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Negligent Credentialing: Will Our Systems Save Us From Ourselves?

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A B S T R A C T

This article seeks to challenge the reader to question whether our practitioner credentialing systems can really keep our patients safe, protect them from harm, and at the same time, save us from ourselves. Hospitals have the duty to hire and retain qualified, competent, and safe clinicians as members of its medical, employed, and affiliated staff. The process is clearly designed to ferret out those practitioners whose backgrounds cannot be fully and accurately verified and substantiated.

Introduction

Credentialing and privileging play a critical role in ensuring that patients have access to the highest quality health care. Indeed, the hospital is in one of the best positions to evaluate and ensure the competence of its clinicians because it is the most consistent vehicle available to coordinate the delivery of high-quality health care to large numbers of patients every day.

It would stand to reason then that most US courts have recently recognized a claim against hospitals for the failure to properly investigate, hire, and retain competent and qualified clinicians. The hospital's failure to fulfill this duty with due diligence, or its breach of this duty, is called negligent credentialing. More than 27 states recognize the civil tort of negligent credentialing. Most courts have required that for the theory of negligent credentialing to apply, medical malpractice must first exist. That is, a practitioner must have negligently treated and harmed a patient before the credentialing entity can be held liable for negligence in the way in which it credentialed the practitioner. This theory of liability and recompense, which has been consistently applied to hospitals, is now expanding to any entity, which is responsible for the comprehensive medical care of its patients.

Clinician credentialing and privileging

Credentialing is defined as the attestation of clinical qualification and competency. It is a term that usually encompasses two separate processes: credentialing and privileging. Credentialing is the primary source verification of a health care practitioner's education, training, work experience, and licensure. Privileging is the granting of approval for a practitioner to perform specific procedures based on documented competence in the specialty in which the privileges are requested. Before a practitioner's competency can be assessed for purposes of determining the scope of privileging, verification of each element of a practitioner's background is required.

Hospitals have the duty to hire and retain qualified, competent, and safe clinicians as members of its medical, employed, and affiliated staff. Employment as part of a hospital's staff is a privilege. The credentialing process a clinician undergoes to become a member of a hospital's staff is a serious, elaborate, complex, and should be, an onerous process. The hospital is required to perform a diligent inquiry into the practitioner's background, training, and credentials to ensure that she or he is sufficiently qualified to practice the type and scope of medicine for which they have requested privileges. The practitioner's application is reviewed and scrutinized and independently verified, piece by piece, step by step. This process includes a review of the practitioner's completed education, training (residency if applicable), and licensure. It also includes any certifications routinely issued by a specialty board following standards established by states, regulatory bodies, and accrediting organizations, such as the National Committee for Quality Assurance.

More specifically, the diligent inquiry process should involve at least gathering information about the practitioner's background and qualifications through a formal application process, including contacting all states where the practitioner reports having licensure and certification; reviewing any complaints, claims, lawsuits against, or payments made on behalf of the practitioner; contacting schools and hospital programs to ensure that the practitioner's training is complete and performance acceptable; and contacting former employers to verify references and that work history is accurate, practice is standard of care, and that no privileges or

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positions have been lost, suspended, ended early, or terminated. Many organizational applications also inquire whether the practitioner has a criminal history of arrests, charges, or convictions. Some organizations also inquire whether the practitioner has maintained good standing in professional organizations. Gaps in education and employment are highly scrutinized and often require a written explanation from the practitioner about the reason for the gap or activities pursued during the gap. The process is clearly designed to ferret out those practitioners whose backgrounds cannot be fully and accurately verified and substantiated. The inability to fully verify or substantiate the practitioner's background and/or qualifications raises a red flag to the credentialing and privileging agents. At the very least, it should stimulate additional inquiry with the primary sources about the practitioner's history and also should stimulate inquiry directly with the practitioner.

The ultimate responsibility for the approval of a practitioner's credentials and privileges lies with the hospital's governing boards (Joint Commission Standards, 2011). This is perhaps one of the primary reasons officers, directors, and members of the board receive a separate malpractice and association liability policy. Most hospitals use their bylaws, rules, and regulations to enforce credentialing and privileging requirements. Hospital medical and affiliated clinical staff bylaws typically, in addition to education and employment verification, also require documentation of the practitioner's adherence to professional ethics and character or good reputation. Most require that the practitioner undergo, if requested, a mental or physical examination, or to provide information concerning his or her mental and physical health to determine whether there exists any mental or physical condition that could affect the provision of safe patient care, or which would require an accommodation. Many also include criteria related to decorum, demonstrated judgment, and history of adherence to bylaws, rules, and regulations. In this vein, on hire, more and more organizations are now requiring practitioners to sign a professional code of conduct.

The reappointment process for physicians, allied health professionals including nurse physician assistants, and nurse practitioners is another opportunity to verify the practitioner's competency, good standing, and character and to investigate any changes in status. In most organizations, the practitioner's departmental leader approves the reappointment application before it is sent for review and approval by a variety of committees, which may include a credentials committee, a medical or surgical executive staff committee, a quality and professional affairs committee, before the application is ultimately send for final approval. In addition to bylaws, most hospitals require practitioners to adhere to a set of rules and regulations, which require the self-disclosure of more specific information during the reappointment process, including changes in license status; the existence of government agency third-party payer proceedings challenging or sanctioning the applicant's patient admission, treatment, discharge, charging, collection or utilization practices, or alleging insurer fraud and abuse; and contact by a federal or state regulatory investigator regarding patient care practice excluding those audits defined as routine by the agency or the entity. The failure to self-report can trigger the disciplinary process.

The process is very different for staff registered nurses, nursing assistants, and technologists. They are not reappointed but rather are evaluated yearly by their direct report and often are required to undergo or retake competency assessments and updated education. In addition, with any change in position, their competency and scope should always be reevaluated and reassessed for any gaps in knowledge and technique.

All these provisions are designed to ensure that only qualified and competent practitioners are hired, granted appropriate privileges, and retain employment. However, these processes are indeed onerous and take time. For an industry that continues to burgeon, and often sees an increased immediate demand for specialized personnel, the length of the process can sometimes create challenges. For a practitioner looking to take advantage of a cumbersome system, the process can create opportunities.

The increasing need for temporary clinical staffing

The population continues to increase in the United States. The US Census Bureau projects that the population will increase by more than 50 million between 2008 and 2025 (Dill & Salsberg, 2008). The population is also aging. The first baby boomers turned 65 in 2011, and by 2030, 70 million US residents or about 20% will reach the age of 65 or older (2000 US Census of Population and Housing, 2001). A significant impact of this trend is that those 65 years or older use twice as many health care resources as those who are younger than 65 years (Dill & Salsberg, 2008). Concurrently, the rate of growth of the heath care segment of the economy has been rapid. The 2002 US Economic Census revealed that, between 1997 and 2002, the health care and social services industries gained 1.8 million jobs, representing a 13% increase in merely 5 years (2002 US Economic Census, 2003). The health care industry provided more than 13 million jobs in 2004 and has been expected to account for 19% of all new jobs created between 2004 and 2014—more than any other industry (US Department of Labor, 2007). This expansion in health care employment is attributable in part to the aging of the population and attendant increase in health care needs (US Department of Labor, 2007).

At the same time, there is evidence of a growing caregiver shortage in the United States, which emerged in the early 2000s when the Association of American Medical Colleges (AAMC), the American Hospital Association, and other industry groups began investigating the potential impacts of demographic changes, such as baby boomer aging, population growth, and chronic disease growth. Although projections vary slightly, all studies have agreed that there is and will be a shortage, and it will become substantial. Most studies before passage of the Affordable Care Act projected shortages of at least 124,000 physicians and 500,000 nurses by 2025; and there is general agreement that the additional 32 million covered lives resulting from the Affordable Care Act requires inflating those projections—by 31,000 physicians, for example, according to the AAMC (Buerhaus, Auerbach, & Staiger, 2008). One 2009 survey of hospital chief executive officers found that 95% believe that there is a shortage of physicians, 91% believe there is a shortage of nurses, and 79% believe there is a shortage of allied health care professionals (AMN Healthcare, 2009).

At the same time, there is a growing caregiver shortage, many of the currently employed caregivers, similarly to the patients, are aging. One study predicted that 36.4% of registered nurses would reach ages 50 to 64 by 2015 (Buerhaus, Auerbach, & Staiger, 2009). At the same time, graduate schools have been unable to accept would-be applicants as the result of nurse and nurse practitioner faculty shortages. According to three-fourths of nursing schools surveyed in 2008, faculty shortages accounted for refusing admission to almost 50,000 qualified student applicants that year (Derksen & Whelan, 2009).

The shortage of all types of health care clinicians has given rise to another constant—the growing use of temporary providers who move from one assignment to another. Today, tens of thousands of health care professionals work as locum tenens or travelers, filling gaps caused by shortages or by the temporary absence of clinicians. So has grown the need for temporary agencies that recruit these temporary workers and assume the responsibility to ensure that they are properly educated, trained, qualified, and competent to assume the assignments given to them.