

Boardroom Basics

Knowledge Resources for Health Care Governance Effectiveness

Medical Staff Credentialing

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KNOWLEDGEPoints

- Definition of credentialing and privileging of the medical staff
- The board's role in the credentialing and privileging process
- The process of credentialing and privileging
- Process for removing providers from the medical staff

Overview

As a board member you most likely understand the commitment your organization has to the community to ensure quality patient care is delivered at your institution. Do you know, however, the impact you have on this commitment at every board meeting when you appoint and reappoint members of the medical staff?

Medical staff credentialing is one of the most important tasks boards undertake to ensure quality of care in their organizations.¹ The overall objective of credentialing is to ensure that only qualified doctors are admitted to (and remain on) the hospital's medical staff, and that they practice within their scope of experience and competence. This *Boardroom Basics* is designed to inform board members about the credentialing process and their role in the process.

What is Credentialing and Privileging?

Medical staff credentialing is a two-pronged process that involves establishing requirements and evaluating individual qualifications for entry into a particular medical staff status. Credentialing first involves considering and establishing the professional training, experience, and other requirements for medical staff membership. The second aspect of credentialing involves obtaining and evaluating evidence of the qualifications of individual applicants.² Basically, credentialing is verifying that each applicant:³

1. Is who he/she claims to be;
2. Has been properly licensed;
3. Has appropriate malpractice insurance; and
4. Meets minimum requirements established by the hospital to be on staff.

In past years, credentialing verification was no more complicated than having the applicant present some form of documentation, such as a diploma or certificate. Today's credentialing, however, goes far beyond this approach and requires primary source verification — direct contact of the sources of credentialing, such as schools, residency programs, and licensing agencies — to guarantee that statements of education, training, experience and other qualifications are legitimate. Primary source verification is not only important in meeting requirements of main accreditors, such as JCAHO, but also critical in avoiding legal problems and ensuring quality patient care.⁴

Another aspect of the credentialing process is privileging the medical staff applicant. Privileging is a three-pronged process that determines:²

1. The diagnostic and treatment procedures a hospital is equipped and staffed to support;
2. The minimum training and experience necessary for a clinician to competently carry out each procedure; and
3. Whether the credentials of applicants meet minimum requirements and allow authorization to carry out requested procedures.

Often called “delineation of clinical privileges,” this process determines what procedures may be performed or which conditions each medical staff member may treat. As new technologies are developed and new subspecialties are discovered, privileging medical staff members will become more challenging for organizations and their leaders. Delineation of privileges is an ongoing process that must not only be flexible enough to add new procedures or conditions to treat, but also be firm, fair and consistent.⁵



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Roles and Responsibilities of Key Individuals in the Credentialing Process

To ensure that the credentialing process is carried out as efficiently and effectively as possible, all participants in the process must fully understand their roles.⁶ In smaller organizations, individuals may be responsible for multiple roles.

Applicant – The applicant’s responsibility is to ensure that the hospital receives, in a timely manner, all of the information needed to evaluate his/her application for medical staff membership. The applicant must be up front and honest, and willing to come for a personal interview if requested.

Medical staff services professional – The medical staff services professional is responsible for processing and maintaining the applicant’s credentialing file.

Department Chair (in a departmentalized hospital) – The department chair is typically the first person to see the completed credentials file (other than the medical staff office) and the first person to review the file. Further, the department chair makes a recommendation to the credentials committee or the medical executive committee.

Credentials committee chair – The credentials committee chair oversees the credentialing program and ensures that the hospital is carrying out the credentialing activities in the most effective, efficient manner. The chair also ensures that the credentialing program is in compliance with all of the hospital’s credentialing policies and other outside regulators.

Credentialing committee – The credentialing committee is responsible for reviewing each complete application and for making the recommendation to the medical executive committee (MEC) regarding appointment, reappointment and clinical privileges. Committee members may also be asked to solicit information from past practice settings during the application process.

Medical executive committee (MEC) – The MEC has traditionally had a significant role in the credentialing process. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that the MEC at least make recommendations to the board of directors regarding appointment, clinical privileges, reappointment, and corrective action, and to develop specific policies for the MEC’s role in the fair hearing, investigation, appointment and privileges delineation processes.

Chief Executive Officer (CEO) – The CEO has a largely administrative function in the credentialing process. He/she assists in ensuring that the application and its supporting documentation reach the appropriate individuals/groups at the appropriate steps of the process. The CEO is responsible for forwarding the application to the MEC for submission to the board, and for ultimately informing each candidate by letter if their application was approved or declined.

Governing Board – The board of directors assumes all legal responsibility for the hospital and is ultimately responsible for approving all bylaws, policies and procedures.⁶ The board has two key functions in credentialing and privileging:³

1. **Attend to process** – The board must delineate steps of the credentialing process and specify/approve criteria that it uses to make recommendations or decisions at each step. They also must ensure that the process is thorough, fair, consistent and functioning effectively.

Questions the board may want to ask to ensure these objectives are being met in the process:³

- Are the steps of the credentialing process and the specific responsibilities of various groups clearly delineated in the board’s bylaws and/or policies?
- Are the criteria used at each step of the process explicit, objective, valid and reasonable?
- Does the board periodically assess the extent to which it follows the specified process?
- Within the last several years, has the board evaluated its credentialing process to ensure that it is conforming to applicable laws, regulations, and JCAHO standards?

The credentialing process definitely requires more oversight from the board than in most areas of hospital management. Board participation in the process is integral in assuring a viable, effective credentialing process⁶ and a high quality medical staff.

2. **Decision making** – The board must ultimately decide which doctors will be admitted to the medical staff (initial appointment), allowed to remain on the medical staff (reappointment), and which procedures they can perform and diseases/conditions they may treat (privilege delineation).

Although in the past the board’s role in credentialing and privileging has often been minimal, recently boards are becoming intricately involved in the credentialing process. In many instances, boards are designating responsibility for appointment and privileges decisions to a board subcommittee that better understands the credentialing issues and that the board has authorized to act on its behalf in such matters. The credentialing process requires more oversight from the board than most areas of hospital management, and board participation in the process is integral in assuring a viable, effective credentialing process⁶ and a high quality medical staff.

Background Checks

One essential component of credentialing is utilizing practitioner data banks that allow organizations to gather pertinent background information on physicians. The intention of these data banks is to protect the public from incompetent medical practitioners and reveal any negative sanctions taken against specific physicians. The three data banks that are used most often are:

1. *The National Practitioner Data Bank (NPDB)* – the NPDB is a national register of physicians, dentists and other health care practitioners that was established by the federal government in response to a need for improved quality of health care. It was established in a midst of a “malpractice crisis” and was initially created to reduce the incidence of medical malpractice. Contents of the NPDB include:⁷
 - Medical malpractice payment information
 - Disciplinary action taken by the Board of Medical Examiners
 - Professional review actions that result in suspensions, limitations or reductions of clinical privileges
 - Adverse membership actions taken by a professional society that engages in peer review activities
2. *The Board Action Data Bank of the Federation of State Medical Examiners (FSMB)* – the FSMB functions as the representative organization for the state licensing agencies and is responsible for carrying out many different services related to physician licensure and discipline. Contents of the FSMB include:⁸
 - Disciplinary actions, such as revocation, probations, suspensions, consent orders and Medicare sanctions
 - Non-disciplinary actions, such as reinstatement of licensure, replacement of lost or destroyed license, or license denials
3. *American Medical Association Physician Masterfile (AMA)* — the AMA database is a comprehensive source of demographic, educational, and practice information on all United States physicians with M.D. degrees. Contents of the AMA database include:⁹
 - Full name, address, and telephone number
 - Date and place of birth
 - AMA membership status
 - Medical or osteopathic school name and year of graduation;
 - State licensure — year(s), state(s), status, expiration date(s), and type(s) (temporary, limited, or unlimited)
 - Year of national board certification;
 - ABMS certification and subcertification year(s) and expiration date(s)
 - Professional activity history
 - Specialty area (primary, secondary, and tertiary)
 - Residency training (hospital name, dates of training, and specialty)
 - Federal Drug Enforcement Administration (DEA) registration status
 - Medicare/Medicaid sanctions

In addition to basic background checks, many health care organizations are now doing criminal background checks to further guarantee the safety of their patients.

- Self-reported area of practice (primary and secondary)
- ECFMG applicant number

In addition to basic background checks, many health care organizations are now doing criminal background checks to further guarantee the safety of their patients. There are several resources to use for criminal background checks, which can provide such information as a county criminal records search, a state criminal records search, a national wants and warrants search, a motor vehicle report, social security number verification, and other itemized searches.

Investigative/Correction Action

Even though most organizations go through a stringent process of physician credentialing and privileging medical staff members, there are times when organizations or individuals may want to “reverse the process” and remove a physician from the medical staff.

An investigation may be initiated whenever a practitioner with clinical privileges exhibits behavior – either within or outside the hospital – that is likely to be detrimental to the quality of patient care or safety, the hospital’s operations or the community’s confidence in the hospital. An investigation may be initiated by any medical staff officer, the chair of the department in which the practitioner holds appointment or exercises clinical privileges, the CEO, the MEC or the governing board.¹⁰ All requests must be submitted in writing to the MEC.¹¹

Prior to determination by the MEC if an investigation should be undertaken, oftentimes the individual or committee considering the investigation request may ask for an interview with the involved practitioner. This assists in the decision of whether or not there is relevant cause for further examination.¹⁰ If the decision is made to continue the investigation there are two forms of suspensions that may affect the individual involved:

Automatic Suspension

Automatic suspension of the involved practitioner will take place if:¹⁰

- The practitioner’s state license or DEA number is revoked, suspended, restricted, or placed under probation;
- The practitioner fails to satisfy an interview requirement;
- The practitioner fails to maintain malpractice insurance; and/or
- The practitioner’s medical records are not completed in a timely manner.

Summary Suspension

The CEO or any member of the MEC or the governing board may initiate summary suspension on the involved practitioner’s medical staff status or clinical privileges. Summary suspension is typically initiated whenever a practitioner’s conduct requires that immediate action be taken to prevent immediate danger to life, or injury to him-or herself, patients, employees, or other persons present in the hospital.¹⁰

After a summary suspension, the MEC will typically convene to review and consider the suspension. The MEC may recommend modification, continuation or termination of the suspension. Unless the MEC recommends immediate termination of the suspension, or one of the lesser sanctions, the practitioner is entitled to the procedural rights contained in a fair hearing. Any, and all decisions or conclusions that are drawn by the MEC are assessed by the governing board before any final decision is made.¹⁰

Finally, any applicant who has been denied appointment, clinical privileges or reappointment, or who has been removed from the medical staff during the appointment year, may not reapply to this hospital for a period of one year (12 months), unless specified otherwise in the terms of the specific corrective action.¹⁰

The CEO or any member of the MEC or the governing board may initiate summary suspension on the involved practitioner’s medical staff status or clinical privileges.

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