CREDENTIALING & PRIVILEGING ALLIED HEALTH PROFESSIONALS and CAM PROVIDERS

Presented by:
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About the Presentor:

Kathy Matzka, CPMSM, CPCS is a speaker, consultant, and writer with over 25 years of experience in credentialing, privileging, and medical staff services. She holds certification by the National Association Medical Staff Services (NAMSS) in both Medical Staff Management and Provider Credentialing. Ms. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker.

Ms. Matzka has authored a number of books related to medical staff services including Medical Staff Standards Crosswalk: A Quick Reference Guide to The Joint Commission, CMS, HFAP, and DVN Standards, Chapter Leader’s Guide to Medical Staff: Practical Insight on Joint Commission Standards, Compliance Guide to Joint Commission Medical Staff Standards, and The Medical Staff Meeting Companion Tools and Techniques for Effective Presentations. For eight years, she was the contributing editor for The Credentials Verification Desk Reference and its companion website The Credentialing and Privileging Desktop Reference. She is co-author of the HcPro’s publication Verify and Comply: Credentialing and Medical Staff Standards Crosswalk, Sixth Edition. The Credentialing and Privileging Desktop Reference. She is co-author of the HcPro’s publication Verify and Comply: Credentialing and Medical Staff Standards Crosswalk, Sixth Edition.

She has performed extensive work with NAMSS’ Education Committee developing and editing educational materials related to the field including CPCS and CPMSM Certification Exam Preparatory Courses and Study Guides, CPMSM and CPCS Professional Development Workshops, Standards Comparison Grid, and NAMSS Core Curriculum. These programs are essential educational tools for both new and seasoned medical services professionals. She also serves as instructor for NAMSS.

Ms. Matzka shares her expertise by serving on the editorial advisory boards for two publications - Briefings on Credentialing, and Credentialing & Peer Review Legal Insider.

Ms. Matzka is a highly-regarded industry speaker, and in this role has developed and presented numerous programs for professional associations, hospitals, and hospital associations on a wide range of topics including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

In her spare time, Ms. Matzka takes pleasure in spending time with her family, listening to music, traveling, hiking, fishing, and other outdoor activities.
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Credentialing and Privileging AHP and CAM

CREDENTIALING AND REcredentialing AHP and CAM PROVIDERS

DEFINITIONS OF CREDENTIALING AND REcredentialing

NAMSS
Credentialing is the process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity.

Recredentialing is the process of obtaining and evaluating data to support the continued competence of the healthcare practitioner to provide patient care services in or for a healthcare organization.

Source NAMSS Core Curriculum

JOINT COMMISSION
The process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity.

NCQA
Process by which MCO reviews and evaluates the qualifications of licensed independent practitioners to provide services to its members.

WHY DO WE DO IT?

There are a number of reasons for credentialing providers.

Patient Protection

This is the number one concern. The patient is put before anything else. If you look at the mission statement of any healthcare organization, you will find language that refers to providing high quality patient care. This can only be accomplished by allowing only those providers who meet certain high standards to treat patients.

Risk Management Concerns

If the patient suffers an adverse outcome at the hospital, the hospital can be held liable. If the provider has problems that would have been revealed by credentialing, but credentialing was not performed, the hospital may be liable for any patient harm caused by the substandard clinician.

The case Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (Ill. 1965) set the precedent that a hospital can be directly liable for negligent failure to properly credential a provider.
In this case, the patient alleged that the hospital was negligent in permitting the physician to treat his orthopedic injuries and not requiring him to update operative procedures, failing, through its medical staff, to exercise adequate supervision, especially since Dr. Alexander had been placed on emergency duty by the hospital, and in not requiring consultation especially after complications set in.

The hospital’s defense was that only the physician can practice medicine, therefore the hospital cannot be liable for the acts of a physician where reasonable care was exercised in selecting the physician.

The Illinois Supreme Court sided with the patient noting that hospitals do more than just provide facilities for treatment, but assume certain responsibilities for the care of the patient.

In a case pertaining to managed care, the court in Pennsylvania determined that HMOs and managed care organizations are liable for the malpractice for their participating physicians. In *McClellan v. HMO PA*, 413, Pa. Super. 128, 604 A.2d 1053 (1992), the court found that HMOs are liable for the actions of their physicians on much the same basis as hospitals are liable for the negligence of members of their medical staff in the hospital. The court found that HMOs have a "corporate responsibility" to uphold a proper standard of care for their members and concluded that an HMO could be liable for the negligent selection and retention of physicians whose quality of care was substandard.

**Required By Accrediting and Regulatory Agencies**

Another reason healthcare organizations credential is that it is required by accrediting bodies and regulatory agencies.

The Medicare Conditions of Participation (CoPs) are requirements hospitals must meet in order to participate in the Medicare and Medicaid Programs. The CoPs, which are in the Code of Federal Regulations, are intended to protect patient health and safety and to ensure quality of care for hospitalized patients.

**DEPENDENT VS. INDEPENDENT PRACTITIONER**

Employees of a medical staff appointee are sometimes called “dependent” AHPs. These “physician extenders” work under the supervision of the physician employer and see only patients of that physician employer or his/her partners. State law may require a collaborative practice agreement. Examples of dependent AHPs include dental assistant, private scrub, social worker, private nurse, and physician assistant.

An independent practitioner is typically licensed by the state and is able to provide patient care, treatment, or services without supervision. Examples include advanced practice nurse (midwife, nurse anesthetist, and in some states, physician assistants)

The licensure requirements of individual states designate which providers can function independently and which providers function only under physician supervision. Some
examples of LIPs include Nurse Midwife, Licensed Clinical Psychologist, and Certified Registered Nurse Anesthetist.

In determining whether or not a practitioner will function independently, the following things should be considered:

- Is it allowed by the scope of license, certification, (State regs)?
- How will he/she function in a specific setting?
- What patient care, treatment, or services will be provided?
- Will the AHP
  - take call or cover for physician on call?
  - make independent decisions?
  - practice with or without supervision (and what degree of supervision)?
  - need a physician to co-sign records?

CREDENTIALING AND PRIVILEGING APRNS AND PAs

NCQA requires that non-physician practitioners who have an independent relationship with the organization and provide care under the organization’s medical benefits must be credentialed.

Joint Commission requires any individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision to be credentialed. These individuals are known as licensed independent practitioners (LIP). Although the granting of clinical privileges to these LIPs is required, Joint Commission does not require that they be appointed to the medical staff. This is left up to the hospital and varies by organization dependent upon the services provided by the facility, state regulations, and the mind-set of the medical staff and community. Joint Commission’s Human Resources standards apply to the organization’s staff. Joint Commission defines “staff” as follows: “As appropriate to their roles and responsibilities, all people who provide care, treatment, and services in the organization, including those receiving pay (for example, permanent, temporary, and part-time personnel, as well as contract employees), volunteers, and health profession students. The definition of staff does not include licensed independent practitioners who are not paid staff or who are not contract employees.”

PAs and APRNs who are providing a medical level of care (meaning they are making medical diagnosis and treatment decisions) must be credentialed and privileged through the medical staff process.

PAs and APRNs who are not providing a medical level of care can be credentialed and privileged through the medical staff process or an equivalent process that has been approved by the governing body. An equivalent process at a minimum:

- Evaluates the applicant’s credentials;
- Evaluates the applicant’s current competence;
- Includes peer recommendations; and
Credentialing and Privileging AHP and CAM

- Involves communication with and input from individuals and committees, including the medical executive committee, in order to make an informed decision regarding the applicant’s request for privileges.

**Hospital Privileges Under Joint Commission Standards**

Joint Commission standards allow an alternative means of privileging AHPs that do not provide a medical level of care – meaning – they do not make independent patient diagnosis and treatment decisions. This allows the hospital to develop a process for granting “hospital privileges” with input by the medical staff, for hospital-employed non-LIP APRNs and PAs. Using this process, the hospital human resources department develops a credentialing and privileging policy that includes elements required by standards and “hospital privilege” lists for non-LIP PAs and APRNs.

After completion of credentialing and review by the non-physician department manager for the area in which the prospective employee will be working, the file is presented to the physician department chair for the area in which the Non-LIP PA or APRN will be working, the credentials committee, and the MEC for input. The department chair, credentials committee, and MEC review the application and list of privileges and provide input such as a comment that “credentials are appropriate for privileges requested” or “suggest additional training in _______ prior to granting privileges”. After the opportunity for medical staff input, the application is put through the routine human resources hiring procedure. An additional element, which would vary dependent on the organization, would be the granting of “hospital privileges”. Privileges would then be approved by the board. (See sample policy.)

The concept of “hospital privileges” may take some getting used to. Human resources personnel or hospital department managers may have trouble relating to this concept.

The Leadership standards require the organization leaders to define the required qualifications and competence of those staff who provide care, treatment, and services, and recommend a sufficient number of qualified and competent staff to provide care, treatment, and services. The determination of competence and qualifications of staff must be based on the organization’s mission, care, treatment, and services provided, the complexity of care, treatment, and services needed by the organization’s patients, technology used, and health status of staff, as required by law and regulation.

See sample policy and procedure on the next pages.
Sample Policy and Process For Credentialing And Privileging Of Non-Independent Practitioners Through The Human Resources Department

It is the policy of ________________ Hospital (the Hospital) to evaluate the credentials, qualifications and competency of all employed or contracted non-independent advance practice nurses and physician assistants (practitioner) providing patient care, treatment, or services directly under the supervision and on order of a physician. (Note: Licensed independent practitioners providing a medical level of care (ie. making independent patient diagnosis and treatment decisions) must be credentialed and privileged through the Medical Staff.)

The following Practitioners fall under this policy:

- Nurse practitioners
- Physician Assistants
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists

Individual credentialing and privileging criteria will be developed for each type of Practitioner. No new category of provider will be added until credentialing and privileging criteria for the category is developed and approved. The medical staff will have input into all grants of hospital privileges.

Practitioners may provide patient care, treatment, or services only as permitted and privileged by the hospital, within their scope of practice, and in keeping with all applicable rules, policies, and procedures and any formal written agreement between the Practitioner and the Hospital. Practitioners may participate directly in the medical management and/or care of patients under the general or direct supervision of a physician member of the medical staff.

Employment vs. Privileges

“Privileges” are a specific scope and content of patient care services authorized for a Practitioner by a health care organization based on evaluation of the individual's credentials and performance. “Employment” means work or service performed by an individual for another person or entity in exchange for wages or other remuneration or under a contract of hire. Employment is not synonymous with privileges.

Credentialing Policy and Procedure

I. Credentials Verification

A. In addition to all applicable Personnel policies, the following credentials verifications will be obtained for all Practitioners from the primary source or a designated equivalent source:

1. Advance practice degree;
2. Current state licensure;
3. Controlled substance license, if applicable;
4. Verification of professional liability history for the past 10 years
5. education, experience, and competence for assigned responsibilities; and
6. Verification of past employment and/or medical staff appointment and privileges for the past 10 years.

If circumstances arise in which it is not possible to obtain verification from the primary source, information may be solicited from a secondary source if the secondary source obtained the information from the primary source and the hospital believes the information to be credible and accurate

B. In order to evaluate current competence and experience, peer recommendations will be solicited from 3 peers in the same professional discipline as the Practitioner, who are knowledgeable about the applicant's professional performance. This evaluation will include any effects of health status on privileges being requested.

C. A criminal background check will be conducted.

II. Department Manager/Physician Director Review:

After completion of credentialing as noted in Section I above, the personnel file and privilege request will be reviewed by the Department Manager of the area(s) in which the Practitioner will be working for review. Upon the department manager’s positive recommendation, the file will be forwarded to the applicable Physician Service or Department Chair. The Physician Service or Department Chair will review the personnel file and privilege request and provide input to the Department Manager.

III. Credentials Committee/Medical Executive Committee Review/Input

Prior to granting of privileges, the Medical Staff Credentials and Medical Executive Committees will be given the opportunity to review the application and privileges and provide input to the hospital. (Note: This does not have to occur in a meeting.)

IV. Final Approval

After the opportunity for medical staff input, the application and request for privileges is processed in accordance with human resources policy and privileges are granted by the board.
Single Set of Criteria

Joint Commission standards require the use of a single set of criteria for judging the competency of all clinicians who provide care, treatment, and services within the organization, regardless of whether they are an employee of the organization or an LIP. This also applies to students and volunteers who work in the same capacity as staff. Before providing care, treatment, or services, the qualifications and competence of a non-employee individual, brought into the organization by an LIP must be assessed by the organization and determined to be the same as the qualifications and competence required if the individual were to be employed by the organization to perform the same or similar services. If the service to be provided is not currently performed by anyone employed by the organization, leadership must consult the appropriate professional organization guidelines with respect to expectations for credentials and competence.

In addition, Joint Commission’s Management of Human Resources Standards require a hospital process to ensure that a person’s qualifications are consistent with job responsibilities. This applies to staff and students and volunteers who work in the same capacity as staff. Staff must supervise students when they provide patient/resident/client care, treatment, and services as part of their training. If the hospital or law/regulation requires current licensure, certification, or registration, the organization must verify these credentials at the time of hire and on expiration. The hospital must also verify:

- Education, experience, and competence appropriate for assigned responsibilities
- Information on criminal background if required by law and regulation or organization policy
- Compliance with applicable health screening requirements established by the organization.

The hospital must review the qualifications, performance, and competence of each non-employee individual brought into the organization by a licensed independent practitioner to provide care, treatment, or services at the same frequency as individuals employed by the organization. This means that if an annual evaluation is conducted for hospital staff, the same must be done for AHPs providing the same services who are credentialed through the medical staff. (Note: Annual evaluations are not required by Joint Commission.)
# Sample Indicators for LIP APRNs and PAs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>FPPE</th>
<th>OPPE</th>
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</thead>
<tbody>
<tr>
<td>Nurse Midwife</td>
<td>• Proctor for first 2 cases vaginal delivery</td>
<td>• 3rd and 4th degree lacerations following vaginal delivery</td>
</tr>
<tr>
<td></td>
<td>• Review of charts for first 5 cases</td>
<td>• Delivery unattended by provider</td>
</tr>
<tr>
<td></td>
<td>• Discussion with nurse manager of OB and NB nursery</td>
<td>• Significant birth trauma</td>
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<tr>
<td></td>
<td></td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>CRNA</td>
<td>• Anesthesiologist present in OR room to proctor first 2 major surgical procedures</td>
<td>• ICU admission due to anesthesia management</td>
</tr>
<tr>
<td></td>
<td>• Discussion with OR nurse manager/OR staff</td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>Emergency Department PA</td>
<td>• ED physician closely monitor/proctor for (X) shifts</td>
<td>• Death in ED.</td>
</tr>
<tr>
<td></td>
<td>• Visual monitoring of (X) procedures performed</td>
<td>• Unplanned returns within 48 hours for same complaint.</td>
</tr>
<tr>
<td></td>
<td>(suture of laceration, removal of foreign body, nasogastric intubation etc.)</td>
<td>• Patients admitted to Med/Surg and moved to ICU within 4 hours of admission</td>
</tr>
<tr>
<td>APRN</td>
<td>Customize per medical specialty</td>
<td>• Refer to other health care professionals, as appropriate</td>
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<tr>
<td></td>
<td></td>
<td>• Order appropriate diagnostic tests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical records documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any department-specific indicators relevant to all LIPs</td>
</tr>
</tbody>
</table>
Department of Emergency Medicine
Focused Professional Practice Evaluation (FPPE) Proctoring

INFORMATION

PRACTITIONER’S NAME: __________________________________________

EVALUATOR’S NAME: __________________________________________

MEDICAL RECORD NUMBER:______________________________________

VISIT DATE: _________________________

OBSERVATION:

<table>
<thead>
<tr>
<th></th>
<th>SATISFACTORY</th>
<th>UNSATISFACTORY</th>
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<tr>
<td>ACCURACY OF DIAGNOSIS &amp; MEDICAL JUDGEMENT</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>QUALITY OF MEDICAL RECORDS</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>COOPERATION WITH HOSPITAL STAFF</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>RELATIONSHIP WITH PATIENT</td>
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EVALUATION OF CLINICAL CARE PROVIDED:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

EVALUATORS SIGNATURE: __________________________________________

DATE: ____________

Kathy Matzka, CPMSM, CPCS  3/2015  Page 9
Provisional Performance Evaluation Nurse Practitioner or Physician Assistant

CONFIDENTIAL FOR FILE OF:

<table>
<thead>
<tr>
<th>Practitioner Name:</th>
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<table>
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<tr>
<th>Evaluator(s):</th>
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<table>
<thead>
<tr>
<th>Patient Medical Record #:</th>
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<table>
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<tr>
<th>Diagnosis or Procedure:</th>
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<table>
<thead>
<tr>
<th>Complications:</th>
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PLEASE ANSWER ALL OF THE FOLLOWING
(If the answer to any of the following questions is no, please attach an explanation)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1.</td>
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<td>4.</td>
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<td>8.</td>
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<td>9.</td>
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(OVER)
Credentialing and Privileging AHP and CAM

Provisional Performance Evaluation
Nurse Practitioner/Physician Assistant - Page Two

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>11. Was the practitioner’s use of the following services appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. X-Ray</td>
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<td></td>
<td>b. Lab</td>
<td></td>
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<tr>
<td></td>
<td>c. Invasive Diagnostic Procedures</td>
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<tr>
<td>12. Was the practitioner’s technique for procedures appropriate? (if applicable)</td>
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<tr>
<td>13. Did pre-admission diagnosis coincide with discharge findings?</td>
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<tr>
<td>14. Were complications (if any) recognized and managed appropriately?</td>
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</table>

(If the answer to any of the following questions is yes, please attach an explanation)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was there evidence of any patient dissatisfaction with the practitioner?</td>
<td></td>
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<tr>
<td>2. Was there any evidence of unethical behavior on the part of the practitioner?</td>
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<td>3. Did the practitioner exhibit any disruptive or inappropriate behavior?</td>
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<tr>
<td>4. Was there any evidence that the practitioner did not adhere to Medical Center or Medical Staff policies, bylaws or rules and regulations?</td>
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</tbody>
</table>

Comments/Additional Information

Practitioner Evaluator’s Signature ___________________________ Date ____________

Kathy Matzka, CPMSM, CPCS 3/2015
# Anesthesia Proctor's Report

<table>
<thead>
<tr>
<th>Patient medical record number</th>
<th>Proctoring Anesthetist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Anesthetist</td>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Procedure</td>
<td>Emergency case</td>
</tr>
</tbody>
</table>

**Evaluate in Terms of Completeness and Accuracy:**

<table>
<thead>
<tr>
<th>1. ANESTHESIA PLAN</th>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Preop Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Special Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Technique</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

<table>
<thead>
<tr>
<th>2. ANESTHETIC MANAGEMENT</th>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Use of Appropriate Agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Control of Hemodynamic Stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Response to Changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Fluid and Blood Replacement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

<table>
<thead>
<tr>
<th>3. IMMEDIATE POSTOP CARE</th>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Emergence from Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Analgesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Appropriate Orders</td>
<td></td>
<td></td>
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</tbody>
</table>

Comments

<table>
<thead>
<tr>
<th>4. CONDUCT OF PROCEDURES (if indicated)</th>
<th>Acceptable</th>
<th>Unacceptable</th>
</tr>
</thead>
</table>

Comments

<table>
<thead>
<tr>
<th>5. OVERALL PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unacceptable</td>
</tr>
<tr>
<td>a. Cooperation with Colleagues and Staff</td>
</tr>
<tr>
<td>b. Overall impression of care provided</td>
</tr>
<tr>
<td>c. Is there any aspect of this patient's care with which you are uneasy or uncomfortable?</td>
</tr>
</tbody>
</table>

Comments

Date                     Proctoring Anesthesiologist Signature
Recredentialing

Recredentialing is the process of obtaining and evaluating data to support the continued competence of the healthcare practitioner to provide patient care services in or for a healthcare organization. Reappointment is performed to reevaluate the provider, assure competency, update files, and make sure privileges reflect practice.

The process for reappointment, reappraisal and renewal of clinical privileges must be defined in the Medical Staff Bylaws and or policies and procedures. This should include the applicant’s responsibilities, the medical staff’s methods of evaluation and recommendation and the governing body’s authority to reappoint. The reappointment process collects a great deal of information from various sources within and outside the institution. The Bylaws or policies and procedures should specify the professional criteria which will be applied to MS members and others with clinical privileges. In evaluating physician-employed AHPs, an evaluation by the employer may be required.

Joint Commission Standards Regarding Reappointment of LIPs

Independent AHPs privileged through the medical staff process are subject to the requirements of the medical staff bylaws.

Joint Commission standards require that grants of privileges do not exceed two years. On renewal of privileges, the medical staff evaluates individuals for their continued ability to provide quality care, treatment, and services for the privileges requested as defined in the medical staff bylaws. The process for renewal of privileges involves the same steps as those outlined under the standards for granting initial privileges. It also requires the medical staff to evaluate a practitioner’s ability to perform the privileges requested based upon his or her performance during the period of time he or she has been practicing at the organization.

Joint Commission standards require that the same four professional criteria used for assessment at the time of initial appointment also be used at the time of reappointment: licensure, relevant training or experience, current competence, and ability to perform the privileges requested. In addition, decisions on reappointments must consider criteria that are directly related to the quality of care and must include at least: previously successful or currently pending challenges to any licensure or registration or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital and involvement in a professional liability action under circumstances specified in the medical staff bylaws, rules and regulations and policies. The results of ongoing and focused professional practice evaluation must be evaluated at recredentialing.

Each individual’s participation in continuing education must be documented and considered in decisions about reappointment to the medical staff or renewal or revision of individual clinical privileges.

The medical staff must use peer recommendations in its consideration of recommendations for appointment and initial granting of privileges and in consideration
of termination from the medical staff or revision/revocation of clinical privileges. Peer recommendations may be used to recommend individuals for the renewal of clinical privileges when insufficient practitioner-specific data are available. The peer must be an appropriate practitioner in the same professional discipline as the applicant with personal knowledge of the applicant. In situations where there is no peer available for a specific category or LIP, it may be necessary to obtain a reference from a physician with essentially equal qualifications who is familiar with the LIP’s performance. For example, a pediatrician could provide a reference for a pediatric nurse practitioner, or an internist could provide a reference for an adult nurse practitioner. The recommendation should come from someone in the same clinical specialty.

Peer recommendations must address the practitioner’s relevant training and experience, current competence, and any effects of health status on privileges being requested.

Approved sources for peer recommendations include:

- a hospital performance improvement committee, the majority of whose members are the applicant’s peers;
- reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant’s professional performance and competence;
- a department or major clinical service chairperson who is a peer; or
- the medical staff executive committee.

Additionally, peer recommendations must include evaluation of the applicant’s medical knowledge, technical and clinical skills, clinical judgment, communication skills, interpersonal skills, professionalism.

National Practitioner Data Bank (NPDB) Query for AHPs

The NPDB was created by Title IV of P.L. 99-660, the Health Care Quality and Improvement Act of 1986, as amended. Its intent is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior and to restrict the ability of incompetent practitioners to move from State to State without disclosure or discovery of previous medical malpractice payment and adverse action history.

Hospitals are the only health care entities with mandatory requirements for querying. This must be done:

- When a practitioner applies for privileges/ medical staff membership
- Every 2 years for practitioners on the medical staff or holding privileges
- Expanding existing privileges
- Temporary privileges
NPDB querying and reporting requirements apply to physicians, dentists, and other licensed health care practitioners. **Other health care practitioners** are defined as individuals other than physicians or dentists who are licensed or otherwise authorized (certified or registered) by a State to provide health care services; or individuals who, without authority, hold themselves out to be so licensed or authorized. 2010 changes to Section 1921 of the Social Security Act expanded the information that the NPDB collects and discloses on nurses and other practitioners, but did not extend new reporting requirements to hospitals. Hospitals may, but are not required to report actions taken against the clinical privileges of allied health professionals.

**COMPLEMENTARY AND ALTERNATIVE MEDICINE**

According to the National Center for Complementary and Alternative Medicine:

“CAM is a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. Complementary medicine is used together with conventional medicine, and alternative medicine is used in place of conventional medicine. Integrative medicine combines conventional and CAM treatments for which there is evidence of safety and effectiveness. While scientific evidence exists regarding some CAM therapies, for most there are key questions that are yet to be answered through well-designed scientific studies—questions such as whether these therapies are safe and whether they work for the purposes for which they are used. NCCAM's mission is to explore CAM practices using rigorous scientific methods and build an evidence base for the safety and effectiveness of these practices.”


**NCCAM**
National Institutes of Health
9000 Rockville Pike
Bethesda, Maryland 20892 USA

**Major Domains of Complementary and Alternative Medicine**

Complementary and alternative healthcare and medical practices (CAM) are those healthcare and medical practices that are not currently an integral part of conventional medicine. The list of practices that are considered CAM changes continually as CAM practices and therapies that are proven safe and effective become accepted as "mainstream" healthcare practices. Today, CAM practices may be grouped within five major domains: (1) alternative medical systems, (2) mind-body interventions, (3) biologically-based treatments, (4) manipulative and body-based methods, and (5) energy therapies. The individual systems and treatments comprising these categories are too numerous to list in this document. Thus, only limited examples are provided within each.
Alternative Medical Systems

Alternative medical systems involve complete systems of theory and practice that have evolved independent of and often prior to the conventional biomedical approach. Many are traditional systems of medicine that are practiced by individual cultures throughout the world, including a number of venerable Asian approaches.

Traditional oriental medicine emphasizes the proper balance or disturbances of qi (pronounced chi), or vital energy, in health and disease, respectively. Traditional oriental medicine consists of a group of techniques and methods, including acupuncture, herbal medicine, oriental massage, and qi gong (a form of energy therapy described more fully below). Acupuncture involves stimulating specific anatomic points in the body for therapeutic purposes, usually by puncturing the skin with a needle.

Ayurveda is India's traditional system of medicine. Ayurvedic medicine (meaning "science of life") is a comprehensive system of medicine that places equal emphasis on body, mind, and spirit, and strives to restore the innate harmony of the individual. Some of the primary Ayurvedic treatments include diet, exercise, meditation, herbs, massage, exposure to sunlight, and controlled breathing.

Other traditional medical systems have been developed by Native American, Aboriginal, African, Middle-Eastern, Tibetan, Central and South American cultures.

Homeopathy and naturopathy also are examples of complete alternative medical systems. Homeopathy is an unconventional Western system that is based on the principle that "like cures like," i.e., that the same substance that in large doses produces the symptoms of an illness, in very minute doses cures it. Homeopathic physicians believe that the more dilute the remedy, the greater its potency. Therefore, homeopaths use small doses of specially prepared plant extracts and minerals to stimulate the body's defense mechanisms and healing processes in order to treat illness.

Naturopathy views disease as a manifestation of alterations in the processes by which the body naturally heals itself and emphasizes health restoration rather than disease treatment. Naturopathic physicians employ an array of healing practices, including diet and clinical nutrition; homeopathy; acupuncture; herbal medicine; hydrotherapy (the use of water in a range of temperatures and methods of applications); spinal and soft-tissue manipulation; physical therapies involving electric currents, ultrasound, and light therapy; therapeutic counseling; and pharmacology.

Mind-Body Interventions

Mind-body interventions employ a variety of techniques designed to facilitate the mind's capacity to affect bodily function and symptoms. Only a subset of mind-body interventions are considered CAM. Many that have a well-documented theoretical basis, for example, patient education and cognitive-behavioral approaches are now considered "mainstream." On the other hand, meditation, certain uses of hypnosis, dance, music, and art therapy, and prayer and mental healing are categorized as complementary and alternative.
Biological-Based Therapies

This category of CAM includes natural and biologically-based practices, interventions, and products, many of which overlap with conventional medicine's use of dietary supplements. Included are herbal, special dietary, orthomolecular, and individual biological therapies.

Herbal therapies employ individual or mixtures of herbs for therapeutic value. An herb is a plant or plant part that produces and contains chemical substances that act upon the body. Special diet therapies, such as those proposed by Drs. Atkins, Ornish, Pritikin, and Weil, are believed to prevent and or control illness as well as promote health. Orthomolecular therapies aim to treat disease with varying concentrations of chemicals, such as, magnesium, melatonin, and mega-doses of vitamins. Biological therapies include, for example, the use of laetrile and shark cartilage to treat cancer and bee pollen to treat autoimmune and inflammatory diseases.

Manipulative and Body-Based Methods

This category includes methods that are based on manipulation and/or movement of the body. For example, chiropractors focus on the relationship between structure (primarily the spine) and function, and how that relationship affects the preservation and restoration of health, using manipulative therapy as an integral treatment tool. Some osteopaths, who place particular emphasis on the musculoskeletal system, believing that all of the body's systems work together and that disturbances in one system may have an impact upon function elsewhere in the body, practice osteopathic manipulation. Massage therapists manipulate the soft tissues of the body to normalize those tissues.

Energy Therapies

Energy therapies focus either on energy fields originating within the body (biofields) or those from other sources (electromagnetic fields).

Biofield therapies are intended to affect the energy fields, whose existence is not yet experimentally proven, that surround and penetrate the human body. Some forms of energy therapy manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi gong, Reiki and Therapeutic Touch. Qi gong is a component of traditional oriental medicine that combines movement, meditation, and regulation of breathing to enhance the flow of vital energy (qi) in the body, to improve blood circulation, and to enhance immune function. Reiki, the Japanese word representing Universal Life Energy, is based on the belief that by channeling spiritual energy through the practitioner the spirit is healed, and it in turn heals the physical body. Therapeutic Touch is derived from the ancient technique of "laying-on of hands" and is based on the premise that it is the healing force of the therapist that affects the patient's recovery and that healing is promoted when the body's energies are in balance. By passing their hands over the patient, these healers identify energy imbalances.

Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating current or direct current.
fields, to, for example, treat asthma or cancer, or manage pain and migraine headaches.

Guidelines for Use of CAM

Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice – Federation of State Medical Boards

In 1995, the Federation of State Medical Boards established a special committee charged with developing strategies for recommendation to state medical boards for the regulation and discipline of physicians who engage in unsafe and/or deceptive health care practices. The Federation’s House of Delegates adopted the Committee’s recommendations as policy in April 1997. That same year, the Committee was charged with providing objective information to medical boards for their use in educating licensees, the public and state legislators on issues surrounding health care practices that may be potentially harmful and/or deceptive. In 2000, the Committee was charged with the development of these guidelines

Introduction

Physicians, indeed all health-care professionals, have a duty not only to avoid harm but also a positive duty to do good— that is, to act in the patient’s best interest[s]. This duty of beneficence takes precedence over any self-interest. Because of the increasing interest in and use of complementary and alternative therapies in medical practices (CAM), state medical boards have a responsibility to assure that licensees utilize CAM in a manner consistent with safe and responsible medicine. On behalf of the Federation of State Medical Boards and its continued commitment to assist state medical boards in protecting the public and improving the quality of health care in the United States, the Special Committee for the Study of Unconventional Health Care Practices (Complementary and Alternative Medicine), undertook an initiative in April 2000 to develop model guidelines for state medical boards to use in educating and regulating (1) physicians who use CAM in their practices, and/or (2) those who co-manage patients with licensed or otherwise state regulated CAM providers. CAM is a fluid concept that has been defined differently by various organizations and groups. For the purposes of these guidelines, the Committee has chosen to use the term CAM as defined by the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM) (see Definitions). The Committee acknowledges that some therapies deemed CAM today may eventually be recognized as conventional, based on evidence over time. This initiative focuses on encouraging the medical community to adopt consistent standards, ensuring the public health and safety by facilitating the proper and effective use of both conventional and CAM treatments, while educating physicians on the adequate safeguards needed to assure these services are provided within the bounds of acceptable professional practice. The Committee believes adoption of guidelines based on this model will protect legitimate medical uses of CAM while avoiding unacceptable risk. The intention of the Committee is to provide guidelines that are clinically responsible and ethically appropriate. These guidelines are designed to be consistent with what state medical boards generally consider to be within the boundaries of professional practice and accepted standard of care.
Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice

Section I. Preamble
The (name of board) recognizes that the practice of medicine consists of the ethical application of a body of knowledge, principles and methods known as medical science and that these objective standards are the basis of medical licensure for physicians of the state of (name of state). These standards allow a wide degree of latitude in physicians’ exercise of their professional judgment and do not preclude the use of any methods that are reasonably likely to benefit patients without undue risk. Furthermore, patients have a right to seek any kind of care for their health problems. The Board also recognizes that a full and frank discussion of the risks and benefits of all medical practices is in the patient’s best interest.

There are varying degrees of potential patient harm that can result from either conventional medical practices or CAM:

Economic harm, which results in monetary loss but presents no health hazard;

- Indirect harm, which results in a delay of appropriate treatment, or in unreasonable expectations that discourage patients and their families from accepting and dealing effectively with their medical conditions;
- Direct harm, which results in adverse patient outcome.

Regardless of whether physicians are using conventional treatments or CAM in their practices, they are responsible for practicing good medicine by complying with professional standards and regulatory mandates. In consideration of the above potential harms, the (name of board) will evaluate whether or not a physician is practicing appropriate medicine by considering the following practice criteria. Is the physician using a treatment that is:

- effective and safe? (having adequate scientific evidence of efficacy and/or safety or greater safety than other established treatment models for the same condition)
- effective, but with some real or potential danger? (having evidence of efficacy, but also of adverse side effects)
- inadequately studied, but safe? (having insufficient evidence of clinical efficacy, but reasonable evidence to suggest relative safety)
- ineffective and dangerous? (proven to be ineffective or unsafe through controlled trials or documented evidence or as measured by a risk/benefit assessment)

Inasmuch as the (name of board) is obligated under the laws of the state of (name of state) to protect the public’s health, safety and welfare and recognizes that the standards used in evaluating health care practices should be consistent, whether such practices are regarded as conventional or CAM, the Board recognizes that a licensed physician shall not be found guilty of unprofessional conduct for failure to practice medicine in an acceptable manner solely on the basis of utilizing CAM. Instead, the
Board will use the following guidelines to determine whether or not a physician’s conduct constitutes a violation of the state’s Medical Practice Act.

Section II.

Definitions
For the purposes of these guidelines, the following terms are defined as indicated:

Complementary and Alternative Therapies in Medical Practices (CAM)

CAM refers to a broad range of healing philosophies (schools of thought), approaches and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional Oriental medicine to promote well-being or treat health conditions. People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a complementary or an integrative approach. Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional and spiritual aspects.

Conventional Medical Practices

Conventional medical practices refer to those medical interventions that are taught extensively at U.S. medical schools, generally provided at U.S. hospitals, or meet the requirements of the generally accepted standard of care.

Section III. Guidelines

The (name of board) has adopted the following guidelines when evaluating the delivery or co-management of CAM:

1. Evaluation of Patient

Parity of evaluation standards should be established for patients whether the physician is using conventional medical practices or CAM. Prior to offering any recommendations for conventional and/or CAM treatments, the physician shall conduct an appropriate medical history and physical examination of the patient as well as an appropriate review of the patient’s medical records. This evaluation shall include, but not be limited to, conventional methods of diagnosis and may include other methods of diagnosis as long as the methodology utilized for diagnosis is based upon the same standards of safety and reliability as conventional methods, and shall be documented in the patient’s medical record. The medical record should also document:

- what medical options have been discussed, offered or tried, and if so, to what effect, or a statement as to whether or not certain options have been refused by the patient or guardian; that proper referral has been offered for appropriate treatment;
that the risks and benefits of the use of the recommended treatment to the extent known have been appropriately discussed with the patient or guardian;
that the physician has determined the extent to which the treatment could interfere with any other recommended or ongoing treatment.

2. Treatment Plan

The physician may offer the patient a conventional and/or CAM treatment pursuant to a documented treatment plan tailored to the individual needs of the patient by which treatment progress or success can be evaluated with stated objectives, such as pain relief and/or improved physical and/or psychosocial function. Such a documented treatment plan shall consider pertinent medical history, previous medical records and physical examination, as well as the need for further testing, consultations, referrals or the use of other treatment modalities. The treatment offered should:

- have a favorable risk/benefit ratio compared to other treatments for the same condition;
- be based upon a reasonable expectation that it will result in a favorable patient outcome, including preventive practices;
- be based upon the expectation that a greater benefit will be achieved than that which can be expected with no treatment.

3. Consultation and/or Referral to Licensed or Otherwise State-Regulated Health Care Practitioners

The physician may refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives and may include referral to a licensed or otherwise state-regulated health care practitioner with the requisite training and skills to utilize the CAM therapy being recommended. However, the physician is responsible for monitoring the results and should schedule periodic reviews to ensure progress is being achieved.

4. Documentation of Medical Records

The physician should keep accurate and complete records to include:

- the medical history and physical examination;
- diagnostic, therapeutic and laboratory results;
- results of evaluations, consultations and referrals;
- treatment objectives;
- discussion of risks and benefits;
- appropriate informed consent;
- treatments;
- medications (including date, type, dosage and quantity prescribed);
- instructions and agreements;
- periodic reviews.

Records should remain current and be maintained in an accessible manner, and readily available for review.
5. Education

All physicians must be able to demonstrate a basic understanding of the medical scientific knowledge connected with any method they are offering or using in their medical practices as a result of related education and training.

6. Sale of Goods from Physician Offices

Due to the potential for patient exploitation, physicians should not sell, rent or lease health-related products or engage in exclusive distributorships and/or personal branding;

- Physicians should provide a disclosure statement with the sale of any goods, informing patients of their financial interest; and
- Physicians may distribute products to patients free of charge or at cost in order to make products readily available.
- Exceptions should be made for the sale of durable medical goods essential to the patient’s care, as well as nonhealth-related goods associated with a charitable or service organization. [Language on the sale of goods from physician offices is contained in the report of the Special Committee on Professional Conduct and Ethics as adopted in April 2000.]

7. Clinical Investigations

As expected of those physicians using conventional medical practices, physicians providing CAM therapies while engaged in the clinical investigation of new drugs and procedures (a.k.a. medical research, research studies) are obligated to maintain their ethical and professional responsibilities. Investigators shall be expected to conform to the following ethical standards:

- Clinical investigations should be part of a systematic program competently designed, under accepted standards of scientific research, to produce data which are scientifically valid and significant.
- A clinical investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the patient involved as is required of a physician who is furnishing medical care to a patient independent of any clinical investigation.

Furthermore, investigators shall be expected to abide by all federal guidelines and safeguards, such as approval and monitoring of the clinical trial by an Institutional Review Board (IRB), when applicable, to ensure the risks to the patient are as low as possible and are worth any potential benefits.

In Conclusion

The Committee recognizes that legitimate standards of medical practice are rooted in competent and reliable scientific evidence and experience. However, these standards are subject to continual change and improvement as advances are made in scientific
investigation and analysis. In addition, standards of medical practice to some degree, and the provision of medical services in individual circumstances in particular, are influenced by psychological, social, political and market forces. It is the responsibility of state medical boards to balance all of these considerations in fulfilling their mission of protecting the public through the regulation of the practice of medicine. Public protection is carried out, in part, by ensuring physicians in all practices, whether conventional or CAM, comply with professional, ethical and practice standards and act as responsible agents for their patients. Accordingly, the Federation encourages state medical boards to adopt these guidelines to assist them in educating and regulating physicians who are (1) engaged in a practice environment offering conventional and/or CAM treatments; and/or (2) engaged in cooperative therapeutic relationships for their patients with a non-physician licensed or otherwise state-regulated health care practitioner offering CAM. State medical boards should ensure a balance between the goal of medical practices being evidence-based while remaining compassionate and respectful of the dignity and autonomy of patients. This balance should also ensure informed consent and minimize the potential for harm. The Federation reaffirms its commitment to cooperate with physicians and professional, governmental and other organizations and agencies in supporting the further study of all health care practices that offer promise.

CAM RESOURCES


NCCAM Clearinghouse

Toll-free: 1-888-644-6226
International: 301-519-3153
TTY (for deaf or hard-of-hearing callers): 1-866-464-3615
E-mail: info@nccam.nih.gov
Web site: nccam.nih.gov
Address: NCCAM Clearinghouse, P.O. Box 7923, Gaithersburg, MD 20898-7923
Fax: 1-866-464-3616
Fax-on-Demand Service: 1-888-644-6226
http://nccam.nih.gov/

Department of Defense Forms

Includes searchable database with privilege forms for all branches of the military.

http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm
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TEST YOUR KNOWLEDGE

1. According to Joint Commission standards for the hospital, non-independent employees of a medical staff appointee who provide care in the hospital must have an evaluation at the same frequency as hospital employees.
   □ True □ False

2. Which of the following is an example of a typical licensed independent practitioner?
   a. dental assistant
   b. surgical technician
   c. advance practice nurse
   d. medical assistant

3. If a physician assistant is making clinical diagnosis and treatment decisions, he/she should be granted clinical privileges through the medical staff process.
   □ True □ False

4. According to Joint Commission standards for the hospital, PAs and APRNs who are not providing a medical level of care can be credentialed and privileged through the medical staff process or an equivalent process that has been approved by the governing body. Which of the following is an element of the equivalent process?
   a. Evaluation of the applicant’s current competence
   b. Credentials Committee review and recommendation
   c. Due process
   d. Review by a multidisciplinary committee consisting of nursing managers

5. According to Joint Commission standards for the hospital; before providing care, treatment, or services; the qualifications and competence of a non-employee individual, brought into the organization by an LIP must be assessed by the organization and determined to be the same as the qualifications and competence required if the individual were to be employed by the organization to perform the same or similar services.
   □ True □ False
6. Which of the following would be the most appropriate peer reference for a nurse midwife applicant?
   a. Physician assistant
   b. RN Nurse manager in the obstetrics department
   c. Another nurse midwife who has knowledge of the applicant’s quality of patient care
   d. The OB/GYN department chairman

7. Hospitals are required to report actions taken against the clinical privileges of allied health professionals to the National Practitioner Data Bank.
   □ True □ False

8. Which of the following practitioners would most likely perform manipulative and body-based methods?
   a. Physician assistant
   b. Chiropractor
   c. Medical doctor
   d. Advanced practice nurse

9. Acupuncture, herbs, homeopathy, therapeutic massage are examples of
   a. Complementary and alternative therapies
   b. Allied health professionals
   c. Pharmaceuticals
   d. Privileges

10. If the state allows a practitioner to work independently, a hospital must also allow the practitioner to function independently.
    □ True □ False
Correct Answers to Test Your Knowledge Questions

1. True
2. C
3. True
4. A
5. True
6. C
7. False
8. B
9. A
10. False