PROCESSING THE NON-PRIVILEGED HEALTHCARE PROFESSIONALS (A.K.A. "CLINICAL ASSISTANTS")

There are additional healthcare professionals who are required to be authorized by the organization to provide patient care. One such group is RN first assistants and surgical assistants. *(It has been noted under Step 3 that certain tasks performed by these individuals might require privileging, but the remainder of their clinical activities can be authorized in a more streamlined manner as described here.)*

Another group that typically does not require privileging but requires authorization to provide patient care is physician-employed RNs and licensed vocational nurses, who round on patients, provide education, and so forth. Other disciplines in the category of Clinical Assistants include licensed clinical social workers, perfusionists, massage therapists, echo technicians, dialysis technicians, sleep study technicians, rehabilitation specialists (e.g., orthotists, prosthetists), neurodiagnostic technicians, and many other emerging clinical fields. In many organizations, these non-privileged healthcare professionals are often included in the definition of allied health professionals (AHP) contributing additional confusion to this term and further highlighting the need for clarifying terms.

CMS, the Joint Commission, the Healthcare Facilities Accreditation Program (HFAP), and DNV GL do not require clinical assistants to be privileged via the medical staff process. Instead, organizations should take steps to ensure that prior to the provision of care, the qualifications and competence of a non employed clinical assistant brought into the hospital by an LIP to provide care, treatment, or services are assessed by the hospital and determined to be the same as the qualifications and competence required if the individual were to be employed by the hospital to perform the same or similar services.

What does this mean? It means that in order to provide one standard of care, the organization must determine that all healthcare professionals must demonstrate the same qualifications and competence for providing the same or similar services. Thus, if the organization hires RNs and requires specific qualifications such as education, training, or experience in order to serve as an RN, all RNs—whether employed or not—must meet the same qualifications. It does not matter if they are employed by the organization or employed by a physician, they must meet the stated qualifications.

When a clinical service is not currently performed by anyone employed by the hospital, it is leadership's responsibility to consult appropriate professional organization guidelines with respect to expectations for

qualifications and competence. This is not a new concept; hospital HR departments have done this for years as new types of clinical disciplines are employed or contracted to expand the care being provided.

Once a clinical assistant has been authorized to provide care, it is essential that the competence of this individual be continually assessed. Thus, the hospital should require a review of the qualifications, performance, and competence of each non-employee brought into the hospital by an LIP to provide care, treatment, or services at the same frequency as individuals employed by the hospital.

Most organizations assess new employees at three or six months and annually thereafter. The competence assessment of clinical assistants should reflect the current method of assessment for hospital employees. The organization's competence assessment tool would be tailored for the non-employed clinical assistant.

In summary, privileging is not appropriate or required for this last category of practitioners. Rather these individuals should be managed via a contracted service or through a human resources process. Since it is the management of human resources standards that are being applied, it is reasonable to assume the HR department is in a better position than the organized medical staff to ensure that there is equity between what is in the job description of an employed surgical or dental assistant and a surgical or dental assistant brought in by a LIP. This includes the qualifications that must be met by an individual in order to provide services as a surgical or dental assistant. There are other ramifications, such as health screening, chemical screening, criminal background verification, orientation, and so forth that are more efficiently managed by the HR department.

This is a complex issue and we hope this document provides some clarity on the issue of practitioners who should be privileged and those practitioners who should not be privileged and should have qualifications defined and undergo competence assessment equivalent to hospital employees.

For over 30 years, The Greeley Company has helped hospitals and health systems across the country find practical solutions to their toughest credentialing and privileging challenges. For more information, you may contact us at 888.749.3054.

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