

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 1 of 14</b>
<b>Departments Affected:</b> All Departments	

**I. PURPOSE**

To outline individuals who are authorized to provide care as an Allied Health professional as well as describe which categories of individuals who will be processed by Human Resources (HR) or Medical Staff Services Department (MSSD).

**II. POLICY**

Stanford Hospital and Clinics (SHC) and Lucile Packard Children’s Hospital (LPCH) allow Allied Health Practitioners (AHP) to provide patient care services as permitted by law and accreditation regulations, and in keeping with all applicable rules, policies and procedures of the institutions. An appropriate authorization process is followed to ensure that any individual providing patient care has the required education, training, licensure/certification and competency requirements.

Questions about the implementation of this policy should be addressed to one’s supervisor. Further questions can be addressed to Medical Staff Services or Human Resources, as appropriate.

**III. DEFINITIONS**

**A. Allied Health Practitioners (AHP)**

AHPs are defined as supervised health care personnel, who are not eligible for medical staff membership, and who are qualified to provide clinical services to patients, working collaboratively with a supervising Medical Staff member or under the auspices of the Human Resources regulatory requirements. There are two categories of AHP:

**1. Advanced Practice Professionals (APP)**

Advance Practice Professionals are advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, CRNA – certified registered nurse anesthetist) or a PA – physician assistant. CNS – Clinical Nurse Specialist based on clinical practice and other advanced practice categories requiring a supervising physician as identified and as approved by the Governing Body. These individuals are credentialed and privileged through the Medical Staff structure and are required to have a practice protocol evaluated by the Interdisciplinary Practice Committee (IDPC).

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 2 of 14</b>
<b>Departments Affected:</b> All Departments	

**2. Clinical Specialist (CS)**

Clinical Specialists are individuals who have been authorized to provide clinical care or service. These individuals include, but are not limited to the following categories:

1. Audiologist
2. Clinical Nurse Specialist
3. Optometrist
4. Acupuncturist
5. Perfusionist
6. Speech Pathologist
7. Surgical Tech
8. Physical Therapist
9. PH.D Medical Geneticist
10. Massage Therapist
11. Registered Dental Assistant
12. Marriage Family Counselor
13. Registered Nurse First Assistant (RNFA)
14. Any other category identified by the Hospital Board

These individuals are authorized to provide care through the Human Resource process and competency is evaluated by the practitioner’s department manager.

**IV. AUTHORIZATION**

1. Individuals applying for membership as an Advanced Practice Professional must complete the full credentialing and privileging process and receive appropriate Medical Staff approval and are not entitled to provide services at either SHC or LPCH until the credentialing process is completed through Medical Staff Services, Credentials and Privileging Committee and/or the Interdisciplinary Practice Committee (IDPC), Medical Executive Committee and Board Subcommittee.
2. Individuals applying for membership as a Clinical Specialist must complete the Human Resource process.
3. Requests to add new AHP categories, or to modify existing job categories, job descriptions, privileges or protocols, must be submitted in writing to IDPC Committee. Any relevant documentation needed to review and recommend

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 3 of 14</b>
<b>Departments Affected:</b> All Departments	

category additions or deletions will be requested. All requests must be approved by the Interdisciplinary Practice Committee, Medical Executive Committee, and Board of Directors.

For new categories, the protocol/job description, privileges must be approved through the Board of Directors before a provider can apply to the position.

**V. PROCEDURE**

**A. Pathways for Credentialing**

1. To be eligible to provide services, an Advance Practice Professional must:
  - a. have written approval, both on the application form and on applicable practice protocols, job descriptions and/or privileges, from the clinical service chief or department chair and/or the appropriate administrative department to provide services under the supervision of an active medical staff member as an AHP.
  - b. completes the credentialing and privileging process and be approved through the appropriate committee structure.
2. To be eligible to provide services, a Clinical Specialist must:
  - a. be contracted to provide services within SHC or LPCH; or
  - b. have written approval, both on the job description and/or practice protocol from Human Resources or Department Supervisor.
3. All categories of AHP must meet hospital HIPAA requirements, attend Hospital Orientation and complete any training modules required for hospital clinical systems.
4. All Advanced Practice Professionals will be reappointed to the AHP staff, through Medical Staff Services, every two years
5. Clinical Specialist staff will also be evaluated annual by their supervisor.

**B. Scope of Services Oversight**

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 4 of 14</b>
<b>Departments Affected:</b> All Departments	

1. The Interdisciplinary Practice Committee (IDPC) of each facility oversees the development, review and approval of authorization criteria, scope of services, practice protocols and other relevant specifications of the following types of providers, in accordance with Title 22:
  - a. Nurse Practitioners
  - b. Physician Assistants
  - c. Clinical Nurse Specialist, as appropriate
  - d. Certified Nurse Midwives
  - e. Certified Registered Nurse Anesthetist (CRNA)
  - f. Other providers whose practice patterns overlap the medical scope of practice.
  - g. Other providers as identified by the Board of Directors
  
2. The Interdisciplinary Practice Committee, or the sponsoring department has, the responsibility of establishing a framework for the categories they oversee. This framework shall include at least the following:
  - a. Category description, including title and general description of category.
  - b. Training and qualifications, including specific guidelines regarding certification, licensure, experience, continuing education requirements, etc.
  - c. Scope of services, which identifies the patient populations to be served and the specific procedures to be performed by the AHP.
  - d. Level of supervision of the AHP. Documentation should specify how the AHP is supervised when performing services, provide evidence of appropriate supervisor licensure as required and identify authority for documentation/medical record signature.
  - e. Standardized procedures or protocols as appropriate, including standardized procedures for the assessment and management of patients, standardized procedures for dispensing and furnishing of drugs, etc.
  - f. Specific rules, regulations and/or policies that apply to the category of AHP.
  - g. Special requirements which must be met prior to provision of any services, which may include department-specific orientation, health screening, Basic Life Support (BLS) certification, etc.
  - h. Requirements for completion of probationary period or competency assessment for all AHPs.

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 5 of 14</b>
<b>Departments Affected:</b> All Departments	

- i. Method for evaluating competency to perform scope of services (which must identify proctoring or precepting requirements).
  - j. Physician or Supervisor responsible for monitoring and documenting the provider’s performance.
  - k. Review timeframes and any related materials such as monitoring forms or skills checklists.
  - l. At all times the supervising physician must be physically, telephonically or electronically available to the PA and NP for consultation, except in emergency situations.
  - m. In cases of emergency, the PA and NP, to the extent permitted by the laws relating to license or certificate may render emergency services to a patient pending establishment of contact with physician.
  - n. The supervising physician must not supervise more that 4 PAs or NPs at one time.
3. These documents must be forwarded to Interdisciplinary Practice Committee (IDPC) and/or the Credentials and Privileging Committee and the Medical Executive Committee of the appropriate institution for review and recommendation for approval to the SHC and LPCH Boards of Directors.

**C. Verification Responsibilities**

- 1. Medical Staff Services maintains credentialing files on Advance Practice Professionals. All other AHP files are maintained by Human Resources and/or respective Departments.
- 2. Advance Practice Professionals
  - a. Medical Staff Services, through its normal verification process as outlined in Credentialing and Privileging Policy and Procedures, confirms that each Advance Practice Professional applicant meets the established qualifications and requirements as defined in the Credentialing Policy and Procedures.
  - b. Medical Staff Services also ensures that Advance Practice Professional applicants are informed of the following:
    - 1) Professional Ethics

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 6 of 14</b>
<b>Departments Affected:</b> All Departments	

The professional conduct of each APP shall be governed both by the principles of professional ethics established by the profession, by law, and in accordance with the mission and philosophy of SHC and LPCH.

- 2) Suspension, Modification, or Termination of Permission to Provide Services  
APP's may be subject to discipline and corrective action, and his or her permission to provide services may be suspended, modified, or terminated as delineated in Section E of this document.
- 3) Requirement for background check.

3. Clinical Specialists

- a. The Human Resources Department (or designated department manager) maintains a personnel file for each Clinical Specialist. This file includes a Job Description, Performance Appraisals, and other documentation as required by SHC and LPCH Human Resources policies and procedures, including licensure and certification.
- b. Human Resources perform the appropriate verifications based on Human Resource Policies and Regulatory Guidelines.
- c. Clinical Assistants may be subject to discipline and corrective action, and his or her permission to provide services may be suspended, modified, or terminated in accordance with the Hospital's employment policies and procedures.

**D. Billing**

As allowed by California law, and SHC and LPCH policies, certain categories of AHP are eligible to bill for their services. These providers must be authorized to provide services as defined in this policy prior to any billing activity.

**E. Procedural Rights for Advance Practice Professionals (APP)**

1. Non-renewal, Restriction, Suspension, or Termination

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 7 of 14</b>
<b>Departments Affected:</b> All Departments	

- a. The Medical Executive Committee, IDPC, Chief of Staff or Hospital Administrator may, at any time, recommend the non-renewal, restriction, suspension, or termination of the practice prerogatives or status of any APP, with or without cause. If feasible, the person or body so doing shall consult the Supervisor and/or the Service Chief and the supervising physician of the APP prior to taking action.
  
- b. Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP to the procedural rights set forth in Article Seven of the Bylaws. Any APP, however, shall have the right to challenge any action that would constitute grounds for a hearing under Article Seven of the Bylaws by filing a written grievance with the IDPC within fifteen (15) days of such action. The grievance shall set forth the specifics of the action or inaction challenged and shall detail the remedy requested. On receipt of such a grievance, the IDPC or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as that term is defined in Article Seven of the Bylaws and the procedural rules applicable to such hearings shall not apply. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The IDPC shall make a decision based on the interview and all other information available to it.

After the IDPC makes a final recommendation to the Medical Executive Committee, the APP may then request reconsideration by the Medical Board of an adverse IDPC recommendation. In that reconsideration, the APP may present to the Medical Board additional written arguments relevant to the IDPC recommendation. There is no right for the APP to personally appear before the Medical Executive Committee. After considering the AHP's additional written arguments, if any, the Medical Executive Committee shall make a final decision on the IDPC's recommendation. The final decision will be made by the Board of Directors via the Board Subcommittee.

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 8 of 14</b>
<b>Departments Affected:</b> All Departments	

2. Automatic Termination

An APP practice privileges shall automatically terminate, without review, in the event:

- a. The Medical Staff membership of the Supervising Physician of the APP is suspended, terminated, or restricted whether voluntarily or involuntarily. An employed APP may be assigned a different supervising physician by the Service Chief.
- b. Any contract between the Hospital and the Supervising Physician of the APP is terminated, regardless of the reason therefore; the APP's Supervising Physician no longer agrees to act as a supervisor, for any reason, or the relationship between the APP and the Supervising Physician is otherwise terminated, regardless of the reason. An employed APP will be assigned a different supervising physician by the Service Chief.
- c. The APP's license or certificate to practice expires, is revoked, suspended, or otherwise restricted.

3. Other Corrective Action

- a. When the APP's DEA Certificate is revoked, suspended, or subject to probation, the action and terms shall automatically apply to his/her right to furnish or transmit orders for medications covered by the certificate.
- b. For failure to comply with the Medical Record Regulations and Policies established by the Medical Staff Rules and Regulations or hospital-specific policies and procedures, the APP's practice privileges shall be automatically suspended upon the expiration of five (5) days after he/she is given written notice. Practice privileges shall remain suspended until all delinquent medical records are completed. A failure to complete the medical records within two (2) months after the date a suspension becomes effective shall be deemed a voluntary resignation.
- c. For failure to maintain the appropriate amount of professional liability insurance or its equivalent, if any, an APP's practice

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 9 of 14</b>
<b>Departments Affected:</b> All Departments	

privileges may be automatically suspended after ten (10) days written warning of delinquency. Privileges shall remain suspended until the APP provides evidence to the Medical Executive Committee that he/she has secured professional liability coverage in the amount required. A failure to provide such evidence within three (3) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation. APP's on leave of absence are not subject to automatic suspension for failure to provide evidence of professional liability insurance.

3. Review of Category Decision  
The procedural rights afforded by this section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges at the Hospital. Questions regarding such decisions shall be submitted to the Governing Body, which has the discretion to decline to review the request, or to review it using any procedure it deems appropriate.
4. Provider Rights to Amend Application  
If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked to resolve this discrepancy.
5. Confidentiality of files  
APP Credentialing files are treated as confidential and are protected from discovery by Section 1157 of the California Evidence Code. Documents in these files may not be reproduced or distributed, except for confidential peer review and authorization purposes consistent with Section 1157.

## **VI. COMPLIANCE**

- a. All workforce members including employees, contracted staff, students, volunteers, credentialed medical staff, and individuals representing or engaging in the practice at SHC/LPCH are responsible for ensuring that individuals comply with this policy.
- b. Violations of this policy will be reported to the Department Manager and any other appropriate Department as determined by the Department Manager or in accordance with hospital policy. Violations will be investigated to determine the nature, extent, and potential risk to the hospital. Workforce members who

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 10 of 14</b>
<b>Departments Affected:</b> All Departments	

violate this policy will be subject to the appropriate disciplinary action up to and including termination.

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 11 of 14</b>
<b>Departments Affected:</b> All Departments	

**V. DOCUMENT INFORMATION**

A. References:

The Joint Commission Standards for Human Resources and Medical Staff  
HR 01.02.05 and HR. 01.02.06

B. Author/Original Date:

Director, Medical Staff Services, February 2009  
Director, Practice Professional Practice February 2009

C. Custodian of Document:

Medical Staff Services, Human Resources and Interdisciplinary Practice  
Committee (IDPC)

D. Distribution and Training Requirements:

1. This policy resides in *Administrative Manual and Medical Staff Policies* located on the SHC and the LPCH websites.
2. New or revised documents will be communicated as appropriate.

E. Review and Renewal Requirements:

This policy will be reviewed every three years and as required by change of law or practice. The entities or persons who provided initial approval must approve any changes to the policy.

F. Review/Revision History:

3/01, 1/04, 10/05, 12/07, 1/09. 7/09

G. Approvals:

SHC Interdisciplinary Practice Committee, 3/09  
LPCH Interdisciplinary Practice Committee, 3/09  
LPCH Policy Committee, 4/09

H. Board Approvals:

SHC Medical Executive Committee – 2/04, 2/08, 7/09  
LPCH Medical MEC – 2/04, 11/05, 2/08, 4/09  
SHC Board of Directors – 2/04, 2/08, 7/09  
LPCH Board of Directors – 2/04, 11/05, 2/08, 4/09

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 12 of 14</b>
<b>Departments Affected:</b> All Departments	

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<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 13 of 14</b>
<b>Departments Affected:</b> All Departments	

**Stanford Hospital and Clinics and Lucile Packard Children’s Hospital  
Transition plan for nonprivileged AHPs (clinical assistants) to Human Resources**

Clinical assistants who were previously credentialed or authorized via the medical staff organization to provide services at SHC and LPCH are to be transitioned for authorization via human resources (HR) mechanisms. These clinical assistant categories include:

1. Audiologist
2. Clinical Nurse Specialist
3. Optometrist
4. Acupuncturist
5. Perfusionist
6. Speech Pathologist
7. Surgical Tech
8. Physical Therapist
9. PH.D Medical Geneticist
10. Massage Therapist
11. Registered Dental Assistant
12. Marriage Family Counselor
13. Registered Nurse First Assistant (RNFA)
14. Any other category identified by the Hospital Board

**Implementation:**

Implementation of the administrative clinical assistants credentialing plan will be effective **August 2009**. The HR department of SHC and LPCH will become responsible for the authorization process of **38** healthcare professionals who were previously authorized via the medical staff organization mechanisms. In preparation for this transition, the following will occur:

- A. The medical staff services department (MSSD) will prepare all the files of all clinical assistants who are not required to have clinical privileges but are or will be authorized to provide services at SHC and LPCH in the future and will provide those files to HR. A listing of the files will include the clinical assistant’s name, clinical Department/Section, employing or sponsoring supervisor if applicable, initial date of credentialing, and most recent credentialing event (initial appointment or reappointment) that was coordinated by the MSO. At the time the files are turned over to the HR department, all information will be current (e.g., information related to licensure, professional liability coverage, physician employer or sponsor, office address and phone, etc.).

The clinical assistants’ files will include the following elements:

- Application form
- Verification of education, training and licensure.
- Reference checks made at the time of initial credentialing and additional documentation that shows the clinical assistant is qualified to perform services requested
- Current scope of care or task list of services that may be performed/provided

<i>Stanford Hospital and Clinics</i>	<b>Last Approval Date:</b> July 2009
<b>Name of Policy:</b> AHP: Authorization for Individuals to Provide Services to Allied Health Practitioners	<b>Page 14 of 14</b>
<b>Departments Affected:</b> All Departments	

- All information related to reappointments and reappraisal data (includes application form/updates, verifications, etc.)
- Name of supervising practitioner (or supervising group), if applicable

- B. The MSSD will retain the files of clinical assistants who were authorized to provide services in the past but are no longer “active.” These files will be placed in storage.
- C. The MSSD will retain the files of all individuals who will be credentialed and privileged through the medical staff (advanced practice professionals) and will continue to be responsible for privileging these practitioners in the future. Those categories of advanced practice professionals are currently defined as:
- Nurse Practitioner (NP)
  - Certified Nurse Midwife (CNM)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Physician Assistant (PA)
- D. It is the plan of SHC and LPCH that all clinical assistants will be reauthorized to provide services at SHC and LPCH via HR mechanisms by bi-annually in accordance with an administrative policy. In accordance with this policy, the HR department and/or specific departmental areas (as defined by HR) will assume responsibility for providing oversight, coordination, and expertise related to these issues. The MSSD department will notify all clinical assistants and their physician employers/sponsors by **September 1, 2009** of the transition and any actions that need to be taken to maintain their status at SHC and LPCH.
- E. The Interdisciplinary Practice Committee (IDPC) will continue to review the privileges and practice protocols for Advanced Practice Professionals. The committee will also review job descriptions and/or practice protocols for those Clinical Assistants who are not employed by LPCH and SHC and who may be under contract.