

Compliance Strategies

Non-advanced Allied Healthcare Professionals: New JCAHO Standards and Approach

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Recent changes to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards have forced hospitals to better define roles and privileges for certain groups of people who function within the walls of their institutions, as well as define exactly how these individuals must be processed. It has become the hospital's responsibility, and not the responsibility of the medical staff, to assure competence of personnel who are under the employ of private physicians who provide care, treatment or services within the hospital.

The Standard:

Until recently, individuals who provide care, treatment, or services were grouped into two categories for the purposes of establishing their entitlement to provide care in the hospital: hospital employees, and those credentialed and privileged through the medical staff function. Hospital employees were processed by the Human Resources department using the JCAHO human resources standards; the medical staff, non-member licensed independent practitioners (LIP), and the employees of the medical staff, both advanced practice personnel (APP) and non-advanced, physician-employed (NAPE), were processed by the medical staff office using the JCAHO medical staff set of standards.

This system was simple because the NAPE staff performed relatively low risk functions. However, this situation has changed over the years, and the current functions performed by NAPE staff have become complex, frequently requiring these individuals to assume non-traditional roles.

JCAHO standards have always mandated credentialing and privileging of LIPs, including not only physicians, but also podiatrists, dentists, and any other discipline defined as independent. The definition of LIP also has changed recently in some states. The Center for Medicare and Medicaid Services, for example, began granting independent status to certified registered nurse anesthetists at the request of some states. Therefore individuals who were formerly APPs have now become LIPs, requiring credentialing and privileging through the medical staff process.

It was evident that the medical staff process was not appropriate for processing NAPEs. There were many items required by this process, such as a National Practitioner Data Bank query, that were not applicable. As a result, the files on these individuals were frequently not compliant with the medical staff standards. Missing items included primary source verification of all professional education and training, such as a nursing school or a perfusion school, or any type of significant evaluation of their skills. Physicians were simply filling out meaningless evaluations on their own employees because the hospital required it. This continued until 2005.

In 2005, JCAHO released standard LD.3.70 with four elements of performance. JCAHO had recognized that NAPEs had taken on more responsibility in organizations by providing important care functions, and the processes currently used to evaluate them were inadequate. Also included in this standard were elements of performance to guide hospitals on how to process APPs.

LD.3.70 EP 1 and EP 2 were written to address specifically APPs. These elements were designed to include APPs who were not employed by the hospital, as well as APPs who were employed by the hospital, even though the latter group underwent a human resources process as part of their employment relationship.

EP 1 and 2 require the credentialing and privileging of APPs using the medical staff process or "an equivalent process." The equivalent process requires the inclusion "at a minimum" of the following:

- Evaluation of the applicant's credentials
- Evaluation of the applicant's current competence
- Inclusion of peer recommendations
- Inclusion of communication with and input from individuals and committees, including the Medical Staff Executive Committee, to make an informed decision regarding the applicant's request for privileges

Upon examination of the requirements in the standard, it is evident the human resources process used by most hospitals is, in no way, equivalent to these requirements. Larger hospitals developed an AHP committee for this purpose, but most found it more efficient to use the existing medical staff process. There was only one major difference: when the medical staff process was used, the individual would be entitled to a hearing and appeals process, if action were taken on their privileges. This process did not need to be the same as that afforded members of the medical staff. If the AHP committee process were used, no entitlement was required. In addition, by using the equivalent process, no action by the Board of Trustees would be required.

EP 3 and 4 of LD.3.70 were written to clearly address the NAPEs. This set of EPs was a surprise to the entire accreditation field. The EPs clearly required what could only be described as a human resource standards-like approach to NAPEs.

The 2006 LD.3.70 EP 3 and 4 are as follows:

EP 3: Prior to the provision of care, treatment or services, the qualifications and competence of a non-employee individual, brought into the hospital by a licensed independent practitioner to provide care, treatment or services within scope of the hospital's services are assessed by the hospital and determined to be commensurate with the qualifications and competence required if the individual were to be employed by the hospital to perform the same or similar services.

EP 4: The hospital reviews the qualifications, performance, and competence of each non-employee individual brought into the hospital by a licensed independent practitioner to provide care, treatment, or services at the same frequency as individuals employed by the hospital.

EP 3 describes an initial assessment of competence. An initial assessment of competence is a human resources standard for hospital employees. Since the criteria must be equivalent, there is an implied requirement for a specific job description. Such a document is required to develop a meaningful performance evaluation. In addition, the initial assessment of competence cannot be done by the physician employer, but must be done by the hospital.

EP 4 requires a re-evaluation at the same frequency as required by the hospital under human resources standards. In most hospitals, this is an annual process.

The Predicament Today:

A predicament occurs when one realizes the medical staff office is totally unfamiliar with the human resources process. How will they develop job descriptions? How will they conduct competency assessments? The answer is simple: they can't.

This is further complicated when the human resources department declares it does not "want" these individuals. They state that they have insufficient support to assume the responsibilities. Though some of the requirements are similar such as job descriptions and performance evaluations, not all of them are exactly the same, and the HR department currently is staffed to serve only the employees of the hospital.

How should an organization resolve this dilemma?

The Good News:

Few hospitals where I have consulted are truly compliant with this standard, but none have received RFIs at LD.3.70. Many also have not begun developing a pathway for NAPEs. However, this standard has essentially gone "not scored" in 2006. It would appear that surveyors are completely unaware of it or perhaps they have not encountered these individuals in tracer surveys.

This situation will probably change soon. In 2007, this standard (LD.3.70) will be moving to the HR standard as HR 1.20 EP 13 for APPs (replacing LD.3.70 EP 1 and 2), and HR 1.20 EP 11-12 (replacing LD.3.70 EP 3 and 4) for NAPEs.

All new standards will be presented to surveyors at Annual Surveyor Training Conference in the first week of January 2007. It is likely that the "underscored" and "new" standards will be emphasized.

Designing a Good Process for NAPEs:

The goal of these actions is to develop a compliant process for NAPEs that parallels the process and requirements of hospital employees. Some hospitals require employees to undergo urine drug screening and criminal background checks. Though these two items are frequently required for hospital employment, JCAHO is currently not requiring these for NAPEs. However, I believe the handwriting is on the wall. Since hospitals require these items for employees, it seems logical that those staff providing the same or like services should meet the same criteria. It follows that it would likely be scorable under LD.3.20 (uniform processes). In my estimation, the best practice would be to develop a completely equivalent process.

During consultations, I recommend the following to ensure compliance and a comprehensive process:

1. Interview each of these NAPE staff to determine exactly what functions they will be performing.
2. Develop a job-specific (not generic) job description with criteria.
3. Develop a performance evaluation.
4. Primary source verify the license or registration.
5. Arrange for hospital and department orientation, signing of confidentiality agreements, and other HR requirements (drug screening and background checking).
6. Arrange for someone of like competence to conduct the initial evaluation.
7. Arrange for someone to conduct the annual evaluation.
8. Decide who in the hospital administrative chain of command will be responsible for granting these individuals the authority to provide services.
9. Remember that nurses should evaluate nurses who perform nursing functions.

Conclusion:

Following human resources standards when approaching NAPE staff will assist organizations in guaranteeing the integrity and competence of those staff. It is the “right thing to do” though the task will not be easy. This will cost money, and it must be the hospital that decides who will cover the cost of processing these individuals—either the employing physician or the hospital.

Definitions/Acronyms:

Advanced Practice Personnel (APP): individuals who practice with relative independence but who are required by law to have supervision or a collaborative agreement with a physician to provide their services. For the purpose of this paper, these will include: Certified Registered Nurse Anesthetists (CRNA), Certified Registered Nurse Practitioners (NP), Certified Registered Nurse Midwives (CNM), and Physician Assistants (PA).

Allied Health Professionals (AHP): a now antiquated term that contained both the APPs and NAPEs. The change in standards has now forced the field to divide this group. This is the purpose of this paper.

Element of Performance (EP): an individual element of a standard that is separately scored.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): the oldest and largest U.S. health care accrediting body serving more than 15,000 health care organizations and programs by assessing their compliance with national standards.

Licensed Independent Practitioner (LIP): those permitted by state law and regulation to function independently without requirements of supervision. These may be physicians, podiatrists, dentists, other non-physician practitioners, as well as some advance practice nurses in some states.

National Practitioner Data Bank (NPDB): primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials.