

**PROVIDENCE HEALTH & SERVICES – OREGON**

**ALLIED HEALTH PROFESSIONAL  
POLICIES AND PROCEDURES**

*Providence Hood River Memorial Hospital*

*Providence Medford Medical Center*

*Providence Milwaukie Hospital*

*Providence Newberg Medical Center*

*Providence Portland Medical Center*

*Providence Seaside Hospital*

*Providence St. Vincent Medical Center*

*Providence Willamette Falls Medical Center*

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## **PHSOR Allied Health Professional Policies and Procedures**

### **I. Definitions:**

- A. Dependent Allied Health Professionals (DAHP) means the practitioners who are not members of the Professional Staff but who have been authorized by the Oregon Community Ministry Board (OCMB) to provide services within the scope of their license, registration, certification, or special training as employees or independent contractors of physician or dentist Members of the Professional Staff. These DAHPs include but are not limited to physician assistants, registered nurse first assistants and other professional assistants.
- B. Independent Allied Health Professionals (IAHP) means the practitioners who are not members of the Professional Staff but who have been authorized by the OCMB to provide certain health care services upon order by a member of the Professional Staff but without ongoing supervisory relationship by any specified member of the Professional Staff. IAHPs are limited to Licensed Acupuncturists (LAc), Audiologists (AUD), and Intraoperative Neurophysiologists.
- C. Supervising Member means the physician or dentist who provides oversight, direction or supervision of the DAHPs' practice.
- D. Primary Hospital means the hospital where the AHP will perform most of the activities.
- E. "Hospital" or "Hospitals" means Providence Hood River Memorial Hospital, Providence Medford Medical Center, Providence Milwaukie Hospital, Providence Newberg Medical Center, Providence Portland Medical Center, Providence Seaside Hospital, Providence St. Vincent Medical Center and/or Providence Willamette Falls Medical Center. Applicants must apply at each Providence facility where the applicant is requesting clinical privileges.
- F. "PHSOR Policies" means the Policies and Procedures of the Professional Staff as established by the Oregon Medical Executive Committee.

### **II. Categories of the AHP**

- A. Independent AHPs (IAHPs)
- B. Dependent AHPs (DAHPs)
- C. Inactive – AHPs may be placed on Inactive status when a temporary absence from practice in the Hospital is expected due to prolonged illness or other valid reasons. The AHP can be upgraded to AHP category within two years from the date of placement on inactive status by satisfactorily completing the re-evaluation process as indicated in Section VIII. After two years of inactive status, the AHP will automatically resign.

- D. Unless specifically noted, the AHP policies and procedures apply to all DAHPs and IAHPs.

### **III. Responsibilities of Supervising Member for DAHPs:**

The Supervising Member shall assume full responsibility and be fully accountable for the conduct of said individual within the Hospital. It is the responsibility of the Supervising Member to acquaint the DAHP with the applicable Bylaws, Policies and other policies and rules governing the Hospital, as well as appropriate members of the Professional Staff and Hospital personnel with whom the DAHP shall have contact.

The Supervising Member shall assume the responsibility for malpractice (as defined by the PHSOR Policies, Article IV, Section 3), public liability, workers compensation and personal injury insurance in connection with such activities as may be performed by the DAHP at the Hospital. If the Supervising Member does not provide insurance for the DAHP, the Supervising Member shall assume the responsibility to ensure the DAHP maintains malpractice, public liability, workers compensation and personal injury insurance.

The authorization for the DAHP to perform the specified clinical privileges within the Hospital shall terminate or be modified if the Professional Staff appointment or hospital-specific clinical privileges of the Supervising Member are resigned, terminated, limited, or restricted for any reason. The clinical privileges of the DAHP are limited through his or her continued employment or agreement with the Supervising Member. The DAHP shall immediately cease all clinical activities within the Hospital when employment or contract arrangements with the Supervising Member are terminated. It is the responsibility of the Supervising Member to notify the Hospital of such an occurrence.

The Supervising Member may designate another physician or dentist Member of the Professional Staff to supervise the DAHP. The designation of such a physician or dentist must have the prior authorization of the applicable Professional Staff Department, Division or Section Chief or Chair.

### **IV. Responsibilities**

#### **Section 1. Dependent Allied Health Professionals:**

The DAHP shall agree to practice strictly within the scope of the approved clinical privileges. The DAHP shall further agree to perform such clinical privileges consistent with applicable laws and regulations and within the scope of his or her professional license, certification or training, and agree to abide by these Policies and Procedures, PHSOR Professional Staff Bylaws, and Policies, and other policies and rules governing the Hospital.

The DAHP's ability to practice at the Hospital will automatically terminate or be modified with no right of review or other administrative process if the Supervising Member's Professional Staff membership and/or hospital-specific clinical privileges are limited, revoked, or restricted to any degree, or voluntarily resigned. In addition, the ability to practice at the Hospital will automatically terminate with no right of review or other administrative process in the event the employment or

contractual relationship with the Supervising Member terminates.

The DAHP shall provide documentation to support the clinical privileges requested, including current competence to perform them based on training, health status, as it is applicable to the clinical privileges requested, and recent experience.

All DAHPs must clearly identify themselves as such when performing their clinical privileges and shall at all times when in the Hospital wear a PHSOR photo identification badge.

## Section 2. Independent Allied Health Professionals

The IAHP shall agree to practice strictly within the scope of the approved clinical privileges. The IAHP shall further agree to perform such clinical privileges consistent with applicable laws and regulations and within the scope of his or her professional license, certification or training, and agree to abide by these Policies and Procedures, PHSOR Professional Staff Bylaws and Policies, and other policies and rules governing the Hospital.

The IAHP's ability to practice at the Hospital will automatically terminate or be modified with no right of review or other administrative process if the license of the IAHP is in any way limited, revoked or restricted to any degree.

The IAHP shall provide documentation to support the clinical privileges requested, including current competence to perform them based on training, health status, as it is applicable to the clinical privileges requested, and recent experience.

All IAHPs must clearly identify themselves as such when performing their clinical privileges and shall at all times when in the Hospital wear a PHSOR photo identification badge.

## **V. Application Process:**

An application to practice in the Hospital may be requested by either the Supervising Member for his or her employees or independent contractors (DAHP) or by the Independent Allied Health Professional (IAHP). Application materials include an application, PHSOR Professional Staff Bylaws and Policies, these Policies and Procedures, orientation materials, confidentiality agreement and a cover letter explaining the application process and the information required to complete the process. Application fees apply at primary Hospital, and as applicable at other facilities. Annual dues and/or reappointment fee requirements apply as applicable. The Primary Hospital is responsible for the application process. The application shall include the following. Primary source verification is required as indicated by an asterisk (\*).

- Current and previous licenses and registrations (if applicable)\*
- Professional certifications (if applicable)\*
- Other certifications, including DEA Certification (if applicable)
- Liability insurance carrier for the last five years, including current coverage limits in the amount required for Professional Staff members\* (if available)
- Malpractice claims history \*
- Professional education and training\*

- Continuing professional education (if applicable)
- Previous medical/clinical practice since completion of professional education/training\*
- Previous and current hospital and other healthcare facility affiliations\*
- Professional peer references\* (Peer references from individuals in the same professional discipline knowledgeable about the applicant's professional performance requested. When not available, references from individuals holding credentials that encompass the applicant's practice and knowledge about the applicant's professional performance are requested.)
- Clinical privileges describing the clinical activities of the applicant based on the individual's education, licensure, training, experience, demonstrated ability, judgment, ability to work with others, and ability to perform the requested clinical privileges.
- Completed Attestation Form
- Health status as it relates to clinical activities requested, with or without accommodation
- AHP Accountability Statement
- For DAHPs Supervising Member Accountability Statement
- National Practitioner Data Bank (if applicable)\*
- Additional information or documentation may be requested.
- Criminal Background Checks at initial appointment, and as deemed necessary.\*
- Contact information including, but not limited to: current office addresses, phone, fax, and e-mail addresses.

## **VI. Evaluation Process:**

The application may be processed through a Credentialing Verification Organization for relevant documentation and primary source verification. When the application file is complete, it is forwarded for review and recommendation to the applicable Professional Staff Department or Section Chair, Oregon Credentials Committee (OCC), Medical Executive Committee (MEC), Oregon Medical Executive Committee (OMEC), and Oregon Community Ministry Board for final approval. Information contained in the complete application shall not be more than 180 days old at the time of the OMEC's review, except for information previously verified from a prior application and not subject to change, such as verification of education, training and prior professional affiliations, which may be older than 180 days.

The appropriate hospital departments will be notified of the approved clinical privileges of the AHP.

### **Notification to Supervising Member for DAHPs):**

The Supervising Member and DAHP are notified in writing of a favorable determination, including any change in function from the clinical privileges. The supervising physician or dentist shall be notified in writing of an adverse determination with the reasons for such action and will be afforded an opportunity of review through the Fair Hearing Plan. (PHSOR Policies, Article X)

### **Notification to IAHPs:**

The IAHP will be notified in writing of a favorable determination, including any change in function from the clinical privileges. The IAHP shall be notified in writing of an adverse determination with reasons for such action. IAHPs have no right of review or administrative process.

## **VII. Orientation:**

All approved applicants will participate in a mandatory Orientation at their Primary Hospital. Failure to participate after two attempts will be considered a voluntary withdrawal of his/her application. During the orientation, the applicant will receive at least the following:

- Information on the mission of Providence Health & Services (PH&S) - Oregon;
- General Information regarding Hospital departments, safety, visitor information, cafeteria, library, volunteer services and medical records;
- Professional Staff information regarding organization, continuing medical education opportunities, Member services and computer services; Information on Oregon's Advance Directive Law;
- Professional Staff and AHP Policies and Procedures, and a reference to Hospital policies pertinent to AHP, e.g. verbal abuse, non-smoking, hostile and abusive patient, code of conduct, and hospital code procedures.
- PH&S photo identification badge. The PH&S identification badge is required prior to exercising privileges.

## **VIII. Reevaluation Process:**

### **A. DAHPs other than Physician Assistants (PAs)**

Each DAHP is evaluated after the first six months of affiliation and annually, thereafter. The Supervising Member is requested to evaluate the DAHP for clinical knowledge and competence, professional judgment, technical skill, patient management and patient relationships, sense of responsibility, professionalism, cooperation with staff, and compliance with Policies. Appropriate Hospital staff members may also be requested to complete the evaluation.

The applicable Professional Staff Department Chair or designee reviews the completed evaluation and any other information regarding the DAHP's clinical privileges. A recommendation for a more extensive review for continued approval may be recommended to the OCC.

### **B. Physician Assistants (PAs), Acupuncturists (LAc), Audiologist (AUDs), or Intraoperative Neurophysiologists**

Every two years the PA, Lac, AUD, or Intraoperative Neurophysiologist is evaluated for the clinical privileges requested. Prior to expiration of the PA's, Lac's, AUD's or Intraoperative Neurophysiologist's appointment, the Primary Hospital will initiate the reevaluation process. An application shall be completed by the PA, Lac, AUD, or Intraoperative Neurophysiologist and shall be subject to the same requirements and processes described in these Policies, Section V (Application Process) and Section VI (Evaluation Process), specific to the time period since the last application.

**Physician Assistant:** The Supervising Member is also requested to provide the specific clinical privileges being requested for the PA and verify that the PA has the training, experience and current competence to perform the requested clinical privileges.

**Lac, AUD, or Intraoperative Neurophysiologist:** The IAHP is requested to provide the specific clinical privileges being requested and verify their training, experience and current competence to perform the requested clinical privileges.

Information considered in the review includes Hospital clinical activity, results from any ongoing monitoring or assessment, complaints, and patient survey responses.

#### **IX. Adverse Determination Procedure for AHPs**

The Hospital retains the right, either through the Chief Executive, or upon recommendation of the Medical Executive Committee, to suspend or terminate any or all of the clinical privileges of any AHP.

**DAHP:** The Supervising Member shall be notified in writing of an adverse determination with the reasons for such action. The Supervising Member will be afforded an opportunity of review through the Fair Hearing Plan (PHSOR Policies, Article X)

**IAHP:** The IAHP shall be notified in writing of an adverse determination with reasons for such action. IAHPs have no right of review or administrative process.

#### **X. Temporary Approval of Clinical Privileges:**

Temporary approval may be granted under special circumstances only. Special requirements for supervision and reporting may be imposed by the Hospital or the appropriate Department Chair on any AHP granted temporary approval. AHPs granted temporary approval must sign a statement agreeing to abide by these Policies and Procedures, PHSOR Professional Staff Bylaws and Policies, and other policies and rules governing the Hospital, sign a confidentiality agreement, and adhere to any requirements or restrictions applicable to temporary approval. A temporary identification badge must be worn.

Time-limited temporary approval, not to exceed one hundred twenty (120) days, may be granted under the following conditions by the Chief Executive or designee, acting on behalf of the OCMB, and with the recommendation of the appropriate Department Chair and Professional Staff President. A processing fee for administration of temporary approval will not be assessed.

##### **A. Application.**

Temporary approval may be granted to AHPs with a complete application as defined in the Application Process Section of this policy, which reasonably supports a favorable determination. Under no circumstances may temporary approval be granted if the application is pending because applicant has not responded to or provided requested information.



**B. Disaster.**

Temporary approval may be granted to AHPs, required by law and regulation to have a license, certification or registration to practice their profession, in the event of an emerging incident event and as directed by the Incident Command Center, when immediate patient needs are not being met. Emerging Incident Events include events that have potential to negatively impact the ability to provide services, such as, but not limited to, mass casualty incidents, earthquakes, bioterrorism, civil disturbance, fire, evacuation, hazardous material spill and/or utility failure. Primary source verification, which reasonably supports a favorable determination, must be obtained, as soon as possible. In cases where the complete verification process cannot be accomplished immediately, the Chief Executive or designee may grant temporary approval for up to 72 hours upon presentation of a current PHSOR photo identification card, or valid state or federal government-issued photo identification and at least one of the following: current hospital photo identification card with professional designation, copy of current state professional license applicable, identification of federal, state or municipal entity authority to provide patient care, treatment, and services in disaster circumstances, or identification by current hospital staff or Professional Staff members with personal knowledge regarding the practitioner's qualifications. The Chief Executive or designee may grant continuation of temporary approval based on review of primary source verifications obtained and evidence of a demonstrated ability to continue to provide adequate care, treatment, and services. The practitioner will be paired with a Member.

**C. Termination.**

Temporary approval may be terminated, reduced or modified on discovery of any information or occurrence of any event that places in question the AHP's professional qualifications, ethical standing, or clinical competence, or when the life or well-being of a patient is in danger. Disaster privileges are terminated as directed by the Incident Command Center or at the conclusion of the emerging incident event.

If temporary privileges are terminated, reduced or modified, the AHP and/or Supervising Member will not be entitled to any of the procedural rights accorded to a Member. The Supervising Member retains the rights afforded under these Policies in the instance of termination of an DAHP's temporary privileges while in the initial application process.

**XI. Early Assistance Program:**

The Professional Staff is committed to providing programs, resources and education to enhance physical and emotional well being. Healthy practitioners are fundamental to quality patient care, more productive and enhance the work environment. With this in mind the Professional Staff offers assistance and support through a program that provides confidential assessments, counseling and referral services.

The Professional Staff Early Assistance Program is available to Members and AHPs for self-referral and includes 24 hour, seven-days/week availability for assessment and triage, family

support, education and consultation services. If ongoing treatment is appropriate, referral is made to the appropriate provider in the community.

All employees and practitioners are strongly encouraged to express concerns about an affiliated practitioner's health and to make a referral to the President, Department Chair or the Medical Staff Office. Confidentiality and peer review protection of practitioners referred for assistance or self-referred will be maintained according to the PH&S Hospital and PHSOR Professional Staff confidentiality policies (PHSOR Policies, Article XVII, Section 6) and by applicable laws of the State of Oregon.

## **XII. Students:**

DAHP students may be allowed to participate in training with a Member in the Hospital under the following guidelines:

- Must be currently enrolled in an accredited professional school. A letter from the school is required and must include:
  - Name of preceptor (must be a Member)
  - Proposed length of training period
  - Professional liability insurance as required of Members
  - Workers Compensation coverage
- Must work under the direct supervision of a Member
- May be an assistant at a procedure, but shall not carry out any function in the Operating Room without the presence of the Supervising Member
- Patients must be made aware of, and consent to, DAHP student involvement in their care

## **XIII. Clinical Privileges:**

All AHPs shall perform only those clinical privileges which have been approved by the applicable Professional Staff Department, Division or Section Chief or Chair, MEC, OCC, OMEC, and the OCMB and as permitted by law and licensure.

The following restrictions and responsibilities apply to all AHPs within the Hospital. The Department Chair may establish and recommend criteria for specific clinical privileges, including mentoring or proctoring or specific procedures.

- AHPs shall perform only those clinical privileges within the scope of the approved clinical privileges, and only upon order by a Member caring for the patient, as applicable.
- AHPs shall document in the medical record procedures and evaluations carried out by the AHP and shall not supplant the requirement that the physician or dentist document the patient's hospital course.
- AHPs may not assume a member's responsibility to round on their patients every 24 hours.
- AHPs shall not assume the "on-call" responsibility of a physician or dentist.
- AHPs may attend educational meetings as desired, and may attend committee meetings or quarterly general staff meetings upon written invitation of the chair.

**XIV. Amendments to the Policies**

Amendments to these Policies will be made in accordance with the PHSOR Professional Staff Bylaws Article XVI, Sections 1 through 4. After OMEC approval, notice of amendments to or restatements or repeal of the model regional Policies shall be transmitted to the IAHPs, or DAHPs/Supervising Member through notices, newsletters, or electronically.