Healthcare

VANTAGE POINT®

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Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging

Healthcare organizations have traditionally been held legally responsible for granting staff privileges only to competent physicians and advanced practice providers.[1] At a time when healthcare reform has pressured organizations to merge with other healthcare entities and acquire large numbers of medical providers, facilities that accord privileges without fully verifying an applicant's qualifications and proficiency risk lawsuits alleging negligent credentialing practices.

The need for greater organizational accountability of provider credentialing is recognized from various perspectives. The federal Medicare Conditions of Participation require healthcare organizations to examine credentials of all eligible candidates and conduct periodic appraisals of performance. State regulations also require medical staffs to verify that applicants can demonstrate their ability to perform surgical and/or other procedures competently at the time of application, and at least bi-annually thereafter. In addition, under the Joint Commission's Medical Staff (MS) Standards, accredited facilities must develop and maintain a credible credentialing and privileging process based upon a continuous, evidence-driven analysis of provider performance.

This edition of *Vantage Point*® examines the legal basis of negligent credentialing claims and addresses critical risk exposures in the privileging process. The checklist on page 7 provides additional guidance in establishing core credentialing and assessment standards for prospective medical staff, as well as developing a focused, ongoing process to evaluate competence and professional performance.

1 *Darling v. Charleston Hospital*, 211 N.E.2d 253, 257 (Ill., 1965), was the seminal case recognizing the right of patients to recover damages under the doctrine of hospital corporate negligence. The Illinois Supreme Court decision affirmed the legal duty of hospitals to properly credential providers, as well as the right to impose liability for negligent selection and monitoring of providers who later commit professional malpractice.

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Legal Considerations

The claim of negligent credentialing derives from the legal doctrine of corporate negligence, which asserts that healthcare organizations have an independent duty to provide safe care to patients. (See "Origins of Negligent Credentialing" on page 2.) For an organization to be held liable for negligent credentialing, the plaintiff's attorney must establish the following four elements:

1. The organization had a legal duty to select and retain competent practitioners.
2. In granting staff privileges to the practitioner, the organization failed to meet established standards of credentialing and privileging.
3. The practitioner was negligent in treating the patient and caused injury while practicing under the medical staff privileges that had been granted.
4. The negligent granting of medical staff privileges caused or contributed to the plaintiff's injuries.

Prior to asserting a negligent credentialing claim, the plaintiff's attorney typically performs informal discovery of a practitioner's background, seeking to discover what an organization knew, or should have known, about the practitioner's competence. To prove the allegation, an expert witness must convince the jury that the defendant organization's credentialing committee deviated from the ordinary standard of care in making its decision. In addition, the plaintiff's attorney will often seek to introduce evidence intended to demonstrate that staff privileges were accorded to the practitioner in contravention of the organization's own medical staff bylaws.

Although healthcare organizations' privileging standards and procedures are subject to frequent challenge, the threshold of proof for a negligent credentialing claim remains relatively high. Unless the plaintiff's attorney has compiled a history of practitioner misconduct and/or inadequate training, such a claim will probably be dismissed due to lack of evidence.

While the legal elements of **negligent credentialing** may vary from state to state, most **courts now recognize** the doctrine as a **cause of action in litigation**.

Origins of Negligent Credentialing

The doctrine of negligent credentialing, which has evolved over the 50 years since the landmark case of *Darling v. Charleston Hospital* (see footnote 1), permits plaintiffs who allege negligent medical care by a provider to assert a secondary claim of negligent credentialing against the hospital. Courts continue to recognize negligent credentialing as a separate cause of action against a hospital or medical center.

In *Larson v. Wasemiller* 738 N.W.2d 300 (Minn., 2007), the Minnesota Supreme Court first recognized that a cause of action may lie against a hospital based upon physician credentialing. The ruling stemmed from a medical malpractice claim initially asserted against two physicians who performed gastric bypass surgery, resulting in costly subsequent corrective surgeries and long-term rehabilitation for the plaintiff. After suing the physicians, the plaintiff amended her complaint to sue the hospital, asserting the hospital should have investigated the significant number of prior medical malpractice claims involving the physicians, among other adverse findings. The state high court upheld a $7 million verdict against the hospital for the negligent manner in which it credentialed the physicians.

In the decade that has followed the *Larson* ruling, negligent credentialing claims have been on the rise, especially when publicly accessible malpractice cases or professional board actions are overlooked during the initial review process by the medical staff of a healthcare organization. In some instances, punitive damages are awarded as punishment for intentional or grossly negligent conduct, such as when facilities permit providers to perform medically unnecessary procedures in order to enhance their revenues. While the legal elements of negligent credentialing may vary from state to state, most courts now recognize the doctrine as a cause of action in litigation.

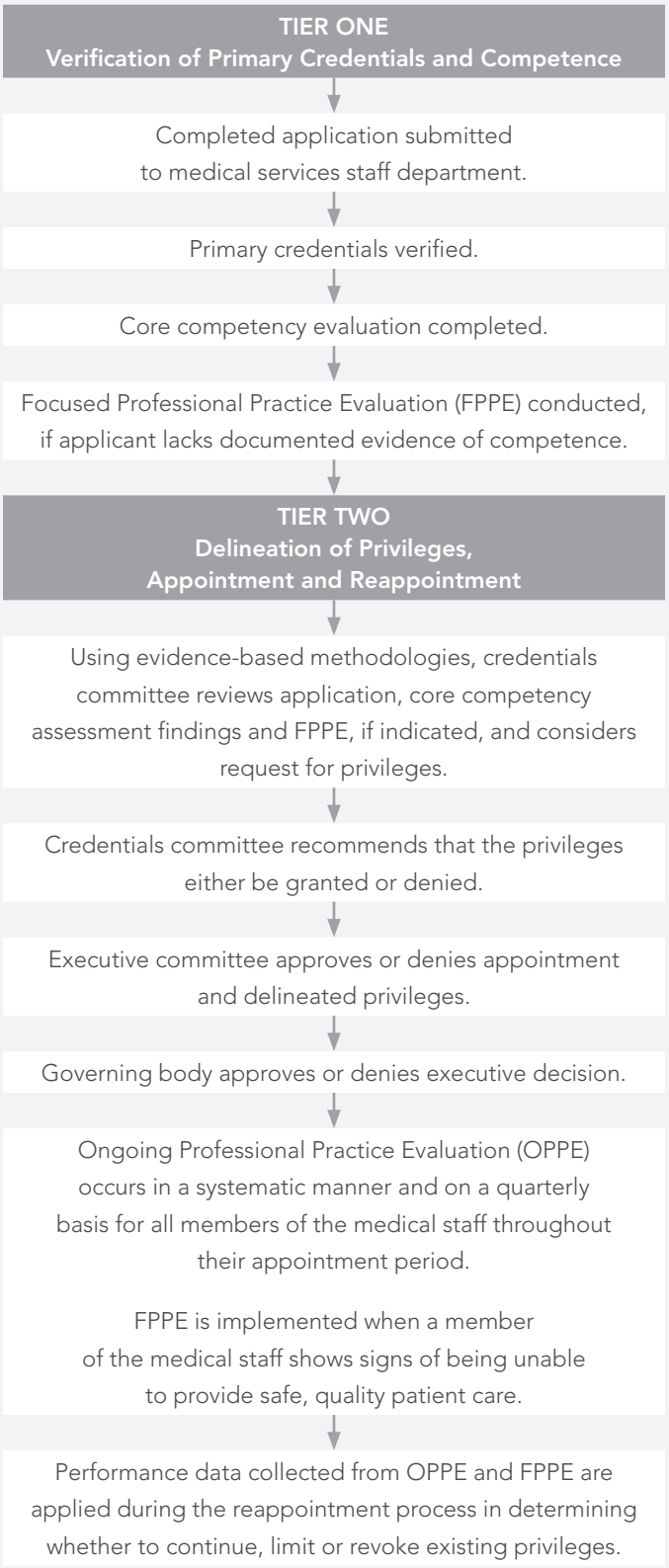
Eight Strategies for Effective Credentialing

The credentialing process consists of two phases: verification of primary qualifications pursuant to medical staff application, and the granting of specific clinical privileges based upon evaluation of competence. (See right for a visual overview of the credentialing and privileging process.) Successful credentialing thus requires sound initial assessment procedures, as well as access to comprehensive, reliable and practitioner-specific performance data. The following strategies can help healthcare organizations protect patients and reduce liability risk by enhancing both major phases of the medical staff screening process.

1. Identify red flags when reviewing applicants' history.
Negligent credentialing claims that survive initial judicial scrutiny tend to be egregious in nature, often involving a blatant failure to identify past medical malpractice claims or verify training and certification. To reduce the likelihood of such oversights, the credentialing committee should be attentive to certain risk indicators in the applicant's history, including the following:

- **No response to a reference inquiry** from a prior medical staff, medical group, healthcare entity, training program or professional society with which the applicant has been affiliated.
- **Difficulty in verifying compliance** with general requirements, including training and education, professional liability insurance coverage and patient coverage arrangements.
- **Gaps in education** and/or work history.
- **Discrepancies in applicant responses** and information received from primary verification sources.
- **History of disciplinary actions** by medical staff organizations, healthcare entities, state medical boards or professional societies.
- **Resignation from a medical staff** at any time in the applicant's career.
- **Credible reports of problems** in the applicant's professional practice.
- **Past or pending investigative proceedings** by a state licensing board, medical staff organization or professional society.
- **Claims or investigations of fraud, abuse and/or physician misconduct** by professional review organizations or private and public third-party payors, such as Medicare and Medicaid.
- **Criminal investigations, charges and/or actual convictions** of a misdemeanor or felony.
- **Inability to verify coverage** by a professional liability insurance policy.
- **Jury verdicts and settlements** of professional liability claims within the past five years.
- **Failure to maintain a medical practice** within the organization's service area.

The Two Tiers of the Credentialing and Privileging Process



2. Thoroughly document initial findings regarding professional competence.
Traditionally, provider privileging focused on documenting applicants' education, training and licensure. Today, however, organizations also must demonstrate through scrupulous documentation that they have objectively and thoroughly assessed practitioners' overall professional competence.

A sound and defensible credentialing program utilizes established performance criteria, such as the six "general competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). These competencies focus on a practitioner's ability to:

- **Provide safe, quality patient care** – i.e., care that is compassionate, appropriate and effective.
- **Demonstrate and apply knowledge** of established and evolving biomedical, clinical and social sciences.
- **Apply scientific evidence and methods** to investigate, evaluate and improve patient care practices.
- **Utilize interpersonal and communication skills** in establishing and maintaining professional relationships.
- **Exhibit professional behaviors** that reflect a commitment to continuous professional development, ethical practice and sensitivity to cultural diversity.
- **Understand the context and systems** in which healthcare is provided.

These fundamental competencies are observed and measured using various assessment methods, including:

- "360-degree" evaluations (i.e., performance appraisal by peers, subordinates, supervisors and patients)
- case log reviews
- patient surveys
- examination of patient care records
- simulations and models of care
- live or recorded performances of procedures
- written, oral or practicum examinations

Each organization should establish its own specific qualifications for medical staff membership and clinical privileges within the framework of general competencies. By incorporating widely accepted competency criteria into medical staff bylaws, rules and regulations, and other governance documents, an organization can strengthen its ability to refute assertions that credentialing standards were applied in a random or discriminatory manner.

For various performance measurement resources, see the ACGME-ABMS Joint Initiative's "Toolbox of Assessment Methods©".

3. Implement a consistent, evidence-based evaluation program.
Liability claim experience demonstrates that haphazard compilation of performance data and lax implementation of privileging policies are major sources of risk. The following measures help ensure that privileging criteria are clear, applied in a fair and non-discriminatory manner, and accommodate changes in both practice and technology:

- **Apply criteria uniformly** and document all decisions.
- **Define the practice of "core privileging"** in the medical staff bylaws – i.e., evaluation of applicants based upon a preselected group of procedures or treatments relevant to the medical specialty – and evaluate all skills independently, even if they are grouped together.
- **Draft a written protocol to guide the development of new criteria**, and require the approval of the medical executive committee and governing board before granting the privilege.
- **Document exceptions to adopted criteria,** noting the consensus of organizational leadership and the medical staff.
- **Convene an interdisciplinary team** to review any contested privileging-related decision.

The Joint Commission expects organizations to conduct an evidence-based performance evaluation prior to the granting of specific clinical privileges. A broad range of practitioner-specific data should be reviewed, including but not limited to:

- morbidity and mortality data
- comparative practice patterns
- patient complaints/grievances
- adverse occurrence trends
- case review results
- peer review recommendations

Liability claim experience demonstrates that **haphazard compilation** of **performance data** and **lax implementation** of privileging policies are major **sources of risk**.

4. Collect performance data on an ongoing basis.
The defense of a negligent credentialing claim is jeopardized by testimony indicating that the organization failed to monitor a deficient practitioner following initial appointment. Therefore, written policy should include a process to identify, investigate and address clinical practice concerns throughout the privilege period.

While organizations have some discretion regarding the scope of professional evaluations, it no longer suffices to simply track rates of complications, readmissions and mortality in aggregate form. Instead, organizations require detailed assessment of practitioner-specific data, as provided by the system known as ongoing professional practice evaluation (OPPE). Incorporating such activities as periodic chart reviews, direct observation, monitoring of diagnostic and treatment techniques, and discussions with peers, OPPE provides an opportunity to obtain a more balanced view of practitioner strengths and weaknesses. Major OPPE criteria include:

- involvement in adverse and sentinel events
- appropriateness of operations and other procedures
- medical assessment and treatment methods
- timeliness and accuracy of assessing and treating infection
- test and procedure requests
- length of stay patterns
- consultant use
- use of blood and blood components
- drug usage
- autopsy findings
- response times to clinical pages

Data should be collected and analyzed systematically during quarterly department reviews. This process can be performed internally or, in cases of potential conflict, outsourced to an external peer review organization. If analysis is performed in-house, ensure that the data processing system can minimally compile:

- **monthly and quarterly evaluations** of each practitioner
- **comparisons of practitioners** within the same specialties
- **trend analyses** by individual provider
- **outcomes reports** organized by diagnosis, procedure and department
- **practice patterns**, including readmissions, complications, mortality, blood usage and drug therapy
- **root cause analyses** of provider-related events and quality improvement interventions

5. Establish and enforce evaluation parameters.
In negligent credentialing cases, plaintiffs often emphasize either past poor outcomes or sanctions by a state licensing board or other regulatory body as evidence that an organization should have been aware that the defendant practitioner's performance was substandard. To protect patients and avoid the appearance that a medical staff knowingly failed to take indicated action, organizations are encouraged to implement a practitioner review system known as focused professional practice evaluation (FPPE).

An FPPE should be conducted upon initial request for staff privileges, if the practitioner lacks documented competence in the procedure. It also should be undertaken for practitioners with existing privileges following these circumstances, among others:

- sentinel events
- complaints/grievances by patients, staff and/or peers regarding quality of care
- rising infection rates
- notable decrease in admissions/procedures over time
- longer patient stays relative to other practitioners
- more frequent returns to surgery
- repeated readmissions for the same issue
- pattern of unnecessary diagnostic testing or treatment
- chronic failure to follow approved clinical practice guidelines

Medical staff bylaws should delineate both the events that trigger monitoring and the period of observation, consisting of either an established time frame or a specified number of procedures. Governing documents also should outline how monitoring will be performed, information compiled and evaluated, and performance issues resolved. Common assessment methods include retrospective chart reviews, simulations, external peer reviews, proctoring, and discussions with colleagues and others.

The **defense of a** negligent credentialing **claim is jeopardized** by testimony indicating that the **organization failed to monitor** a deficient practitioner **following initial appointment**.

6. Provide adequate resources.
A common component of negligent credentialing claims involves the assertion that the defendant practitioner, even if properly trained, would nevertheless be unable to perform a given procedure correctly due to insufficient organizational resources. To refute this contention, administrators should compile a list of common clinical privileges and the resources necessary for each privilege, including such factors as the organization's license capacity and the availability of equipment, personnel and services.

Consider developing a standard form to address requests for the privilege to perform specific procedures. The form should document that the organization's executive committee and governing body have:

1. **Reviewed the risks and benefits** of the procedure, including financial analysis.
2. **Considered the need for new equipment** and additional staff training.
3. **Judged the procedure to be appropriate** and within organizational capabilities.
4. **Formally approved the procedure and privilege,** and retained documentation of the approval on file.

The completed form should be attached to the application and included in the practitioner's file.

Quick Links

- *Ambulatory Care Program: The Who, What, When, and Wheres of Credentialing and Privileging*. The Joint Commission. 2018.
- Comerford, J. "Credentialing, Privileging, Clinical Competence, and Peer Review." ECRI Institute, September 10, 2015.
- *Credentialing and Privileging Guide for Health Centers*. ECRI Institute, 2018.
- Abel, L. "Medical Staff Essentials: Clarifying Medical Staff Standards." The Joint Commission, October 27, 2017.
- Schandl, M. "Credentialing and Privileging Toolbox: Field-Tested Documents for Compliance, Management, and Process Improvement." HCPro and Credentialing Resource Center, 2017.

7. Understand the limits of peer review immunity.
As medical staff privileging evolves into an ongoing peer review process, legal immunity and protection against disclosure become critical issues. Under the federal Health Care Quality Improvement Act of 1986 (HCQIA), 42 USC § 11101 et seq., professional review bodies enjoy antitrust immunity from monetary damages if sued by physicians whose privileges were denied or limited, provided that the peer review action is conducted in accordance with designated legal requirements. However, this immunity is lost if a healthcare organization fails to report licensure actions, adverse clinical privilege decisions or malpractice judgments to the National Practitioner Data Bank.

State peer review immunity statutes also provide some measure of protection for healthcare organizations against disclosing important peer review discussions intended to improve the quality of patient care. These laws provide varying degrees of confidentiality for materials generated in the course of peer review, and may not protect all information reviewed by a credentialing committee from disclosure. For example, documents created in the ordinary course of business may be discoverable, even if they are subsequently used by a committee in a peer review process. Consult with legal counsel regarding the relevant limits and rules of discovery in your jurisdiction, as challenges to the immunity afforded healthcare organizations and their medical staffs when investigating physicians through this process have attained a measure of success.

A negligent credentialing claim may seem to place administrators in the difficult position of possibly having to defend a credentialing decision by using information collected while screening a staff member, even though this disclosure compromises federal and state peer review protections. However, by knowing the types of information that may be discovered and introduced later into evidence under these statutory protections, administrators often can resolve this potential dilemma. In general, organizations and administrators can best protect themselves by formalizing the basic framework of peer review in their bylaws, thoroughly documenting all materials examined in privileging procedures and ensuring that all decisions are made in the interest of quality patient care.

For practical recommendations intended to help maximize confidentiality of performance-related data, see *Vantage Point*® 2019-Issue 1 "Patient Safety Data: A Guide to Preventing Unwanted Disclosures."

8. Ensure leadership oversight of the credentialing process. To ensure that medical staff bylaws, rules and regulations comport with national standards regarding oversight of the credentialing and reappointment process, the board of directors and/or executive leadership should independently review all privileges granted and recommendations made by the credentialing and medical staff executive committees. The oversight body also should:

- **Thoroughly investigate the qualifications of medical staff applicants,** focusing on education, training, licensure and medical malpractice history.
- **Review grandfathering provisions and other organizational practices** related to credentialing and appointment, and codify them in the medical staff bylaws.
- **Establish an oversight committee** to ensure compliance with bylaws, rules and regulations.

The duty to select and retain competent medical staff extends to *all* healthcare facilities. At a time of increasing institutional accountability, it can be a costly error for smaller organizations to assume that only large medical institutions with ample resources are expected to scrutinize practitioner credentials and continuously evaluate performance. By implementing a thorough competency assessment process for all medical staff members, organizations can achieve a higher quality of care while strengthening their legal position against potential negligent credentialing claims.

Compliance Checklist for Medical Staff Credentialing

The following questions are designed to help healthcare administrators assess and enhance their organization's process for verifying practitioners' primary credentials and professional competency.

Assessment Questions	Yes/No	Where documented?	Comments
Medical Staff Bylaws and Organizational Rules and Regulations			
Do the bylaws articulate the appointment and reappointment process and define methods of performance measurement?			
Do the bylaws reflect evidence-based decision-making?			
Do the bylaws clearly define exceptions to established credentialing criteria, such as grandfathering provisions?			
Do the bylaws provide that no privilege will be granted without adequate and available resources to support the privilege?			
Do the bylaws endorse a continuous evaluation of practitioners' performance, rather than a traditional cyclical review?			
Do the bylaws clearly define the criteria for core competency assessment?			
Do the rules and regulations list the practitioner roles that require licensure, certification, credentialing and privileging for both direct and indirect patient care?			
Do the rules and regulations require individual departments and medical staffs to determine performance monitoring criteria?			
Do the rules and regulations objectively describe how data relevant to a practitioner's performance will be collected, verified and evaluated?			
Do the rules and regulations include criteria for supervised and independent patient care?			

Assessment Questions	Yes/No	Where documented?	Comments
Credentials Verification			
Are medical staff applicants required to provide, at a minimum:			
• A completed application?			
• Proof of current medical licensure?			
• Proof of education, training and certification?			
• Proof of current Drug Enforcement Administration license?			
• A certificate of professional liability insurance coverage?			
• A *curriculum vitae*?			
• A recent photograph?			
Is the National Practitioner Data Bank routinely queried during the credentialing process?			
Are documentation and verification criteria consistently applied for all applicants seeking appointment or reappointment?			
Initial Competency Assessment			
Is the medical director of each clinical service consulted during the initial assessment of core competency?			
Do core competency criteria encompass:			
• Overall patient care?			
• Medical and clinical knowledge?			
• Practice-based learning and improvement?			
• Interpersonal and communication skills?			
• Professionalism?			
• Understanding of hospital systems and culture?			
Are recognized methods utilized in evaluating core competencies, such as:			
• "360-degree" evaluations?			
• Inspection of case logs?			
• Patient surveys?			
• Patient care record audits?			
• Simulations and models of care?			
• Live or recorded performances?			
• Written, oral and practicum examinations?			
Do medical staff directors have the skills to evaluate and act upon concerns regarding a practitioner's clinical practice or level of competence?			

Assessment Questions	Yes/No	Where documented?	Comments
Privilege-specific Evaluation			
Does the organization undertake a focused privilege-specific evaluation whenever a practitioner initially applies for privileges or lacks documented evidence of competence in a new procedure?			
Is a focused professional practice evaluation performed when a member of the medical staff demonstrates signs of being unable to provide safe, quality patient care, as indicated by the presence of the following occurrences:			
• Sentinel events?			
• Complaints/grievances by patients, staff and/or peers regarding quality of care?			
• High infection rates?			
• Limited number of procedures performed or patients admitted over an extended period of time?			
• Longer patient stays relative to other practitioners?			
• Numerous returns to surgery?			
• Frequent readmissions for the same issue?			
• Pattern of unnecessary diagnostic testing/treatment?			
• Repeated noncompliance with approved clinical practice guidelines?			
Do performance evaluations include retrospective chart reviews, simulations, external peer reviews, proctoring and discussions with others involved in care?			
Do rules and regulations stipulate the length of focused evaluation periods?			
Are the methods employed to resolve performance issues clearly defined and consistently implemented?			
Evidence-based Methodology			
Is an objective, evidence-based process used to make the decision to grant or deny privileges, or to renew existing privileges?			
Is there a process to determine whether sufficient clinical performance data are available to make a privileging decision?			
Are decisions to grant, renew or restrict privileges justified by the practitioner's documented performance record?			
Do peer recommendations and/or letters from authoritative sources address applicants' capabilities in the following defined areas:			
• Medical and clinical knowledge?			
• Technical and clinical skills?			
• Clinical judgment?			
• Interpersonal and communication skills?			
• Professionalism?			

Assessment Questions	Yes/No	Where documented?	Comments
Ongoing Professional Review			
Is information compiled from ongoing professional practice evaluations factored into the decision to maintain, revise or restrict existing privileges?			
Do ongoing professional practice evaluations encompass review of the following criteria, at a minimum:			
• Number and outcomes of surgical and other clinical procedures?			
• Blood and drug usage?			
• Requests for tests and procedures?			
• Length of stay patterns?			
• Morbidity and mortality data?			
• Use of consultants?			
Do evaluation processes include the following activities:			
• Periodic chart review?			
• Direct observation?			
• Monitoring of diagnostic and treatment techniques?			
• Discussions with peers?			
• Examination of national and regional data registries?			
Data Collection and Analysis			
Does the organization collect and analyze performance data in a proactive and systematic manner?			
Are data collected at designated, and, at a minimum, quarterly intervals?			
Is the organization's data collection system capable of producing the following reports:			
• Outcomes data organized by diagnosis, procedure and department?			
• Patterns of readmissions, complications, mortality, blood usage and drug therapy?			
• Root cause analyses of provider-related events and quality improvement interventions?			
• Trend analyses by provider?			
• Comparative data subsets organized by practitioner?			

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