THE CREDENTIALS COMMITTEE MANUAL

MARK A. SMITH, MD, MBA, FACS
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HCPro
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Introduction

This book is intended to be a practical manual for anyone associated with a medical staff credentialing process. It is primarily aimed at the physician members of the credentials committee, but it will also serve physician leaders who are involved in the credentialing process at other points, such as department chairs, service line directors, or members of the medical executive committee. This manual will also be of value to the people who support the credentialing process, such as medical staff services and quality department personnel.

Why is credentialing important?

Credentialing is the process of establishing and verifying the qualifications of a licensed professional. These qualifications include their license, training, and experience, all of which help determine their competency to exercise the clinical privileges they are requesting. Any licensed practitioner who is granted privileges in your organization—including physicians and high-level advanced practice professionals, such as nurse practitioners and physician assistants—must undergo this credentialing process.

Like the rest of modern healthcare, the credentialing process is evolving. More information is available about practitioners, their education, and their outcomes than ever before, yet the credentialing process isn’t getting easier. In addition, more types of practitioners are being identified as needing clinical privileges and membership on the medical staff, so more are going through the credentialing process. For example, many organizations are starting to credential pharmacists because they are becoming more involved in the medication-prescribing process.
Introduction

A word about credentialing and privileging

Although they are closely related, credentialing and privileging are not the same process and will be discussed in detail in separate chapters. That said, typically, credentialing is the term used to describe the overall activity and, when used in a broad manner, includes privileging.

Despite the importance of this work, members of the credentials committee don’t always know what the committee’s purpose is, or they might view their appointment as “extra work.” Although the tasks associated with a credentials committee do take time and energy, they are not frivolous. Credentialing is often described as an institution’s most important activity toward guaranteeing delivery of quality of care. The premise is that, if an organization starts with only excellent practitioners, this will best ensure that excellent care will be delivered. This goal can only be achieved if the organization has an excellent credentialing process in place.

However, we recognize that people are not static over time. Even excellent practitioners may develop issues that affect their ability to continue delivering the highest level of clinical care. Therefore, a good credentialing process also includes an ongoing evaluation of clinical excellence at regular intervals, known generally as the reappointment process. To maintain quality care, rigorous reappointment activities are just as important as initial credentialing of practitioners.

What are the stakes?

The most commonly cited example of the importance of the credentialing process is the infamous case of Michael Swango, a serial killer who was a licensed physician. His case is discussed in detail in the book Blind Eye: The Terrifying Story of a Doctor Who Got Away with Murder, by James B. Stewart. This book should be mandatory reading for any medical staff leaders involved in credentialing and peer review. It details the horrific trail of murder that Swango left during his career as an EMT and then through medical school, multiple residencies, and clinical practice. Although some of his colleagues raised questions, Swango was able to evade the law time after time: He simply moved elsewhere and continued to practice. He was eventually caught after attempting to kill a patient during a tour at a mission hospital in Zimbabwe in 1994, and was apprehended as he attempted to travel to a new area to set up shop yet again. By that time, he might have been responsible for the deaths of 60 people.

Although the book indicates that questions about Swango began to surface as early as 1982, and suspicions followed him wherever he went, no one formally investigated or held him accountable.

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for his actions. There was no easily accessible record of his possible wrongdoing, so institution after institution had no chance to bring Swango’s egregious criminal behavior to light and possibly save lives. Cautionary tale, indeed!

Swango’s story is a notorious and extreme example, but Public Citizen’s Health Research Group estimates that at least 2,247 physicians were convicted of felonies between the years 1990 and 1999. It would not be a stretch to double that number to estimate the total number of physician felons present in the U.S. at the present time.\(^2\) And you probably won’t have to wait long until another news story appears about a physician who was allowed to continue practicing—and possibly endangering patients—because a hospital or health system didn’t thoroughly check his or her credentials and competence, or want to confront him or her and possibly jeopardize its reputation.

Fortunately, a more common issue today is the practitioner who just does not deliver an acceptable level of care, or presents behavior problems in his or her interpersonal interactions with patients, their families, or other providers. If credentialing isn’t done well, a committee might unknowingly admit these clinicians to the staff. Eventually, their limitations will be revealed, and then the institution is stuck with a much bigger problem. First, the institution will have allowed less than acceptable care to be delivered to patients, and second, it will be much more difficult to either remediate the problem or remove the provider from its staff.

Members of the credentials committee become the experts at doing this process well, and this expertise yields great dividends in the level of care delivered to all patients. Whether you’re a recent appointee to a credentials committee or a veteran committee member seeking a refresher on the mechanics of the credentialing process, I hope that this manual assists you in starting down the pathway to personal excellence in credentialing.

**Effective credentialing in action**

I received a call a few years ago from an internist who had been the president-elect of his Midwest institution at the time when I worked with his medical staff to improve the credentialing process. He reminded me that I suggested that everyone on the credentials committee read Blind Eye and how important it was to have every red flag explained before proceeding with application processing.

That advice paid off for his organization’s medical staff and medical staff services department. They had received an application from a physician who, they learned, had been convicted of

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driving under the influence. When they investigated that incident, they discovered that the physician had been disrespectful to the police officer, which had exacerbated the situation.

The internist was the prime reviewer of the file. Having received this information, he decided to make some direct phone calls to ask about the applicant’s behavior in the workplace. From those calls, he learned that the applicant had a terrible record for interpersonal interactions and that they were happy to see him leave. Based on that feedback, the internist then recommended that the applicant get a full psychological evaluation before the hospital processed the application any further.

At this point, the applicant decided to withdraw the application and went elsewhere. But the story didn’t end there.

A year later, the internist heard that this same physician had been admitted to another medical staff about 100 miles away and had created such problems with bad behavior that they suspended his privileges and were about to start a fair hearing process. The internist thanked me again for the advice and noted that this incident was the credentialing equivalent of a “near miss.”

You may not always get such clear confirmation of the importance of what you do, but excellent credentialing well pays off in a big way. I hope that this volume will help to start you down that pathway or reinforce your best practices.
Credentialing Principles

Although many physicians believe that they know a lot about credentialing, their medical staff service departments often think otherwise. In fact, when physicians routinely drag their feet when providing vital application or outcomes data—or deliver it only after the threat of loss of privileges—credentialing specialists often wonder whether certain members of their medical staff understand the process at all.

Every medical staff member should have a basic understanding of what goes into credentialing, but it is imperative for credentials committee members to thoroughly understand the credentialing process in their organization, the principles of credentialing, and the roles that they as members of the credentials committee play, both in evaluating an initial applicant and in reviewing the reappointment application for a current medical staff member. The committee members must understand the scope of the work that either their department or the group leaders and medical staff office personnel will conduct.

Once the pertinent data has been assembled, the credentials committee will focus primarily on review and recommendations. This portion of the manual provides a refresher on what the credentialing process entails as well as what constitutes a robust process.

A Robust Credentialing Process in Four Steps

What exactly is credentialing? In a healthcare setting, credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide patient care services in a healthcare organization.
A durable credentialing process consists of four steps:

1. **Create and follow policies and procedures**

   Before beginning any complex process, it is imperative to have a blueprint for that process in place. Such a blueprint for credentialing allows the process to be both efficient and consistent. Making up a process as you go along takes a lot of time and effort, and runs the risk of appearing to be arbitrary. Having the proper policies in place both makes the process much easier and saves time because all participants follow the same method.

   Following standardized steps for any process enables participants to become familiar with it if they do it often enough.

   Like policies, a consistent workflow is a cornerstone of an effective process. A process with variations can lead to unwanted outcomes, such as situations in which similar practitioners seeking appointment or reappointment are treated differently. For example, the organization’s policies for credentialing should list the basic information—licensure, training, experience, etc.—that must be collected for each initial application. If such a policy is in place and applied consistently, when two comparable physicians apply for membership to the medical staff, their applications will be considered based on the same information. The ultimate action (i.e., recommendation) may differ depending on the facts for each applicant, but the credentialing process will be equivalent for both practitioners.

   Does flexibility have a place in a process that is built on consistency? Yes, it does, and it’s an important place. Although members of the credentials committee are likely to inherit credentialing policies and procedures that they must learn and follow, as opposed to creating them from scratch, these existing policies and procedures are not written in stone. The credentials committee should review and modify them on a regular basis to ensure that they are relevant to the organization’s delivery of care, to accommodate changes in state and federal regulations and accreditor standards, and to reflect other aspects of modern healthcare. For example, the committee might need to review the recent changes in the National Practitioner Data Bank (NPDB) guidelines to see whether policy revisions are necessary.

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**A few words about the NPDB and ‘reportability’**

The 2015 *National Practitioner Data Bank Guidebook* update attempted to clarify whether certain actions must be reported to the NPDB. However, the update leaves some ambiguity around certain reporting scenarios. For example, if a physician doesn’t ask for renewal of medical staff membership or privileges, the lack of request is not reportable to the NPDB—unless an investigation is underway. If an investigation is underway at the end of the reappointment cycle and the physician doesn’t file an application to renew medical staff membership, then their lack of application can be considered a surrender of...
privileges in the face of an investigation, which is reportable. A routine failure to reapply is not an issue.

The changes in the NPDB guidance warrant conversations not just among the credentials committee, the medical executive committee (MEC), and the medical staff office but also with the governing body, senior management, and allied health professionals.

A new credentials committee member should start by learning and understanding the relevant credentialing policies and procedures.

2. **Collect and summarize data**

As alluded to in the case of the two cardiologists mentioned earlier, once the credentialing process is in place according to policy, support staff must collect and summarize data in an informative format. By and large, this work falls under the purview of the medical staff office or the credentials verification organization (CVO). Once they have completed the work, they then turn it over to the credentials committee for steps 3 and 4.

Sometimes in the course of collecting data, however, questions (or “red flags,” described later in this chapter) arise, and the physician members of the credentials committee will need to get involved. For instance, if the medical staff office or CVO uncovers questions about a particular applicant’s behavior at his or her previous workplace, a credentials committee member or another leader, such as a department chair, may need to have a phone conversation or two to confirm or deny the potential problem.

3. **Evaluate and recommend**

The department chairs and the credentials committee are both primarily responsible for assessing the compiled information. They check on the completeness of the staff’s information gathering and determine whether the file is clean or whether there are questions about the information in it. A clean file usually leads to recommendations of acceptance.

Questions need to be clarified before a recommendation can be delivered. If there is a department chair, section chair, or service line chief review, his or her recommendation typically gets referred up to the credentials committee. The credentials committee performs its work and makes the final recommendation, which it subsequently transmits to the MEC. Finally, the MEC makes the final medical staff assessment and recommendations, which it sends up to the board for step 4.

4. **Grant or deny**

Medical staff officers and committee members do not want to be responsible for the final actions on fellow practitioners because they may be accused of restraining free trade or anti-competitive
practices. However, this criticism can’t be applied to a board that consists mainly of people who are not in direct competition with applicant practitioners; therefore, granting or denying membership and privileges is the purview of the governing body, the board of trustees, or an equivalent body.

**Figure 1.1** The four steps of the credentialing process

<table>
<thead>
<tr>
<th>Create and follow policies and procedures</th>
<th>Collect and summarize data</th>
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<tr>
<td>Grant or deny</td>
<td>Evaluate and recommend</td>
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**Ground Rules for Effective Credentialing**

To get the best results from the general process for credentialing, the credentials committee members must adhere to a set of ground rules, or principles. This section will discuss a basic set of such principles that are necessary for optimal credentialing. Over time, medical staffs may modify the set or include additional principles to hone the process for their specific situation.

*The patient comes first*

Hopefully, this premise is obvious and permeates every area of your organization, but as a credentials committee member, you might encounter situations in which the best interests of the patient might not be easy to identify. One reason for this challenge is the complexity of today’s healthcare systems. (See Figure 1.2.)
The organized medical staff is a group of medical providers. Most of the providers are physicians, but they also can include other licensed independent practitioners (LIP) such as psychologists, nurse practitioners (NP), and physician assistants (PA). The organized medical staff functions under the umbrella of a hospital, a hospital system, or a healthcare organization, but it maintains a certain degree of independence. Members function according to their own set of bylaws, policies and procedures, and rules and regulations. Still, they must also abide by the policies and rules of the hospital or organization.

Medical staff leadership reports to the governing body, which is often called a board of trustees. The governing body delegates two major responsibilities to the organized medical staff: The first is to evaluate and make recommendations on credentials and privileges for all LIPs. The organized medical staff does so both for new LIPs and for current practitioners at reappointment.

The organized medical staff’s second responsibility is to evaluate and maintain the quality of care delivered by the LIPs under the system known as peer review. For the purposes of legal protections, all of these activities—credentialing, privileging, and peer review—fall under a single category: peer-review activities.
From the board’s standpoint, the medical staff is a representative body that elects an MEC to govern the medical staff. Therefore, the board deals with the MEC and holds it responsible for the delegated duties. The MEC, in turn, generally creates other committees to help carry out their assigned responsibilities. For credentialing and privileging matters, the MEC delegates responsibilities to the credentials committee.

When looking at the credentialing and privileging recommendations, the medical staff develops criteria for both basic medical staff membership and for specific privileges. If an applicant meets the criteria after all of his or her data is collected and analyzed, then the medical staff generally gives a favorable recommendation to the applicant.

At the end of the day, all of this activity is designed to ensure the quality of care delivered to patients. Whenever difficult decisions arise in either the credentialing or peer review areas, the ultimate factor that should guide those decisions is what is best for patients and for patient care—not what is best for the practitioner or for the hospital.

Of course, there are complicating factors:

1. The medical staff is usually a collegial group of professionals. Studies have shown that, as healers, physicians and advanced practice professionals generally do not like to confront their colleagues directly if they have concerns.

2. Hospitals are functioning in a time of very narrow margins and extreme economic pressure. Certain decisions are better made quickly rather than over a long period of time, which would incur a delay of production and revenue.

For example, when hospitals employ physicians, as is the case more and more frequently today, they have an incentive to get those physicians working quickly so that they’re not paying high salaries to practitioners who aren’t seeing patients. As a result, the administration often pressures the medical staff to speed up the credentialing process for these employed practitioners. Hospitals aren’t under quite as much economic pressure to bring independent physicians on board quickly, however, so they’re less likely to lean on the medical staff office or the medical staff to get independent physicians credentialed ASAP.

Members of a credentials committee may take on these and other stresses while they carry out their work. Nevertheless, these influences should play no part in credentials deliberations. Again, what is best for the patient should prevail.

The connection between patient care and credentialing decisions might not always be readily apparent, but consider that many patients come into a hospital setting requiring emergency care. They do not have the time or resources to evaluate the quality of the physicians who take care of them. They depend on the hospital and the medical staff to do that. No one wants a Michael
Swango type—or any other criminal who happens to hold a medical degree—to be his or her attending physician. Patients expect physicians to be who they say they are, and they expect that these professionals did indeed attend medical school, are sufficiently trained in the appropriate specialty, and practice with an acceptable level of care outcomes.

Credentialing done well is the method through which the medical staff and hospital can make good on their assurances to patients. To quote what is probably the most famous line from the movie *Apollo 13*, “Failure is not an option.” Credentialing well is a moral responsibility shared by all participants in medical staff credentialing—including credentials committee members.

If there is a dilemma or potential conflict in a credentialing decision, such as insufficient experience to demonstrate competence, always act in the patient’s best interests. Do so even if it means you arrive at a decision that runs counter to what your colleagues had in mind.

**The applicant’s problems are not the institution’s problems; put the burden of proof on the applicant.**

If meeting the criteria established in your medical staff policies and procedures is a burden for the applicant, it is not your job to see that the applicant meets the criteria. For example, say there is an applicant with a history of alcohol abuse. She states that this issue is in the past and that she has been sober for five years. Your policy requires that she contact the state medical board’s practitioner well-being committee for an evaluation. If she chooses not to do so, then you do not have to process her application.

These situations can and will arise periodically, but you should not fall into the trap of doing an applicant’s work for him or her. It’s worth repeating: Put the burden on the practitioner. If a physician on staff is applying for reappointment and has indicated that there have been five malpractice lawsuits since his last appointment, then the applicant can be told that his application for reappointment will not be processed unless he delivers files and particulars on all five cases. That is the extent of the hospital’s duty to the physician.

Putting the burden on the applicant, along with not processing the application until all criteria are met and all information has been processed, creates simplified strategies for dealing with most negative situations without incurring the downside of a fair hearing process.

**Facilitate clinical practice**

Putting the patient first is the most important tenet of sound credentialing, but it’s also vital that committee members aid their fellow practitioners to allow clinical practice to progress. In other words, credentialing should not be an unnecessary barrier to the physician. Until fairly recently, it was common for initial applications to take an average of 60 to 90 days to complete—and that
was when there were no problems on the application. The process may have been thorough, but it was not expeditious.

Not that long ago, the paper forms that had to be filled out were enormous handwritten tomes, and the amount of data to be supplied was immense. Over the past decade or so, electronic forms and storage technology have enabled the credentialing system to be more efficient and somewhat simplified. This development has significantly cut the time required to process medical staff applications and renewals.

In addition to e-forms and easier information storage, online applications have reduced the time and paper necessary for applications—and for the credentialing process as well. Rapid verification of information has reduced processing time. For example, the NPDB, state boards of medicine, and medical schools can be queried in real time rather than waiting for a snail mail report to be delivered. See Chapter 7 for further discussion of technology’s impact on this process.

Medical staffs generally—and credentials committees, in particular—must periodically assess their processes to see whether there are additional opportunities for improvement and thus new ways to facilitate clinical practice. Larger facilities might have an IT committee or a chief medical information officer who is active in refining clinical information systems. After all, it is not only the hospital that benefits from a practitioner starting to practice in a timely manner: It is also advantageous for the practitioner.

As another way to facilitate practice, many organizations have developed fast-track options for applications that are clean and that will quickly receive approval at all levels. The usual range of meetings—wherein the credentials committee recommends to the MEC, which recommends to the governing body—can somewhat convoluted, kind of a Tinker-to-Evers-to-Chance proposition. Even when most of the process is electronic, this meeting cycle, unless it’s timed exquisitely, can take 45 to 60 days to complete. The orthodoxy of the meeting process has traditionally been part of the built-in delay in onboarding new medical staff members. The fast track allows a subcommittee or individuals to approve the application pending full approval when the meetings come around. The expedited approach removes unnecessary bureaucracy from this stage of the process.

A final point about facilitating clinical practice: Taking away bureaucratic barriers can not only get physicians practicing sooner, it also demonstrates to applicants that your organization sees them as valued associates, not as antagonists or drags on the organization. This perception can pay dividends in medical staff members’ desire to stay with your organization, as well as deliver high-quality care. In an era when competition for practitioners is keen, that dividend can differentiate your hospital from the competition.
Protect and enhance the organization

Strong credentialing processes can protect a hospital as well as its parent healthcare organization or health system. There are typically three types of challenges to a healthcare organization: legal, regulatory, and reputational. Each presents its own kind of pain.

The legal challenges that stem from incomplete credentialing should be somewhat obvious: Poor practitioners who are allowed to work will tend to generate more malpractice lawsuits that involve the hospital as well as the individual practitioner, as plaintiffs and their attorneys cite corporate negligence. These cases will be discussed in greater detail in the Chapter 8, but suffice it to say that avoidance of legal action is the best remedy.

Regulatory challenges can be as vexing as legal challenges. Every organization has obligations to perform credentialing according to the accrediting body’s requirements. Failure to meet these standards subjects the organization to possible loss of accreditation or, at least, to penalties that will require expenditure of resources to correct. Hospitals’ failure to meet regulations can greatly affect the practitioners’ ability to deliver care to their patients, so there is a mutual interest in maintaining regulatory compliance.

The potential legal and regulatory risks of poor credentialing practices are obviously serious. However, they pale compared to the potential damage in the third area: the hospital’s reputation. Credentialing failures that lead to poor practitioners providing poor patient care get noticed and discussed in the local community and beyond. With today’s nearly instant dissemination of information (whether truthful or not) on social media, bad publicity can expand exponentially both in speed and in negative public perception.

Once a hospital gets a black mark on its reputation, that mark can be extremely difficult to overcome, causing the organization to suffer long-term consequences if it doesn’t completely address the incident. Reputational damage can spring up quickly and take months or even years to erase. This kind of situation is not good for the medical staff members who are actively practicing at that institution.

Good credentialing practices will help protect the hospital against all three areas of potential challenges.

Beware of credentialing errors

Every medical staff strives for error-free processes. However, the members of the credentials committee are only human, and mistakes can occur. Thankfully, most errors aren’t egregious or life threatening and can be avoided through conscientious reviewing and trouble-shooting. The more familiar a credentials committee member is with the process, the more likely he or she is to spot potential issues.
Chapter 1

There are two major types of credentialing errors: information-based errors and decision-based errors.

Information-based errors arise when information that would have led to a different outcome was not identified. For instance, if a medical staff office or CVO did not check an applicant’s criminal background, then the organization might not find out about the applicant’s recent conviction for assault and robbery. If all of the other data on this applicant looked good, then the credentials committee could very well give the applicant a positive recommendation. Identification of the past felony would yield a negative recommendation or a decision not to process the application for failure to meet the organization’s criteria.

In the medical staff realm, information errors are generally failures of the verification process. In this information age, the facts really are out there—even the harmful ones—and avoiding information errors is a matter of rigorously obtaining all of the correct information about the applicant.

Decision-based errors occur when the full facts are in hand and the committee has the complete picture but comes to the wrong conclusion. Let’s say there is an applicant who has reported bad behavior events in his or her immediate past tenure. The credentials committee has obtained that information and discussed it with the applicant, who blew it off by suggesting that it was politically motivated at the other institution: “They were out to get me.” The organization decides that no further information is necessary and recommends appointment.

Six months later, after three major behavior events, the MEC regrets the decision to let this practitioner onto the staff. The entire hospital now has to deal with this bad behavior, which is damaging morale and sending staff to the less-toxic work environment at the competing facility across town. In addition, it will now be difficult to remove the practitioner from the medical staff. See the following principle.

Avoid denying an application whenever possible

There should be very few times when a medical staff needs to deny an application for privileges. For the most part, the physician and other LIP applicants are practitioners who have excellent records and will continue to deliver high quality in their ongoing patient care.

As for the (thankfully) few “problem children” who may apply, the organization should look for ways to avoid denying their applications. Here is the main reason why: If you process an application and only then discover that the applicant has either a clinical or behavioral problem that requires you to deny his or her application, said applicant has certain rights. If there is a subsequent denial or limitation of a practitioner’s privileges, then he or she has the right to challenge that negative recommendation and have a fair hearing.
Credentialing Principles

The Health Care and Quality Improvement Act (HCQIA) of 1987 guarantees the right to a fair hearing to challenge the recommendation, and these rights are generally spelled out in the medical staff bylaws as well. Fair hearings can result in a protracted quasi-legal process that can take a lot of time and money from the medical staff members and the institution. Attorneys tell me that the typical bill for a fair hearing today averages about $500,000—and that is just the average for legal costs to the hospital and medical staff.

Most of this potential threat can be avoided by having (and following) robust policies and procedures, as well as sound institutional practices. Base all activities on the following premise:
If an applicant does not meet the criteria set out in these policies, then the application cannot be processed.

It’s important to understand that an application that can’t be processed is not the same as an application that is denied—an unprocessed application does not garner fair hearing rights.

Let’s say an organization has a policy that no application is complete or can be processed until complete information is obtained regarding any untoward situation. Now let’s say that an applicant has applied for family medicine privileges and has requested obstetrics privileges to deliver babies. The institution has criteria stating that an applicant must have one year of experience in obstetrical care and must have delivered 30 infants in the past 12 months in order to get obstetrics privileges. If the applicant cannot provide proof of this training and recent activity, then the organization does not have to deny this practitioner; rather, the organization can simply opt not to process that particular request.

The approach—choosing not to process a problematic application instead of denying it—engenders the following principle, which is very important:

**Medical staff membership is not the same as medical staff privileges**

When the credentials committee considers an application, that application contains two parts. The first is for membership in the medical staff. Criteria for such membership may include type of licensure, education, training, and experience. The second part is for privileges, which define the scope of clinical care that an applicant can administer and should be matched to that applicant’s current clinical competency. There are certain criteria that applicants must meet in order to exercise particular privileges in the organization. These criteria may overlap with criteria for membership on the medical staff, but those for privileges tend to be more specific. See Chapter 2 for more details about the privileging process.

Can a practitioner be granted membership without privileges? Yes, absolutely. In fact, it happens all the time. Many medical staffs recognize emeritus staff—those who have retired but still maintain membership on the medical staff. However, since they do not practice any longer and
do not deliver clinical care, there is no reason for them to have clinical privileges. If a practitioner does not have privileges, then there is no reason for the medical staff to evaluate his or her current clinical competency, which makes the reappointment process much easier.

Conversely, practitioners may have privileges but not membership. For example, most medical staffs do not grant membership to non-physician-level practitioners who are LIPs, such as PAs and NPs. Although they are not members of the medical staff, LIPs are granted privileges to render their scope of patient care. Another example would be a physician granted locum tenens (temporary) privileges due to an immediate patient need. If a patient required a neurosurgeon and there wasn’t one on staff, a neurosurgeon might be granted privileges to care for that particular patient, but he or she would not be granted membership to the medical staff.

The difference is that when practitioners are granted membership, they obtain political rights, such as the right to vote and to attend meetings. Privileges, on the other hand, define only what a particular person may do clinically within the organization.

Membership and privileges should not be confused with each other, but sometimes, they are. Historically, such confusion frequently occurred in the area of emergency department (ED) call. Some physicians sought to limit their ED call, which they viewed as undesirable, and claimed that because they were limiting their practice to a subspecialty area, they could not take overall ED call. An orthopedic surgeon who claimed to perform only total knees and hip operations, for example, might declare that he was not competent to do general ED call for orthopedics because it included trauma and other cases that were outside of his subspecialty areas. Of course, that surgeon still wanted to maintain all of his privileges to do all types of orthopedic procedures.

Many medical staffs have decided that you cannot have it both ways. They refer to call generally in the bylaws and detail its specifics in policies and procedures. As a result, many facilities now insist that the orthopedic surgeon in the previous example continue to take ED call because he could still assess and stabilize any orthopedic patient—which is what ED call requires.

**Develop clear criteria and apply criteria consistently**

We have already alluded to the need for clear, robust policies and procedures that support the credentialing process. Once these criteria are identified—which will be even more important in the discussion about privileging criteria—it is just as essential to apply them consistently to all practitioners across the board. Otherwise, an organization might wind up treating like practitioners in a different manner, which can lead to legal entanglements, among other problems.

**Verify qualifications with complete data and proven competency**

Competency is the ability to carry out an identified activity. In clinical care, this ability is referred to as current clinical competency. But recent experience has demonstrated that the
physician’s competency should be examined on a broader scale than was historically used. Today, determining clinical competency is rooted in identifying all dimensions of physician performance that need to be scrutinized to get an overall picture of one’s competency.

The American Council for Graduate Medical Education (ACGME) made the first large-scale attempt to identify all components of clinical competency, and around 2000, the council developed the Six General Competencies. The ACGME aimed to help academic staff evaluate medical students’ and residents’ performance during their educational experience.

The General Competencies are as follows:

**Patient care**
Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

**Medical knowledge**
Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

**Practice-based learning and improvement**
Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

**Interpersonal and communication skills**
Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patients’ families, and professional associates.

**Professionalism**
Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

**Systems-based practice**
Demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value.

Determining clinical competence based on these six areas comes down to answering these two questions:

- Have you done it recently?
- Have you done it well?
To answer the first question, the medical staff may develop criteria, such as requiring a family practitioner to have performed 30 deliveries within the past 12 months to qualify for obstetrics privileges. The answer to the second question is the quality information derived from the peer review process, which is a combination of both ongoing and focused evaluations. The ongoing process is the regular collection and assessment of clinical performance data for a particular practitioner. The focused review may refer to a specific data review, perhaps in response to a particular event, such as a bad outcome in case review that triggers a focused study of all patient care in that area.

To support credentialing decisions properly, the organization must make the effort to gather and verify all data related to its required qualifications for both membership and privileges.

**Follow your policy**

Although it sounds like another statement of the obvious, this ground rule is really a warning not to proceed with ad hoc actions in the absence of a policy.

Consider: If an acupuncturist approaches the medical staff wanting to apply for privileges at a hospital, but the hospital has never credentialed an acupuncturist and has no policy or criteria for doing so, what should the medical staff do? There are two possible responses:

1. “There are no acupuncturist provisions for our medical staff. We therefore cannot process such an application.”

   That works fine if keeping acupuncturists off the medical staff is the desired result. However, let’s say there is a need for a good acupuncturist on the staff and many others have been asking about adding such a service.

2. “There are no acupuncturist provisions for our medical staff. Should we create a policy?”

   The first step would be to have a discussion about whether the hospital wants to add this service. Although the medical staff and administration may have opinions and recommendations regarding the acupuncture service, the governing body must ultimately make this decision, for all the reasons discussed earlier regarding restraint of trade and competition.

   If the governing body decides that, yes, the organization should include acupuncture as a service, then the governing body would look to the medical staff for recommendations on criteria for bringing such a practitioner on board. The medical staff can weigh in on criteria for licensure, education, training, and experience, as well as what specific privilege scope should be allowed. Again, final approval would rest with the governing body.
Once this policy is complete and in place, the medical staff can process the acupuncturist’s application as long as he or she meets the criteria established by the hospital. The same criteria would be applied to any other acupuncturist who applies for privileges as well.

**ALL red flags must be reconciled**

Red flags are warning signs that arise during early investigation of the application information. The best credentialing practice is never to allow a red flag to go unexplained, and all explanations must be complete. Otherwise, as noted earlier in this chapter, there can be unintended consequences: You might credential a practitioner who then has problems that you will need to address when that person is a medical staff member rather than an applicant.

Some of the common red flags in credentialing are as follows:

- Time gaps—periods of time that are unaccounted for, or information reported by the applicant that does not match the timeline or information reported by the organizations with which the applicant is or was affiliated. Ensure that your credentialing policy defines what will be considered a “significant” time gap (e.g., 30 days or 90 days).
- Vague or narrow answers from references, or references who refuse to complete a detailed evaluation.
- Numerous lawsuits reported.
- Prior disciplinary action by any other healthcare organization or licensing body.
- Failure of the applicant to disclose information.
- Extra time necessary to complete a training program.
- Information reported on the application that cannot be verified.
- Information indicating that the applicant holds a license in another state that was not listed on the application.
- Documentation provided by the applicant does not show that he or she ever practiced, trained, or otherwise had a need for a license in that state.
- Inability to provide references who can attest to current clinical competence.
- Rumors, discussion, or documentation from coworkers or staff related to unprofessional conduct or possible impairment.
- Change of malpractice insurance provider several times in recent years.

Although there might be valid explanations for most of these red flags, they all represent areas that need full explanation. I would not recommend processing such an application until the
organization has received a full explanation from the applicant and other parties, if necessary, that would allow a rational decision to be reached.¹

**No news is NOT good news**

Fifty years ago, a lack of bad news about a practitioner was, in all likelihood, good news. In a modern healthcare system, however, an absence of information just means that there is no information. The organization needs to get information about an applicant—positive or negative—from the application, request for privileges, peer review, outcomes data, or references from past or current facilities where he or she practices.

**Think strategically**

In today’s world, healthcare entities are being aligned more than ever because healthcare delivery systems are expanding across the continuum. Hospitals, physicians, and other provider entities (e.g., long-term care facilities, ambulatory surgical centers, procedure centers, etc.) are joining forces in risk contracts to take care of patients for what are described as “cradle-to-grave” care situations.

Naturally, these contracts have changed the relationship between physicians and hospitals. Most new physicians coming into practice either join a large practice or are employed by an organization. The days of the solo independent practitioner, outside of very rural areas, are gone. As a result, many organizations have started to rethink the medical staff and its purpose. Hospitals and healthcare systems must support new, broader missions, and this change is reflected in the requirements for membership on modern medical staffs. If a particular physician is not going to participate in the mission of the organization (or hospital system, which is now the more common scenario), then the organization may not see a reason to have that practitioner on staff.

Many hospitals and medical staffs are requiring new applicants and even reappointment practitioners to submit their proposed practice plan, which is a statement of how the physician intends to carry out his or her practice and use the hospital’s facilities. If the practice plan fits with the governing body’s strategic plan, then they may qualify for the application process. If not, then they may not be able to complete an application and obtain membership.

This chapter should give new credentials committee members a basic understanding of why credentialing must be done well, and what an organization’s policies and procedures should include in order to facilitate the credentialing process. The next section of this book will describe the process itself.

¹ Accreditation Council for Graduate Medical Education (ACGME), Outcome Project, © ACGME 2003. **Note:** This information was revised in 2007 when ACGME updated its Common Program Requirements. For more details and updates on the Common Program Requirements: General Competencies, refer to the Outcome Project or “The Next Accreditation System (NAS)” on the ACGME-NAS or ACGME website.
In *The Credentials Committee Manual*, former credentials committee member/chair Mark A. Smith, MD, MBA, FACS, provides practical advice on committee structure and duties (both current and future, including data analysis and legal considerations), tables and forms for managing meetings, as well as tools MSPs can use for effective committee operations. All forms are downloadable and customizable.

This book provides insights such as:

- What CMS’ guidance for unified, integrated medical staff might mean for credentials committees
- What new and prospective committee members (including APPs) need to know about their part in the credentialing process
- Information on technology’s role in streamlining meetings
- Ways to address the challenges of credentialing telemedicine providers
- The role of simulation training in competence assessment
- Ways to avoid potential legal issues (including negligent credentialing)
- New credentials committee structures

Readers will also learn best practices for compiling and using data in reappointment decisions, navigating credentialing considerations for nonphysician practitioners, and preventing turf battles.