ARTICLE 1: GENERAL GUIDELINES

1.1 Purpose

This AHP manual has been adopted pursuant to 2.12C of the Bylaws of the medical staff of St. Dominic Hospital. Terms used in this procedural manual shall have the same definitions stated in the Bylaws.

ARTICLE 2: DEFINITIONS

2.1 Definitions

Allied Health Professionals (AHPs) shall consist of individuals who are not members of the medical staff but:

- Who are employed by the hospital to provide or participate in patient care services or
- Who are employed by medical staff members to assist them in the care of their patients in the hospital or
- Who are recommended by a single sponsoring member of the medical staff or
- Whose patient care services are provided within the scope of their education, training, Mississippi license or professional certification, as well as in accordance with a scope of practice.

A. Independent Allied Health Professionals (AHPs)

As defined in Article 2.12 of the Medical Staff Bylaws, Independent AHPs are licensed by the appropriate state agencies to provide specific patient care services without immediate supervision of a LIP.

(1) Included in the category of Independent AHPs are professionals such as, but not limited to:

(a) Doctors of psychology; psychologists

(b) Podiatrists

(c) Vendors who are subject to the vendor policy and permitted to be associated under the specification of that policy. See hospital policy on the Vendor Program.

(2) Qualifications - All independent AHPs must meet, at a minimum, the following requirements:

(a) Current licensure by the State of Mississippi;
(b) Be required to maintain in force professional liability insurance from a reputable and sound insurance company licensed or recognized to do business in the State of Mississippi and provide a copy of the $500,000/$1,000,000 either in one’s own name and/or under the name of a physician member of the medical staff;

(c) Appropriate education, experience, background and training to demonstrate sufficient ability to enable the AHP to provide patient care consistent with the standards of St. Dominic Hospital;

(d) Be located within the geographic service area of St. Dominic Hospital and close enough to provide timely care for their patients; and

(e) Provide at least three (3) references by professional associates who know the applicant and can attest completely and accurately as to the applicant’s current ability, judgment, adherence to ethics, and ability to work cooperatively with others.

(3) Additional Qualifications for Podiatrists. All podiatrists must meet the following additional requirements:

(a) Applicants shall be certified or eligible for certification by one of the following advisory boards: American Board of Podiatric Orthopedics or the American Board of Podiatric Surgery. Podiatrists granted privileges shall be assigned to the surgical service.

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery and extent of surgical procedures to be performed must be defined for each podiatrist individually and shall be recommended in the same manner as all other surgical privileges. Podiatrists may write orders and prescribe medications within the limits of their licensure and of the Medical Staff Bylaws, and Rules & Regulations.

(4) Additional Qualifications for Other Independent AHPs and Right to Deny Privileges

The Medical Executive Committee of the medical staff, with approval of the Board of Directors, shall establish particular qualifications for specific categories of independent AHPs provided that such qualifications are reasonably related to St. Dominic’s mission to provide appropriate health care services to
its patients and this community. The Board of Directors reserves the right to deny patient care privileges for any particular category of independent AHP if it is determined that there is not a demonstrated need for the patient care services of that type or that the category is not one which is appropriate for the care of St. Dominic’s patients.

(5) Compliance with St. Dominic Hospital Rules

Independent AHPs shall comply with all requirements and responsibilities established by these Rules & Regulations, by the Medical Staff Bylaws and Rules & Regulations, and hospital policies which would logically pertain or apply to them as providers of services to patients in the hospital. Each independent AHP granted patient care privileges must agree in writing to abide by the aforementioned documents, prior to exercise of patient care privileges.

(6) Admission

Patients of independent AHPs must be admitted by a member of the active or courtesy staff. A history must be taken and a comprehensive physical examination must be performed on each in-patient by a physician with staff privileges. The independent AHP will be responsible for those aspects of the history and physical within his/her profession.

(7) Scope of Practice

The scope of practice in St. Dominic Hospital of each independent AHP shall not exceed the scope of practice accorded that individual by the current statutes and/or rules and regulations governing that individual’s licensure and/or protocol. Privileges shall be requested with specificity by the applicant. Any grant of privileges by the Board of Directors shall also be with specificity. In the event there is any dispute as to whether the applicant is licensed to perform a particular procedure, the applicant shall bear the burden of establishing the scope of his/her licensure.

B. Dependent Allied Health Professionals (AHPs)

As defined in Article 2.12 of the Medical Staff Bylaws, Dependent Allied Health Professionals are employed and sponsored by a Medical Staff Member and have been approved to provide specific services under the direct supervision and control of the employer/sponsor.

There are two types of Dependent AHPs; one is Clinical Assistants (CA) which falls under Human Resources Chapter of The Joint Commission
Accreditation Standards and Advanced Practice Professionals (APPs). Included in these two types of Dependent AHPs are professionals such as, but not limited to:

(a) Advanced Practice Professionals (APP): APPs are designated to be credentialed and privileged through the Medical Staff Office similar to physicians but are not eligible for Medical Staff Membership. They include:

(i) Certified Physician’s Assistants
(ii) Nurse Practitioners. Also to include FNP, NNP, etc.
(iii) Individuals licensed in Mississippi and with a masters or doctorate from an accredited nurse anesthetics program, CRNA.

(b) Clinical Assistants:

Clinical Assistants (CA) are followed jointly by the Human Resources Department and Medical Staff Services Department and are authorized by the hospital to provide services as outlined in the Human Resources Policy. Human Resources will review qualifications, performance, and competence of each non-employee individual brought into the hospital by a licensed independent practitioner to provide, treatment, or services at the same frequency as individuals employed by the hospital. They include:

(i) Audiologists and hearing instrument specialist
(ii) Certified athletic trainers
(iii) Dental assistants
(iv) Genetic counselors
(v) Licensed clinical social workers
(vi) Case managers
(viii) Licensed professional counselor
(x) Nonphysician surgical assistant
(xi) Orthotics/prosthetics/pedorthics
(xii) Psychiatric evaluation nurse
(xiii) Registered nurse first assistant
(xiv) Specialty nurse
(xv) Observer
(xvi) LPN
(xvii) Neuro tech
(xviii) Laser tech
(xix) Litho tech
(xx) Others as defined by the organization

2.2 Qualifications

No Independent AHP shall be entitled to perform healthcare or dental services in the Hospital merely because he is licensed to practice in any state, or because he is certified or eligible to be certified by any particular board, or because he presently has or has had permission to perform healthcare or dental services in the Hospital or any other hospital, healthcare facility, or other practice setting.

Required qualifications for AHP status are presented in the applications requirements established in Section II of this Allied Health Professionals Procedures Manual which shall be governed and managed by the Credentials Committee.

2.3 Prerogatives and Limitations

A. Prerogatives

Allied Health Professionals shall:

(1) exercise judgment in their areas of competence, provided that a Medical Staff appointee shall have the ultimate responsibility for patient care;

(2) participate directly in patient care and management under the general supervision of the Medical Staff sponsor, provided that such activities are within the scope of his license/certificate or other legal credentials;

(3) record reports and progress notes on patient records and write treatment orders to the extent established that are within the scope of his license/certificate or other legal credentials;
have the opportunity to attend, upon request, Medical Staff, Hospital and clinical service education programs and clinical meetings related to their discipline;

have the opportunity to serve on Medical Staff, Hospital and clinical service committees (in an Ad Hoc advisory basis) when invited, where special training and knowledge are desirable, and with vote capability, if so specified by the appointing authority; and

be governed by due process as set forth in Section IV of this Allied Health Professionals Procedures Manual which shall be governed and managed by the Medical Executive Committee.

B. Limitations

Allied Health Professionals are not eligible:

(7) for Membership on the Medical Staff;

(8) to vote in meetings of or hold office on the Medical Staff; nor

(9) for admitting privileges.

2.4 Obligations

Allied Health Professionals are required to:

A. All AHPs, both APPs and CA, must complete a screening prior to providing any service. All AHPs must:

(1) complete the Adjunct Orientation which includes procedures on confidentiality, Code 99, fire, severe weather, infection control, tuberculosis, workplace violence, hazard communication, and Emergency Medical Treatment and Active Labor Act.

(2) complete a Criminal Background check by St. Dominic Hospital or provide recent affidavit copy of a Criminal Background check

(3) submit a current drug screening report that meets the requirement of St. Dominic Hospital policy and has been performed at the time of application or employment.

B. Provide patients with quality care within the applicable scope of practice that meets generally recognized professional standards, including but not limited to:
(1) timely completion of appropriate and authorized portions of patient’s medical records, and

(2) continuous coverage of care;

(3) maintain professional competence within the individual’s licensed discipline;

(4) participate in applicable quality assessment/improvement activities; and

(5) abide by all applicable sections of the Medical Staff Bylaws, Rules and Regulations, related Manuals, Hospital Policies and Procedures, and lawful standards established by local, state, and federal jurisdictions

C. Notify Medical Staff Office immediately of:

(1) any criminal charges brought against the AHP (other than minor traffic violations not involving a DUI charge);

(2) any potential change in the status of his license/certificate to practice;

(3) any potential change in liability insurance coverage including malpractice claims pertaining to professional performance;

(4) any change or withdrawal of sponsorship from a Medical Staff Member;

(5) any changes in affiliation with other institutions where specified services are provided; and

(6) any changes in health status that may affect the individual’s ability to safely provide quality patient care.

2.5 Terms and Conditions

A. Sponsorship

A Medical Staff Member must sponsor each individual applying for AHP status. AHP status will terminate immediately upon withdrawal or termination of Medical Staff Member sponsorship.

B. Scope of Practice

(1) Privileges are granted in accordance with the individual’s professional training, experience, and demonstrated competency.
An AHP shall not perform any task not approved in his protocol. The level of supervision required is contingent on the independent or dependent classification of the AHP.

Limitations may be placed on the AHP’s authorized scope of practice in the Hospital as deemed necessary to ensure:

(a) efficient and effective operation of the Hospital;
(b) proper management of personnel, services and equipment;
(c) quality patient care; or
(d) as otherwise approved by the Medical Executive Committee to be in the best interest of patient care in the Hospital.

(2) Several categories of Nurse Practitioners exist with category degree and/or certification dictating the scope of practice. To include:

(a) NNP – Neonatal Nurse Practitioner. These practice with physicians specializing in Neonatal Medicine. Some in this category obtained an extra certification, CNNP.
(b) FNP – Family Nurse Practitioner.
(c) CFNP and CNP – completed additional certification

C. Identification

All AHPs shall at all times identify themselves, by use of St. Dominic issued badges as required by the Hospital.

The relationship between the AHP and the Hospital will terminate immediately if the AHP has willingly allowed himself to be presented as a Member of the Medical Staff, performed any work assignment outside the scope of practice, or violated or attempted to violate any rules of the Hospital relative to his status.

D. Health Status

An AHP must provide requested documentation of his physical and/or mental health status. In addition, if at any time the Hospital or Board deems it necessary and appropriate in order to protect the health or safety of patients or other individuals, the health status of the AHP shall be determined by a medical examination. Such medical examination may include testing for infectious diseases and/or psychological examinations.
Drug testing may be required. All such examinations shall be paid for by the AHP, and performed by a LIP agreed upon by both the AHP and the Hospital.

E. Automatic Termination

Each AHP may be subject to discipline and corrective action, and his or her permission to provide services may be suspended, modified, or terminated. In the event such termination occurs, the practitioner along with his or her physician employer or sponsor will be accorded an opportunity to discuss same with the credentials committee and the president of St. Dominic Hospital.

An AHP’s practice privileges or authorization to work shall automatically terminate, without review, in the event:

(a) The Medical Staff membership of the Supervising Physician of the AHP is suspended, terminated, or restricted whether voluntarily or involuntarily.

(b) A contractual, employment, or other relationship between the Hospital and one or more AHPs in the affected category limits the number of AHPs in that category who may practice at the Hospital.

(c) The AHPs license or certification to practice expires, is revoked, suspended, or otherwise restricted.

(d) Failure to submit or comply with annual evaluations.

(e) If any material misrepresentations, misstatements, omission or inaccuracies are discovered after the applicant has been authorized for clinical duties, the ability to practice shall be immediately terminated.

F. Specification of Services

Protocols for the performance of specified services by AHPs shall have Medical Staff oversight will be approved by the MEC and/or VPMA, when applicable, from the LIP chair of the clinical service involved. For each category of AHP, such guidelines must include, without limitation:

(a) Specification of classes of patients who may be seen;

(b) Description of the services to be provided, procedures to be performed, and responsibility for medical record completion and ordering of drugs;
(c) Definition of the degree of assistance that may be provided to AHPs in the treating of patients on Hospital premises and any limitation thereof, including the degree of AHP or Physician supervision required for each service; and

(d) Procedure for admission and discharge of patents for whom AHP are to provide service.

G. Sponsor’s Obligations

The Medical Staff Member sponsoring the AHP must:

(1) supply a written statement to the Hospital documenting that he requests the assistance of an AHP to perform specific tasks under his supervision;

(2) accept full responsibility for the acts of himself as supervisor as well as for the acts of the AHP in the capacity for which the application has been made;

(3) familiarize the AHP with the applicable Medical Staff and Hospital rules and regulations, as well as appropriate Medical Staff appointees and Hospital personnel.

ARTICLE 3: CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

3.1 Application Requirements

A. An applicant must submit a fully completed application to the Medical Staff Coordinator including the following information:

(1) Copy of current Mississippi license or certification;

(2) Current copy of valid Driver’s License/Government issued ID

(3) Copy of current malpractice insurance coverage (applicant’s name, expiration dates, and amounts);

(4) Completed application and sponsoring Physician’s signature;

(5) Detailed job description or letter, from the sponsoring Physician(s) to describe the duties to be performed;

(6) Two (2) peer references;

(7) Documentation of competency of the duties requested; and
(8) Name of preceptor or person to be contacted in the event of a problem or concern.

B. The sponsoring Member of the Medical Staff must hold clinical privileges and be in good standing.

C. An applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competency character, ethics and other qualifications and for resolving any doubts about such qualifications. An application is not complete unless the application form is completed, all items required to be verified are completed, and any additional information necessary to evaluate the applicant’s qualifications has been provided. If, after 90 days (from the date of signature), the application is incomplete due to outstanding information, documents, verification/references, the application shall be automatically withdrawn, and the applicant shall be notified that the application will not be considered.

3.2 Evaluation of Applications

The following guidelines shall be used to evaluate completed application:

A. The applicant meets the applicable criteria and qualifications for all requested clinical duties.

B. The applicant submits signed Supervisory Agreement which meets criteria set forth in this manual.

C. The applicant has received acceptable references with respect to the applicant’s competence and ability to work cooperatively with others in the hospital.

D. The applicant has not had any restrictions, suspensions, probations, or revocations of the applicant’s clinical services at a health care facility or managed care plan or of the applicant’s professional license or certification, and if previously employed by St. Dominic Hospital, has “rehire” status.

E. The applicants has not had, nor currently has, any disciplinary actions or investigations by any licensing or certifying authority, health care facility or health care plan including Medicare/Medicaid.

F. Any significant malpractice judgments or settlements.

G. There are no other indications that the applicant does not meet the qualifications for clinical duties.
3.3 Consents and Releases

A. General and Specific Releases

Each applicant shall execute general and specific releases in accordance with Section 12.4 of the Medical Staff Bylaws. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this section.

(1) Malpractice Insurance

The Hospital may request information from the insurance carrier about the status of coverage as well as past and pending claims.

(2) Hold Harmless Agreement

Independent and Dependent AHPs shall, in applying for privileges, be deemed to have agreed to the provision herein for discipline and suspension and also to have agreed that it is in the best interest of good patient care that such disciplinary measures be taken without risk of professional liability on the part of any Members of the Medical Staff, the members of its Committees, the Hospital, or the officers or employees of the Hospital. Therefore, the application for privileges for an AHP shall stipulate that all persons acting in granting or withholding privileges or in disciplinary actions shall be absolutely immune from civil liability arising from any related acts, reports, communications, or recommendations. The AHP shall also agree to indemnify and hold any Members of the Medical Staff, the members of its Committees, the Hospital, or the officers or employees of the Hospital harmless for any second or third party actions arising from related acts, reports, communications, or recommendations of any Members of the Medical Staff, the members of its Committees, the Hospital, or the officers or employees of the Hospital acting in granting or withholding privileges or in disciplinary actions.

B. Review of Application

(1) To apply for initial privileges, a change in privileges or for a change in status, the applicant must submit a fully completed pre-application so as to determine the Hospital’s ability to accommodate the applicant’s requested privileges.

(2) If the pre-application is acted upon favorably, the applicant will be granted the opportunity to submit a fully completed application with required attachments to the Medical Staff Office for initial review. A fee as determined by Hospital personnel will be charged of all applicants to process the application.
(3) The Medical Staff Office completes primary source verification of licensure, schooling, etc.

(4) The Medical Staff Office forwards the application (once deemed complete) to the Department Chair.

(5) The Credentials Committee has 30 days to complete an investigation and forward to the Medical Executive Committee.

(6) The Medical Executive Committee will review and forward the application to the QA/PI Committee unless they opt to defer the advancement of the application by an additional 30 days.

(7) The QA/PI Committee will review the application at the next monthly meeting following the receipt of the application from the Medical Executive Committee.

(8) The Board of Directors will review the application at the next regular meeting or any meeting within 15 days of receipt of the application from the QA/PI Committee. They will ratify all positive Committee decisions so long as the applicant was eligible for the expedited review process.

(9) Upon approval by the Board, the AHP will be granted privileges to practice under the supervision of a sponsoring Member of the Medical Staff for up to two (2) years.

3.4 Expedited Credentials Review

When a completed application and all related and requested material have been obtained, the file will then be reviewed by a designee of the MEC and by the Medical Staff Coordinator, who will categorize the application as follows:

A. Category 1:

A verified application that does not raise concerns as identified in the criteria for category 2. Applicants in category 1 will be granted Medical Staff Membership and privileges following approval by: VPMA or the Department chair, the chair of the Medical Staff Credentials Committee; the MEC; and the QA/PI Committee.

B. Category 2:

If one or more of the following criteria are identified in the course of the review of a completed file, the application will be treated as a category 2. The department chair, the Medical Staff Credentials Committee, the MEC, and the governing board review applications in category 2. The Medical Staff Credentials Committee may request that an appropriate
subject matter expert assess selected applications. At all stages in the review process, the burden in on the applicant to provide evidence that he or she meets the criteria for membership on the Medical Staff and for the granting of requested privileges. Criteria for category 2 applications can be found in the Credentialing Manual.

3.5 Reappointment Procedures

A. Reappointment Application

An applicant for reappointment must submit a fully completed reappointment application to the Medical Staff Office including the following information:

(a) Copy of current Mississippi license or certification;

(b) Copy of current malpractice insurance coverage (applicant’s name, expiration dates, and amounts);

(c) Completed application and sponsoring Physician’s signature;

(d) Detailed job description or letter, from the sponsoring Physician(s) to describe the duties to be performed;

(e) Two (2) peer references; and

(f) Documentation of competency of the duties requested as needed.

B. Penalty for Failure to Apply within Established Time Frames

On or before three months (90 days) prior to the date of expiration of an AHP’s appointment, the Medical Staff Office shall notify the AHP of his appointment expiration date. The AHP must furnish a complete application for reappointment as an AHP to the Medical Staff office, providing sufficient time to process the application. Failure to submit an application for reappointment will result in termination of appointment. If an AHP experiences termination of appointment, and desires continuation of privileges, he must reapply as an initial applicant by submitting a new application for appointment to the Medical Staff office.

C. Verification of annual assessment

The Medical Staff Services Department will verify with the Human Resources Department that the Non-privileged AHPs have completed all annual assessments.
D. Post Approval

(1) Orientation: all newly appointed AHPs must receive a general orientation to St. Dominic Hospital and to the facility area(s) in which each AHP will be providing services.

(2) General Orientation: Clinical area management will provide a general orientation program for AHPs with assistance from the Human Resources Department and/or Education Department.

(3) Orientation to specific patient care areas: AHPs shall also be oriented to the specific patient care areas in which the AHP will provide services. Responsibility for provision of the department-specific orientation will be the responsibility of the clinical area management.

ARTICLE 4: GRIEVANCE PROCESS FOR ALLIED HEALTH PROFESSIONALS

AHPs are not entitled to the fair hearing and appeals procedure set forth in the Bylaws and the Fair Hearing Plan.

If an AHP is not granted permission to provide services designated in the AHP scope of practice or clinical privileges, or his or her permission to provide patient care services has been terminated, the AHP and his or her supervising physician, if applicable, shall only have the right to appear personally before the Credentials Committee within 30 days from a written request, to discuss the recommended action. Such a request must be in writing and presented to the medical staff services department. If unfavorable, the Credentials Committee decision can be appealed to the MEC for advanced license AHPs.

ARTICLE 5: SCOPE OF PRACTICE, SUPERVISORY REQUIREMENTS, & PRIVILEGES

5.1 Job Description

A. All AHPs, other than PAs and advance registered nurse practitioners, will function pursuant to job descriptions. Limitations may be placed on the authorized scope of practice in the hospital as deemed necessary by the Credentials Committee.

B. The Credentials Committee and Human Resources has the responsibility to research and recommend the scope of services for each category of AHP within the parameters set forth by the medical staff. Recommendations for job descriptions will be based on the medical staff’s and hospital’s need for, and ability to accommodate, the services of the categories of AHPs. Recommendations for the specific job description for
an AHP will be based on the individual’s education, licensure, training, experience, demonstrated ability and judgment, information obtained from other sources, ability to work with others, health status, and other factors.

C. Requests by AHPs to perform additional services in the hospital must be made in writing, reviewed by the Credentials Committee or Human Resources.

5.2 Supervision Requirements

For each category of AHPs, the physician supervision requirements will be set forth in the applicable job description or clinical privilege.

5.3 Privileges

A. The Advanced Practice Registered Nurse shall practice according to the following standards and guidelines and in a collaborative/consultative relationship with a licensed physician.

B. Management of Patient Health/Illness Status

1. Obtains an appropriate comprehensive or problem-focused health history from the patient.

2. Performs an appropriate comprehensive or problem-focused physical examination.

3. Differentiates between normal, variations of normal, and abnormal findings.

4. Provides health promotion, disease prevention services, anticipatory guidance and counseling to promote health.

5. Orders, analyzes and interprets data, including history, presenting symptoms, physical findings, and diagnostic information to develop appropriate differential diagnoses.

6. Diagnoses and manages acute and chronic conditions while attending to the patient’s response to the illness experience.

7. Prioritizes health problems and intervenes appropriately including initiation of effective emergency care.

8. Employs appropriate diagnostic and therapeutic interventions and regimens including but not limited to pharmacological, behavioral and other non-pharmacological treatment modalities with attention to safety, cost, invasiveness, simplicity, acceptability, adherence and efficacy.

10. Integrates knowledge or pharmacokinetic processes and factors that alter pharmacokinetics in pharmacologic management decisions.

11. Provides guidance and counseling regarding management of the health/illness condition.

12. Communicates the patient’s health status using appropriate terminology, format and technology.

13. Initiates appropriate and timely consultation and/or referral when the problem exceeds the APRN’s scope of practice and/or expertise.

14. Collaboratively assesses plans, implements and evaluates care with other health care professional using approaches that recognize each one’s expertise to meet the comprehensive needs of patients.

15. Considers the patients needs when termination of the APRN-patient relationship is necessary and provides for a safe transition to another care provider.

C. Monitoring Quality of Health Care Practice

1. Develops and implements a quality assurance/quality improvement plan.

2. Acts ethically to meet the needs of patients.

3. Uses an evidence-based approach to patient management that critically evaluates and applies research findings pertinent to patient care management and outcomes.

4. Evaluates the patient’s response to the health care provided and the effectiveness of the care.

5. Uses the outcomes of care to revise care delivery strategies and improve the quality of care.

ARTICLE 6: COMPETENCY EVALUATIONS

6.1 Competency Evaluations

A. Annual competence assessment: Dependent AHPs will undergo continued assessment of competence and ability to perform their responsibility/scope of service. The competency of the dependent AHP will be assessed by the designated sponsoring physician and/or hospital designee or applicable department Chair (or designee) and documented on an annual evaluation form, including patient age-specific competency. An annual assessment fee of $50.00 will be paid by the practitioner or sponsoring physician in order to defray the administrative costs of reassessment of the dependent AHP.
B. Components of the competence assessment include but are not limited to the outcome of ongoing hospital-wide monitoring activities, peer review activities, the ongoing evaluation by the practitioner’s sponsoring or collaborating physician and designees as required by state law, and completion of an annual evaluation form. Ongoing hospital-wide monitoring activities will include but will not be limited to quality and utilization review data, incidents or near misses, and sentinel events.

C. “Peer review” is defined as the evaluation of the professional performance of individual practitioners, including identification of opportunities to improve care, by individuals with the appropriate subject matter expertise to perform this evaluation. A “peer” is defined as an individual practicing in the same profession or a profession with at least an equivalent level of expertise in the clinical care under review.

All peer review information will be considered confidential and protected in the same or an equivalent manner as outlined in the medical staff peer review policy.

6.2 Annual Competency Evaluations

Competency Evaluations will follow policy standards and will be completed annually for all Allied Health Professionals either by ongoing professional practice evaluation (OPPE) or by job specific competency evaluation.

A. Clinical Assistants (CAs):

   (1) There will be two types of competency evaluations:

      (a) Sponsoring physician assessment

      (b) Peer assessment

      Peer assessment should be completed by those that have direct knowledge or contact with the Allied Health Professional.

B. Advanced Practice Professionals

Through the FPPE and OPPE processes as defined in Article 10 of the Bylaws of the Medical Staff.
ARTICLE 7: DISASTER

The volunteer practitioners that are addressed by this section include only those practitioners who are required by law and regulation to have a license, certification, or registration to practice their profession.

See Disaster Privileges guidelines in the Bylaws of the Medical Staff Section 4.9.

ARTICLE 8: CONFIDENTIALITY & IMMUNITY

8.1 Confidentiality of Information

Any information submitted to a representative of the Hospital or any information, further described below, collected or generated by any representative of the Hospital or any third party shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative of the Hospital. This information may pertain to the evaluation and improvement of quality and efficiency of patient care, reduction of morbidity and mortality, contributions of education and clinical research, determination that services are professionally indicated, compliance with the applicable standards of care, or establishment and enforcement of guidelines to keep costs within reasonable bounds. This information may not be used or disclosed in any way except as provided herein or except as otherwise required by law. This information shall not become part of any patient records.

8.2 Immunity From Liability

A. For Action Taken

By applying for privileges, the applicant understands and agrees that neither the Hospital, any representative of the Hospital, its Board, any member of its Board, its Medical Staff, any Member of its Medical Staff, nor any third party shall be liable to an applicant for damages or any other relief for any action taken, any report of information allowed or required by law or regulation, any report of information in the interest of the public health, or any statement or recommendation made, within the scope of his duties.

B. For Providing Information

(1) Neither the Hospital, any representative of the Hospital, the Board, any member or representative of the Board, the Medical Staff, any Member or representative of the Medical Staff, nor any third party shall be liable to an applicant for damages or any other relief by reason of providing any information, including otherwise privileged or confidential information, concerning any person who
is or has been an applicant or who did or does exercise privileges or provides specified services at the Hospital, to a representative of this Hospital or this Medical Staff or to any other health care facility or organization of health professionals or to any governmental agency as required or allowed by law.

(2) Neither the Hospital, any representative of the Hospital, the Board, any member or representative of the Board, the Medical Staff, any Member or representative of the Medical Staff, nor any third party shall be liable to an Allied Health Professional for damages or any other relief by reason of providing any information, including otherwise privileged or confidential information, concerning an Allied Health Professional who provides specified services at the Hospital, to a representative of this Hospital or this Medical Staff or to any other health care facility or organization of health professionals, or to any governmental agency as required or allowed by law.

C. For Engaging in These Activities.

The immunity provided by this Article 5 shall apply to all acts, communications, reports, recommendations or disclosures performed or made by, to, for, on behalf of, or in connection with the Hospital or any other health care facility’s or organization’s activities concerning, but not limited to:

(1) applications for appointment, reappointment, clinical privileges, or specified services;

(2) periodic appraisals or reappraisals for appointment, reappointment, clinical privileges, or specified services;

(3) corrective action;

(4) hearings and appellate reviews;

(5) medical care evaluations;

(6) peer/focused reviews;

(7) utilization review;

(8) mortality reviews;

(9) other hospital, department, committee, or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
information received from or provided to the National Practitioner Data Bank;

any other matter that might directly or indirectly relate to the applicant, appointee, or Medical Staff member’s competence, to patient care, to patient safety or to the orderly operation of this or any other hospital or health care facility; and monitoring as recommended by the Centers for Disease Control guidelines for prevention of the transmission of any and all infections between health care workers, including Medical Staff Members, and patients.

ARTICLE 9: MISCELLANEOUS

9.1 Definitions

A. The capitalized terms in this Manual are as defined in the Bylaws unless otherwise indicated by the context of the usage of the term.

B. Terms used in this Manual will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in this Manual are for convenience only and are not intended to limit or define the scope or effect of any provision within this Manual.

9.2 Effect of Bylaws on Manual

This Manual supplements provisions in the Bylaws. Any inconsistency between this Manual and the Bylaws will be resolved in favor of the Bylaws.

ARTICLE 10: AMENDMENT

10.1 Amendment and Repeal

This Allied Health Professionals Procedures Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

A. A resolution of the Medical Executive Committee; or

B. A resolution of the Medical Staff recommended to and adopted by the Medical Executive Committee.

C. This Manual must be approved by the Board.

10.2 Review

This Allied Health Professionals Procedures Manual shall be reviewed annually by the Credentials Committee.
### ARTICLE 11: ADOPTION AND APPROVAL

11.1 Medical Staff Responsibility

The medical staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend to the board the Manual of Allied Health Professionals and amendments thereto, which shall be effective when approved by the board.

11.2 Procedure

The Manual for Allied Health Professionals may be adopted, amended, or repealed by the following combined action:

A. The affirmative vote of a majority of the members of the MEC who are present and voting at a meeting at which a quorum is present.

C. The affirmative vote of a majority of the board.

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