

# Credentialing, and Its Importance

By Lizabeth Brott, J.D.

Part one of two

Historically, healthcare providers are familiar with credentialing in the hospital setting, but are not as accustomed to credentialing in the outpatient setting. Credentialing began in the outpatient setting primarily in response to requirements of accreditation organizations. The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) promulgated credentialing accreditation standards for ambulatory healthcare and integrated delivery networks. Similarly, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) and the National Committee for Quality Assurance (NCOA), a major accrediting body for managed care organizations, developed credentialing accreditation standards for ambulatory care. As a result, in the last decade, we have seen a dramatic increase in credentialing in the outpatient setting.

While credentialing is important from an accreditation standpoint, it is also important from a professional liability standpoint. Community health centers can be held both directly and indirectly liable for inadequate credentialing practices. Centers can be held directly liable to patients under a corporate negligence theory. Courts have held that healthcare entities owe an independent duty to their patients to adequately verify the credentials of a provider in order to prevent injury to patients. Additionally, centers may be held vicariously liable (indirectly liable) to patients for the actions of an inadequately credentialed employee.

Although credentialing may seem arduous, and often times repetitive process, a recent case involving a fraudulent "physician" demonstrates the importance of developing a thorough and comprehensive credentialing process. This "physician" was granted a medical license based on fraudulent information provided by a friend of the "physician" at the medical school that he claimed he attended. The "physician" practiced at an urgent care center and with a group of visiting physicians for a number of years. When he applied to a hospital for privileges, the hospital attempted to verify his medical degree with his claimed medical school, but

at that point the friend was no longer at the school and the fraud was discovered. Similar cases of "physician's assistants" practicing without formal training or licensure, or malpractice cases where untrained ancillary clinical staff provide clinical tests or services, emphasize the importance of sound credentialing process. This two-part article will address the often-controversial issue of which staff should be credentialed and the gathering and verification of appropriate information in the credentialing process.

## WHO SHOULD BE CREDENTIALLED?

The JCAHO requires healthcare entities to credential licensed independent practitioners (LIP). LIPs are defined by the JCAHO as those practitioners permitted by law and by the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. LIPs, for example, would include physicians, dentists, psychologists, social workers, pharmacists, podiatrists, chiropractors, and in some states, nurse practitioners.

On the other hand, physician assistants are not considered LIPs; state licensing laws require that physician assistants practice under the supervision of a licensed physician. However, since physician's assistants operate fairly independently in their treatment of patients, from a risk management standpoint, centers would be wise to credential physician's assistants as they would physicians and other LIPs.

Similarly, registered nurses, medical assistants, and other ancillary clinical staff should undergo some form of credentialing. Marty Bree, Director of the Center for Risk Management with the Bureau of Primary Health Care (BPHC), points out that the BPHC's proposed Credentialing and Privileging Policy Information Notice (PIN) would require health centers to "assess the credentials of all licensed or certified healthcare practitioners." The proposed PIN cites the Federally Supported health centers Assistance Act of 1992 which requires that deemed

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health centers participating in the Federal Tort Claims Act credential physicians and other licensed or certified health care practitioners.

While initially, this may seem a burdensome requirement for many health centers, a recent obstetrical claim demonstrates why this can be so important from a risk management standpoint. The case involved a child born missing both arms, the mother had undergone an obstetrical ultrasound and both the ultrasound tech as well as the radiologist did not detect that the fetus was missing both arms. The parents filed a wrongful birth action and in the course of defending the claim, it was discovered that the ultrasound tech had never received formal training. Obviously, this information discovered in the course of defending the claim made an already difficult case more difficult to defend.

While credentialing processes for registered nurses, medical assistants, and other ancillary clinical staff may not need to be as extensive as that for licensed independent practitioners, some credentialing processes should be in place for all staff who provide "hands on" patient care.

## CREDENTIALING OF STAFF WHO ARE NOT LIPS

As indicated previously, centers should credential clinical staff who are not LIPs, but the credentialing process many vary. If a clinical staff member claims a state license, e.g., a nurse, the center should, at least, verify the license with the primary source. Similarly, the center should query the data banks on all licensed practitioners and clinical competency should be assessed at hire and periodically thereafter.

If on the other hand, a clinical staff member claims a private certification, for example, a certified medical assistant, the center would be wise to, at least, verify the certification with the private agency that awarded the certification. In most cases, a query to the data banks would be fruitless as the data banks only maintain information on licensed practitioners. Initial and

ongoing clinical competency should be evaluated as well.

Some health centers also employ or utilize existing staff as clinical assistants who have never received any type of formal clinical training. Dr. Tom Curtin, Associate Vice President of Clinical Affairs with the National Association of Community Health Centers, Inc. (NACHC), points out that processes can be developed within community health centers to establish both external and internal training systems for such staff. Centers can assist non-professional staff in participating in courses toward formal certification and/or licensure. At the same time, centers may wish to develop a parallel system where training is conducted internally by registered nurses and physicians. For example, non-professional staff may be trained in eliciting a limited history specific to the visit, how to take blood pressures, patients' weight, etc. Of course, such training should be documented and the employees' ongoing competency should be evaluated as well.

In the next issue of Community Health Forum™, part two of "Credentialing and Its Importance" will look at how to gather and verify information. ■

*Lizabeth Brott is Vice President, Risk Management ProNational Insurance Company. Please direct any comments to [forum@launs.com](mailto:forum@launs.com).*

**For further information on who should be credentialed, health centers should review the monograph entitled *Credentialing and Privileging in Community, Migrant, Homeless and Public Housing Health Centers*, published by the NACHC in August 1998. Additionally, centers may access the toll-free NACHC/ProNational malpractice risk management consultation line at (888) 800-3772 to seek assistance with credentialing. Centers interested in arranging an NACHC sponsored half-or full-day training session for health centers clinicians and administrators in their region or state on "Minimizing Your Malpractice Risk" should contact Freda Mitchem at NACHC at 202-659-8008, Ext 133 or [fmitchem@nachc.com](mailto:fmitchem@nachc.com).**