In the delivery of healthcare services, identifying and retaining well-trained and competent professionals is a key strategy for attaining an organization’s quality of care and patient safety objectives. Consumers of healthcare services expect that clinical professionals have the appropriate skills and qualifications and that the competencies of members of the care team have been substantiated.

Credentialing is the act of gathering information about a physician or medical provider to verify their training and identify their qualifications and eligibility to provide medical services in their area(s) of practice. This article presents a brief outline of the credentialing process, including a review of some of the areas that pose risks to organizations in order to help them establish an appropriate credentialing risk management strategy.

The principal area of focus of this article is risk associated with allegations of negligent credentialing of providers. Negligence is the failure to exercise the degree of care that a careful or prudent person would have exercised under the same circumstances. Additionally there is consideration in determining whether the conduct of a person lacks reasonable care and that there is likelihood that the person’s action or inaction will result in harm (1, Legal Information Institute). Negligent credentialing refers to professional liability for the failure to exercise appropriate care and diligence in authorizing physicians to provide professional services for a healthcare entity.
NEGLIGENT CREDENTIALING

The relationship between physicians and healthcare entities is typically that the physicians are independent contractors and not employees (although there is an increase in hospitals employing physicians). For non-employed physicians, it is often argued under common law that a hospital can only be vicariously liable for a physician’s acts if the physician is an employee of the hospital (2, Mcelwain v. Van Beek). Changes in the delivery of healthcare have prompted changes in how courts view the relationship between physicians and healthcare entities; facilities are now being held responsible for the negligence of independent contractor physicians (3, Levin; 4, Wiet).

In determining the basis for a negligent credentialing tort, there is generally an assertion that a healthcare facility has a duty to its patients to safeguard them from incompetent and careless providers, there was a breach of that duty, and the breach caused the patient’s injury, resulting in harm and associated damages (5, Heineman; 6, Burroughs).

The landmark legal case under negligent credentialing dates to 1965 in the state of Illinois in Darling v. Charleston Community Memorial Hospital (7, Watkins; 4, Wiet). In this case, Darling went to the emergency room of Charleston Community Memorial Hospital for a broken leg. The attending physician was a general practitioner named Dr. Alexander, who set the break and placed the patient’s leg in a cast. However, the cast was wrapped too tightly, resulting in circulatory restriction and subsequent necrosis. The patient underwent several surgeries to repair the damage, but the leg was ultimately amputated. Darling filed suit against both Dr. Alexander and the hospital; a few of assertions presented by Darling include:

- The physician’s skills in operative and orthopedic treatment procedures were not up-to-date
- The physician should have been prohibited from performing orthopedic treatment
- The physician was required to consult with a specialist for the case but did not do so

During the discovery period it was determined that no one at the hospital had verified any of the information provided by Dr. Alexander as part of the application process. The hospital was unable to demonstrate that during the credentialing process anyone had questioned or reviewed Alexander’s knowledge and skills for treating fractures. Dr. Alexander settled the case, while the hospital went to trial, which resulted in a $150,000 verdict for Darling. The hospital appealed the case, but it was affirmed by the court of appeals. The case then went to the Supreme Court of Illinois, which held that a hospital may be held liable for the negligence of its staff (4, Wiet).
Provider credentialing has developed into a complex process that includes an evaluation of core education, licenser exams, and an associated proof of training. In addition to validating a provider’s knowledge base, other areas evaluated include practice history; local, state, and federal background checks; and whether a provider has lost the privilege to practice at another healthcare organization. From a healthcare compliance perspective, those providers who work at facilities that participate in federally funded programs are evaluated initially and on a routine basis to ensure they are not excluded from participation. In our modern digital age, much of the needed information is available electronically and online. Because of the magnitude of information requested and assessed—often from multiple sources—accuracy, as well as ensuring that an established credentialing process is followed consistently and completely, is vital.

The criteria developed by an organization are reflected in the appropriate governance documents. Depending on the type of facility, there may be a specific set of medical staff bylaws, rules, and regulations that specifically address credentialing.

The following is a list of items that are reviewed as part of the credentialing process:

1. Education — including medical school, residency program(s), fellowship program(s), and any additional post-graduate training and certifications
2. Board certification — demonstrates a physician’s expertise in a particular specialty or sub-specialty of medical practice
3. Background check — an evaluation of local, state, and federal criminal history
4. Verification of the applicant’s driver’s license
THE CREDENTIALING PROCESS (CONT’D)

In addition to determining a provider’s skills and competencies, the credentialing process is also used to identify such issues as behavioral problems, professional practice issues, and inconsistencies with what has been submitted and what the credentialing process reveals. There are other potential risk areas that should be evaluated as well. Below is a list of potential risk areas for consideration (8, NAMSS; 9, Pelletier):

1. Incomplete application
2. Discrepancies between what was provided by the applicant and what was discovered during the verification process
3. Resignations from previous medical staff positions
4. Involuntary termination of medical staff membership and involuntary changes or denials of clinical privileges at another organization or organizations
5. Employment and professional practice issues during previous work engagements
6. Formal investigations by state medical licensing and medical staff review boards, which may or may not include sanctions
7. Formal investigations pertaining to fraud, abuse, anti-kickback, Centers for Medicare & Medicaid (CMS) Services requirements, and other federal healthcare compliance laws and regulations that may or may not include sanctions
8. Exclusion from participation in federally funded programs
9. Disciplinary actions during residency or fellowship programs and/or by previous healthcare organizations, state medical licensure boards, or professional organizations
10. Gaps in professional residency or fellowship training or practice history
11. Inability to hold Drug Enforcement Administration (DEA) registration
12. Inability to verify professional liability insurance coverage
13. Gaps in professional liability insurance coverage
14. History of jury verdicts and settlements of professional liability claims

RECOMMENDED PRACTICES

Depending on the size of the healthcare organization and the resources allocated to credentialing, there are recommended practices to consider to further enhance the credentialing process (7, Watkins; 6, Burroughs; 10, Illinois Hospital Association).

1. Exceed the minimum credentialing requirements. Organizations may opt to establish a program that meets the minimum set of credentialing elements published by professional organizations. However, establishing a program based on recommended best practices, as well as organization-specific risks identified in a proactive risk assessment, will add value to an existing credentialing program.

2. Consider use of third-party services. Whether your organization is large or small, it is good to evaluate the feasibility of utilizing third-party services for components of the credentialing process. Retaining a third-party vendor can help to improve consistency in specific elements of the credentialing process and reduce errors when a strong credentialing partner is identified.
3. Ensure the process is adequately hardwired. High-reliability organizations focus on key operational processes and build systems to ensure the success of the program (11, Studer). This success relies on establishing a strong program, thorough implementation, and the instituting of performance metrics and data collection that are evaluated and acted upon in the spirit of continuous quality improvement.

4. Emphasize the importance of the credentialing program and process with the medical staff and employees as a part of the overall patient safety and just culture of the organization.

5. Establish an audit process based on the organization’s continuous quality improvement and risk management programs.

It is recommended that organizations consider conducting a risk assessment of their internal credentialing process. The following are elements that are recommended to be included in the credentialing program and to be assessed routinely to determine the program's effectiveness (6, Burroughs).

1. The credentialing program is consistent with requirements set by accrediting organizations (e.g., The Joint Commission, if accredited), state licensing organizations, and Medicare Conditions of Participation.

2. The credentialing process is clearly outlined in governance documents, including medical staff bylaws and rules and regulations and associated organizational policies and procedures.

3. There are sufficient resources to effectively execute the credentialing process within the organization.

4. The credentialing process includes appropriate eligibility criteria that are consistently followed.

5. The medical staff bylaws include a requirement that applications must be complete before they are processed and that the application process cannot proceed until all questions and issues are addressed.

6. The bylaws include appropriate provisions for dealing with physicians that either do not respond properly or provide misleading or inaccurate information.

7. The credentialing model is based on continued monitoring that includes quality and safety in accordance with established peer review and quality management processes.

CONCLUSION

The quality and safety of patients is dependent upon the strength of an organization’s leadership and accountability—as well as the strength and integrity of its institutional programs and processes. Having a sound physician credentialing program and process in place that is appropriately hardwired and consistently followed is a key element in meeting the high standards today’s consumers have regarding healthcare organizations. In addition, strategies that improve patient safety processes can also result in helping prevent professional liability claims. Overall, a thorough credentiality program plays a vital role in supporting an organization’s delivery of safe, effective, and quality healthcare services.
REFERENCES


2. Mcelwain v. Van Beek, Minnesota Court of Appeals. 447 N.W.2d 442.


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