MISH

POLICY NAME: Allied Health Professional Policy	Policy #: 179-307
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	Effective: 2 /2015
	Rev: 1/18,2/19, 1/21,3/22

GENERAL

An allied health professional ("AHP") is a health care professional, other than a physician assistant or advanced practice registered nurse (Advanced Practice Providers), physician or dentist, who by academic and clinical training is qualified to exercise certain degrees of independent clinical judgment in the care of patients, whose professional discipline is recognized by an appropriate licensing, certifying, registering or other professional regulatory body in the State of Kansas, and who has been authorized by the Board of Directors (the "Board") to practice at the Minimally Invasive Surgery Hospital (the "Hospital"). AHPs are classified either as Independent or Dependent, as described below.

For the purposes of this Policy, Independent Allied Health Professionals ("IAHP") are those individuals in Allied Health Professional ("AHP") categories that, in accordance with state law, (1) may provide care to patients without direct physician supervision and/or direction; and (2) exercise independent judgement in the provision of care, testing, and/or treatment to a patient.

From time to time by law and the System Hospital to provide patient care services independently within a hospital Independent Allied Health Professionals may provide patient care services within the limits of their education, training, experience, professional licensure, and demonstrated competence. AHP's are eligible to apply for clinical privileges pursuant to the process described below.

SCOPE

This Policy addresses those AHPs who choose to and are permitted to provide patient care services in the Hospital and are listed on Schedule A to this Policy. This Policy sets forth the credentialing process and the general practice parameters for AHPs.

TYPES OF ALLIED HEALTH PROFESSIONALS (AHPS)

a. Independent AHPs.

Independent AHPs are health care professionals licensed by the state and permitted by the state practice acts and the Hospital to provide patient services in the Hospital within the scope of their professional preparation, without physician supervision and direction. Current categories of Independent AHPs are listed on Schedule A. Schedule A may be modified or supplemented by the Board at any time, without the necessity for further revision of this Policy.

b. Dependent AHPs.

Dependent AHPs are, if applicable, licensed by the state and/or certified by a professional organization to perform patient care services only under the supervision of a member of the Medical Staff in good standing ("Sponsoring Physician"). Such patient care services are limited to those ordinarily performed by the Sponsoring Physician and the Sponsoring Physician accepts ultimate medical responsibility for all patient care services provided by the AHP. The Sponsoring Physician must be credentialed in the same clinical service as that in which the AHP has submitted a Scope of Practice (as defined below) and the AHP shall not be granted permission to perform any procedures which are outside the privileges of the Sponsoring Physician. Current categories of Dependent AHPs who are permitted to practice in the Hospital are listed on Schedule A. Schedule A may be modified or supplemented by the Board at any other revision of this Policy.

i. Scope of Practice. For purposes of this Policy and the professional practice of an AHP, "Scope of Practice" means the authorization of the AHP to perform certain clinical activities and functions under the supervision of or in collaboration with a Sponsoring Physician as authorized by the Board and the relevant Clinical Service Director / Manager / Supervisor. For Dependent AHPs, the Scope of Practice is jointly agreed upon by the Dependent AHP and the Sponsoring Physician. The Dependent AHP must submit the Scope of Practice as authorized by licensure and/or certification and agreed upon by the Clinical Service Director / Manager / Supervisor. AHPs are not automatically entitled to provide all services for which they may be licensed. Use of personal DEA numbers by AHPs may be considered individually upon request of the same by the Sponsoring Physician and the Clinical Service Director. All AHPs are to refrain from any conduct or acts that are or could reasonably be interpreted as being beyond, or an attempt to exceed, the Scope of Practice authorized within the Hospital.

ii. Revocation of Sponsoring Physician Privileges. Should the Medical Staff appointment or clinical privileges of the Sponsoring Physician be revoked or terminated, the Scope of Practice of the AHP shall automatically be terminated, with no hearing or appeal rights. However, if subject to the restrictions discussed below, the AHP is an employee of or is supervised by another physician appointed to and in good standing on the Medical Staff, the AHP may maintain his or her Scope of Practice with the Hospital so long as such other supervising physician then becomes the AHP's Sponsoring Physician.

In the case of changing sponsorship to another member of the Medical Staff, if the new Sponsoring Physician is in a different specialty/division where the AHP's Scope of Practice would change, then the new Sponsoring Physician must sign a "Change of Sponsor" agreement as well as supply a Scope of Practice endorsed by the new Sponsoring Physician, which Scope of Practice must be in the same Clinical Service as the new Sponsoring Physician. If there is no lapse in time between Sponsoring Physicians, no additional documentation will be required to be submitted for approval. If, however, there is a lapse or the Clinical Service changes, the AHP will be required to complete a new application and Scope of Practice which must be approved in the same manner as the original application. All application requests and supporting documentation are submitted to the Medical Staff Office for verification. The Application Process is as outlined in Credentialing Procedures Article a. of this Policy.

iii. **Optional Multi-sponsoring physicians**. In some instances the Clinical Service Director / Manager / Supervisor, or his or her designee, may serve as a supervising physician for AHPs practicing within his or her Clinical Service so long as the Scope of Practice for the AHP remains the same as that approved through credentialing process.

Categories of AHP Clinical Privileges

a. **Active**

Active AHP staff will be those AHPs who have successfully completed the FPPE Plan or AHPs, by their specialty/licensure, are not required by TJC to participate in the FPPE Plan.

b. **Temporary**

Temporary AHP privileges may be granted to certain AHPs who strictly meet the following criteria:

i. The AHP's credentialing application is complete, has been completely processed in accordance with the Credentialing Procedures (as defined below), and is awaiting an action by the Executive Committee of the Medical Staff ("Executive Committee");

ii. The AHP has provided the following information and such information has been verified:

a. current Kansas licensure certificate and proof of any other applicable certifications;
b. a certificate verifying the AHP's medical malpractice coverage;
c. a current National Practitioner Data Bank report;
d. proof of the AHP's DEA licensure and registration, if applicable to AHP's practice;
e. criminal background information; and
f. any other documentation that may be requested from the AHP.

Primary Verification Requirements
NEW Licensed or Certified or Contracted Healthcare providers (not LIP)
☐ Verification of employment ☐ Verification of Licensure/Certification ☐ Verification of Liability Insurance ☐ Verification of Education / Training ☐ Verification of NPDB ☐ Verification of KS DEA licensure if applicable ☐ Background check ☐ Verification of OIG/SAM

Primary Verification Requirements from a Join Commission accredited organization
NEW Licensed or Certified or Contracted Healthcare providers (not LIP)
☐ Verification of employment ☐ Verification of Licensure/Certification ☐ Verification of Liability Insurance ☐ Verification of Education / Training ☐ Verification of NPDB ☐ Verification of KS DEA licensure if applicable ☐ Verification of OIG/SAM

For purposes of granting temporary AHP privileges, an AHP credentialing application is "complete" when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources.

Temporary AHP privileges may be granted for a maximum period of ninety (90) days or until the AHP's application is approved, whichever period is shorter, and temporary AHP privileges shall expire automatically at the end of said period. During the temporary AHP privileges period, the AHP may provide patient care services only under the "direct supervision" of the Sponsoring Physician and under no circumstance may the AHP bill for services provided by the AHP pursuant to the AHP's temporary privileges.

For purposes of AHP temporary privileges, "direct supervision" means the Sponsoring Physician is immediately, and locally available by electronic communication or is on the Hospital premises for consultation/ direction of the AHP.

No applicant has a right to be granted AHP temporary privileges. Temporary AHP privileges granted under this Policy are granted as a courtesy only. The failure to grant temporary AHP privileges requested under this Policy shall not constitute grounds for any hearing or appeal process.

Temporary AHP privileges under this Policy are granted by the CEO of the Hospital, or his or her designee, upon the recommendation of the applicable Clinical Service Director / Manager / Supervisor and either the Chairman of the Credentials Committee or the Chief of Staff.

The CEO of the Hospital, or his or her designee, upon the recommendation of the applicable Clinical Service Director / Manager / Supervisor and either the Chairman of the Credentials Committee or the Chief of Staff, may terminate an applicant's temporary AHP privileges, if the applicant fails to comply with any of the conditions, restrictions or limitations imposed on the granting of temporary AHP privileges, or if the applicant violates any rule, regulation, or policy of the Medical Staff or the Hospital.

Qualifications of AHPs

Every AHP who applies for or is exercising specified services or delineated clinical privileges must at the time of initial application for authorization to practice and, if approved, continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and of the Hospital the following qualifications and any additional qualifications as are set forth for the particular category of AHP.

a. Licensure. Current, unrestricted license, registration, certificate or other such credential, if any, as may be required by Kansas law, and no revocation or suspension of any license, certification, or registration to practice in any state.

b. Professional Training and Education. Training school certificate/diploma documenting completion of education for the category and privileges requested.

c. Experience and Professional Performance. Current experience documenting the ability to provide patient care services at an acceptable level of quality and efficiency in the Hospital setting where specified services are or will be provided, adherence to the ethics of his or her profession; good reputation and character; and the ability to work harmoniously with all members of the patient care team.

d. Professional Liability Insurance and Malpractice History. Malpractice insurance coverage consistent with specialty and limits as established by the Hospital. Proof of current existence and extent of professional liability insurance coverage (minimums of $1,000,000 per occurrence, $3,000,000 aggregate), the insurance carrier's name and address, and the inclusive dates of coverage will be supplied with application and continue to be effective during AHP staff appointment. Also, history of malpractice litigation, including any final judgments, settlements and if there are any suits currently pending.

e. Federal Health Care Program Exclusion. No exclusion or preclusion from participation in Medicare, Medicaid or other federal or state government health care programs.

f. Fraud. No conviction of, plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payor fraud or program abuse or the requirement to pay civil monetary penalties for the same.

g. Felonies. No conviction of, plea of guilty or no contest to, any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence (federal or state).

Nondiscrimination Policy

No individual shall be denied Scope of Practice approval or clinical privileges at the Hospital on the basis of gender, race, creed or national origin.

Obligations of AHPs

Each AHP shall:

a. provide patients with care or other services at the level of quality and efficiency professionally recognized as the appropriate standard of care by the Medical Staff;

b. participate in quality assessment/improvement program activities appropriate to his/her discipline in discharging such other functions as may be required from time to time;

c. abide by the applicable sections of the Medical Staff Bylaws, Medical Staff Rules and Regulations, and related manuals, AHP policies and all other applicable standards and policies and rules of the Medical Staff and the Hospital;

d. complete, in a timely manner, all medical and other required records containing all information required by the Hospital;

e. provide the Medical Staff Office evidence of current Kansas license/certificate, professional liability insurance coverage, and if applicable, federal DEA registration;

f. promptly pay any applicable dues and assessments;

g. immediately notify the Medical Staff Office of:

    1. any criminal charges brought against the AHP other than minor traffic violations;

    2. Any change made or formal action initiated that could result in a change in the status of his/her license/certificate to practice; any change in professional liability insurance coverage; any formal action by any entity, including any state or federal government agency, which may result in the denial, limitation, revocation, or involuntary withdrawal or surrender of provider status, including Medicare, Medicaid, or any other government-sponsored healthcare program; all changes in employment or affiliation relationships involving a termination, disciplinary action or reduction in practice privileges with a physician identified as one who supervises the AHP; and changes in affiliation with or specified services at other institutional affiliations where the AHP provides specified services; and

    3. Any change in health status that would affect the AHP's ability to perform safe patient care;

h. refrain from any conduct or acts that are, or reasonably could be interpreted as being, beyond the AHP's Scope of Practice, including refraining from assuming responsibility for diagnosis or care for patients for which the AHP is not qualified or without adequate supervision; and

i. refrain from deceiving patients as to his or her status as an AHP.

Failure to satisfy any of these obligations shall constitute grounds for appropriate disciplinary action, including the reduction or termination of the AHP's privileges.

An AHP's authorized Scope of Practice within any Clinical Service is also subject to any rules and regulations of that Clinical Service and to the authority of the relevant Clinical Service Director / Manager / Supervisor.

Obligations of Sponsoring Physicians

Any physician sponsoring a Dependent AHP must:

a. be a member of the Medical Staff;

b. accept full responsibility for the proper conduct of the AHP within the Hospital, in accordance with the Medical Staff Bylaws, Medical Staff Rules and Regulations and other policies, and for the correction and resolution of any problems that may arise;

c. be immediately available in person or by telephone to provide further guidance when the AHP performs any task or function;

d. maintain ultimate responsibility for directing the course of the patient's medical treatment;

e. assure that the AHP provides care in accordance with accepted medical standards;

f. provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented;

g. abide by all Medical Staff and Hospital Bylaws, polices and rules governing the use and practice of AHPs in the Hospital;

h. as applicable, countersign all orders and medical record entries made by an AHP as required by the Medical Staff Rules and Regulations; and

i. immediately notify the Medical Staff Office in the event any of the following occur:

    1. the scope or nature of the Sponsoring Physician's professional arrangement with the AHP changes;

    2. the Sponsoring Physician's approval to supervise the AHP is revoked, limited, or otherwise altered by action of the applicable state licensing board;

    3. notification is given of investigation of the AHP or of the Sponsoring Physician's supervision of the AHP by the state licensing board; or

    4. the Sponsoring Physician's professional liability insurance coverage is changed insofar as coverage of the acts of the AHP is concerned or the AHP's professional liability insurance is changed.

Limitations of AHPs

a. No Entitlement to Medical Staff Appointment and Rights.

AHPs shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment unless otherwise provided for under this Policy. AHPs are not eligible to vote in meetings of or to hold office on the Medical Staff. AHPs practice at the Hospital

at the discretion of the Board and as such may be denied access and/or terminated at will by the Board.

b. No Entitlement to Medical Staff Fair Hearing Process.

AHPs shall be entitled to the due process defined by the Fair Hearing Process of Article VIII of the Medical Staff Bylaws. Rather, all hearing and appeal rights to which AHPs shall be entitled shall be in accordance with Credentialing Procedures Article d. of this Policy.

c. No Admitting Privileges.

AHPs shall not be eligible to admit patients to or discharge patients from the Hospital.

Credentialing Procedures

a. Appointment Procedure.

1. Each individual applying for AHP staff membership shall file, with the Medical Staff Office, an application on a form provided by the Hospital and agree to abide by the terms of the Medical Staff Bylaws and related manuals, rules and regulations, policies and procedure manuals of the Medical Staff and those of the Hospital, as well as this Policy.

2. For each AHP category approved by the Board to act in the Hospital, there will be specific qualifications and privileges delineated. Individuals applying for AHP staff membership are not automatically entitled to provide all services for which they may be licensed, and must submit a Scope of Practice as authorized by licensure and/or certification and agreed upon by the Clinical Service Director / Manager / Supervisor.

3. The initial appointment process will be similar in process to that of the Medical Staff as outlined in the Credentialing Procedures of the Medical Staff (the "Credentialing Procedures"), Section 1.2 (B), Subsection 1. The relevant Credentials Committee will review each application and make a report of its recommendation for appointment along with written delineation of Scope of Practice to the Executive Committee, which shall then make a report of its recommendation for appointment along with written delineation of scope of practice to the Board.

b. Reappointment.

1. AHP staff members will be considered for reappointment at intervals of not greater than two (2) years. At least ninety (90) days prior to the expiration date, an application for reappointment will be delivered or mailed from the Medical Staff Office and must be completed and submitted to the Credentials Committee prior to the end of the current appointment term.

2. All AHPs will be required to have an annual evaluation as well as competency verification. Quality of services provided by the AHPs are monitored and evaluated regularly through assignment to a Clinical Service or through the quality improvement and risk management system of the Hospital. An evaluation form will be completed by a peer and the Sponsoring Physician (if applicable), and

considered during the reappointment process. The relevant Clinical Service Director / Manager / Supervisor will review each application and forward a report to the Credentials Committee.

3. The reappointment process will be similar in process to that of the Medical Staff, as outlined in the Credentialing Procedures, Section 1.2(B), Subsection 3. After receiving recommendations from the Credentials Committee, the Executive Committee will make recommendations regarding reappointment and specific privileges to the Board.

4. Reappointment as an AHP staff member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the Credentials Committee and/or the Executive Committee; provided however, that the applicant may have the right to appear before the Executive Committee prior to denial of appointment or requested clinical privileges in accordance with Credentialing Procedures Article d. of this Policy.

c. Conditions of Appointment and Reappointment.

1. Appointment and reappointment as an AHP member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the Credentials Committee and/or the Executive Committee; provided however, that the applicant may have the right to due process in accordance with Credentialing Procedures Article d. of this Policy.

2. AHP members may only engage in acts within the Scope of Practice or clinical privileges specifically granted by the Board.

3. Patients cared for by AHP staff member shall be under the daily direction and supervision of a physician on the Active Medical Staff.

4. No individual may be a member of the AHP staff if he/she is excluded involuntarily or otherwise ineligible for participation in any federal health care program, funded in whole or in part, by the federal government, including Medicare and Medicaid.

d. Procedural Rights.

1. In the event that the Board receives a recommendation made by the Executive Committee or the Board determines on its own action to: (1) deny an AHP staff applicant's initial appointment or requested clinical privileges, (2) deny an AHP staff member's reappointment or requested clinical privileges, or (3) deny, limit or terminate an AHP staff member's clinical privileges (an "Adverse AHP Action"), the individual shall be notified of the recommendation or proposed action. The procedural rights pursuant to this Credentialing Procedures Article d. shall not apply to individuals whose clinical privileges are adversely affected secondary to a denial, suspension, or termination of their employment with the Hospital, or as otherwise set forth under Automatic Relinquishment of Scope of Practice or Clinical Privileges Article of this Policy. The notice shall include a general statement of the reasons for the Adverse AHP Action and, if the reasons are due to the AHP staff member's clinical competence or quality of care, shall advise the individual that the individual may request a meeting with the Executive Committee prior to final action by the Board, by submitting a written request to the Chief of Staff within ten (10) days following the date of the notice. However, if the Adverse AHP Action has been taken by the Board following Adverse AHP Action by the Executive Committee, the AHP may not request such a hearing, regardless of whether the AHP exercised his or her hearing rights of the Adverse AHP Action taken by the Executive Committee.

2. Upon receipt of a timely request for a hearing, the Chief of Staff shall appoint a person to act as a hearing officer to conduct a hearing using the same procedures for hearings as are contained within Article VIII (Fair Hearing) of the Medical Staff Bylaws. Said hearing officer shall not have a personal stake in the outcome of the hearing, shall be unbiased with respect to both the Hospital and the AHP, and shall be capable of understanding, interpreting, and objectively weighing the evidence presented at the hearing. Said hearing

shall be scheduled to take place no later than thirty (30) days following the Chief of Staff's receipt of a timely request for a hearing. Written notice of the date of the hearing shall be provided to the individual requesting the hearing no later than fifteen (15) days prior to the date of the hearing.

3. Within twenty (20) days after the deadline for submitting written summaries pursuant to Article VIII of the Medical Staff Bylaws, as such deadline may be extended in accordance with such section, the hearing officer shall make his or her findings and recommendations regarding the Adverse AHP Action and shall prepare a written report of such and forward such written report, together with the hearing record, to the body (either the Executive Committee or the Board) that took the Adverse AHP Action (the "AHP Acting Body"). The report shall include a statement of the basis for the hearing officer's recommendations. A copy of the report shall be provided contemporaneously to the AHP.

4. Within a reasonable time after receipt of the hearing officer's report, the AHP Acting Body shall reconsider the Adverse AHP Action in light of the hearing officer's report and then the AHP Acting Body shall affirm, modify, or reverse the Adverse AHP Action. The decision shall be in writing and shall include a statement as to its basis.

5. If, after receiving the hearing officer's report, the AHP Acting Body takes action on the application that is not a reversal of the Adverse AHP Action, the AHP may, within five (5) days of receiving notice of the AHP Acting Body's action, appeal the decision directly to the AHP Acting Body. The notice of appeal shall be in writing and directed to the Chief of Staff. If the Executive Committee is the AHP Acting Body, such appeal must be made to the Executive Committee and shall not be made to the Board.

6. Within a reasonable time after the Chief of Staff's receipt of notice of appeal, the AHP Acting Body shall meet personally with the AHP for the purpose of allowing the AHP to make his or her appeal.

   The AHP may not call witnesses at such meeting, but upon at least three (3) days written notice to the AHP Acting Body, may have an attorney or advisor present at such meeting. The AHP Acting Body may have an attorney present at such meeting. The appeal shall be a discussion of the testimony and documentary evidence presented to the hearing officer.

7. Within a reasonable time after hearing the AHP's appeal, the AHP Acting Body shall issue a written report affirming, modifying, or reversing the Adverse AHP Action. A copy of such report shall be considered final and shall be promptly sent to the AHP.

Automatic Relinquishment of Scope of Practice or Clinical Privileges

An AHP's clinical privileges or Scope of Practice shall be automatically relinquished without entitlement to any hearing or appeal rights, under the following circumstances:

a. If the AHP is a Dependent AHP and the Sponsoring Physician's Medical Staff appointment or clinical privileges are revoked or terminated for any reason (unless the Dependent AHP is also supervised by another physician on the Medical Staff);

b. The AHP's license or certification expires, is revoked, or is suspended;

c. The AHP no longer satisfies any of the threshold eligibility criteria set forth above;

d. The AHP is indicted, convicted, or enters a plea of guilty or no contest pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) alcohol; (iv) Medicare, Medicaid, or insurance or health care fraud or abuse; or (v) violence against another;

e. The AHP fails to provide information pertaining to his or her qualifications for the Scope of Practice or clinical privileges in response to a written request from the Credentials Committee or the Executive Committee; or

f. a determination is made by the Board that there is no longer a need for the services that are being provided by the AHP.

Leave of Absence

a. An AHP may request a leave of absence, for a period not to exceed one (1) year, by submitting a written request to the relevant Clinical Service Director / Manager / Supervisor. The Clinical Service Director / Manager / Supervisor will determine whether a request for a leave of absence shall be granted.

b. Except for maternity leaves, AHPs must report to the relevant Clinical Service Director / Manager / Supervisor any time they are away from patient care responsibilities for longer than thirty (30) consecutive days and the reason for such absence is related to their physical or mental health or to their ability to care for patients safely and competently. Under such circumstances, the Clinical Service Director / Manager / Supervisor, in consultation with the Chief of Staff and the CEO of the Hospital, may trigger an automatic leave of absence.

c. Individuals requesting reinstatement from a leave of absence shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital, at least thirty (30) days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming practice and safely exercising the clinical privileges or Scope of Practice requested.

d. Requests for reinstatement shall be reviewed by the relevant Clinical Service Director / Manager / Supervisor, the Chair of the Credentials Committee, the Chief of Staff, and the CEO of the Hospital. If all of these individuals make a favorable recommendation on reinstatement, the AHP may

immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, such questions or concerns shall be noted and the reinstatement request shall be forwarded to the Credentials Committee, Executive Committee, and the Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Credentialing Procedures Article d. of this Policy.

e. The Credentials Committee and the Executive Committee may recommend the imposition of specific conditions upon reinstatement from a leave of absence. The conditions may be related to behavior or clinical issues.

Release and Immunity

By applying for appointment and clinical privileges, the AHP applicant accepts the following conditions and intends to by legally bound by them, regardless of whether or not permission to practice and/or clinical duties or clinical privileges are ultimately granted. These conditions shall remain in effect for the duration of any term of permission to practice granted:

a. To the fullest extent permitted by law, the AHP applicant extends absolute immunity to release from any and all liability, and agrees not to sue the Hospital, its Medical Staff, their representatives, and appropriate third parties for any matter relating to clinical duties, or clinical privileges or qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the AHP, which are representatives, or appropriate third parties;

b. The AHP authorizes the Hospital, its Medical Staff, and their authorized representatives to consult with any third party who may have information bearing on professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on the AHP's qualifications for initial and continued permission to practice and to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, the AHP shall provide specific authorization for these third parties to release the information to the Hospital, its Medical Staff and their authorized representatives upon request; and

c. The AHP authorizes the Hospital, its Medical Staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, who solicit such information for the purpose of evaluating the AHP's qualifications pursuant to a request for permission to practice and clinical duties or clinical privileges, participating provider status, or other credentialing matters.

Disaster Responsibilities for Non-Licensed Independent Practitioners

MISH will identify in writing Non-Licensed Independent Practitioners given responsibilities, no matter how minor, during a disaster once the Emergency Operation Plan has been activated and MISH is unable to meet immediate patient needs otherwise. This will also include any regular members of the MISH staff. The CEO will decide in what capacity any non-LIP individuals will assist the LIPs and any other ancillary staff. Designated non-LIP volunteers will be monitored through a mentoring process (pairing with a licensed LIP) and direct observation. All monitoring will have oversight by the CEO or designee.
Before an individual is considered for a non-LIP position, MISH must obtain his or her valid government – issued photo identification such as:

- A current driver's license
- A current license, certification, or registration
- Identification indication that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances
- Confirmation by hospital staff with personal knowledge of the volunteer's ability to act as a qualified non-LIP during a disaster

The CEO or President of medical staff or their designee(s) granting disaster privileges will assess and determine the need for granting disaster privileges. The decision to grant disaster privileges will be handled on a case-by-case basis at his or her discretion. Circumstances which required said emergency disaster privileges will be documented. The verification process of the credentials will be given a high priority, and will begin as soon as the immediate situation is under control, and when possible is completed within 72hrs from the time the volunteer practitioner presents to MISH The privileging process will be identical to that used for granting temporary privileges to meet an important patient care need. The CEO decides based on information gathered by designated medical staff members within 72 hrs whether to continue with granted disaster privileges. The CEO will also oversee their performance by direct observation, mentoring with LIP staff and medical record review.
If licensure cannot be verified within 72 hours of the practitioner's arrival, MISH will document the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival.
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services.
- Evidence of the hospital's attempt to perform primary source of verification as soon as possible

Those Individuals granted disaster privileges will be identified with a Badge labeled as MEDICAL STAFF – EMERGENCY DISASTER and the individual's NAME, to allow staff to readily identify these individuals. Those individuals who do not want to maintain privileges at MISH after the emergency situation is over will follow normal procedure in terminating privileges.

Amendment

This Policy may be amended by a majority vote of the Credentials Committee, with approval of the

Executive Committee and the Board.

Miscellaneous

a. Time Limits. Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

b. Delegation of Functions. When a function is to be carried out by a person in a particular office or by a committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

SCHEDULE A

Categories of Allied Health Professionals Independent AHPs

Independent AHPs

Independent AHP's include but are not limited to:

- Licensed Clinical Psychologist

Dependent AHPs

Dependent AHPs include but are not limited to:

- Aestheticians
- Audiologist (CCC-A)
- Certified Genetics Counselor (CGC)
- Certified Orthotist (CO)
- Certified Prosthetist/Orthotist (CPO)
- Dental Assistant (DA)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Master Social Worker (LMSW)
- Licensed Practical Nurse (LPN)
- Licensed Specialist Certified Social Worker (LSCSW)
- Medical Assistants (MA)
- Nurse Practitioners (NP)
- Occupational Therapist (OT)
- Physical Therapist (PT)
- Registered Diagnostic Cardiac Sonographer (RDCS)
- Registered Dietician (RD)
- Registered First Nurse Assist (RNFA)
- Registered Nurse (RN)
- Registered Physical Therapists (RPT)
- Registered Vascular Technician (RVT)