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INVESTIGATION

Quality Improvement
Department of Public Health
County of Los Angeles

241 N. Figueroa Street
Room 275
Los Angeles, CA 90012

TEL (213) 989-7239
FAX (213) 240-8626

www.publichealth.lacounty.gov

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Credentialing and Privileging Overview

PROFESSIONAL PRACTICE TEAM

Credentialing and privileging of health care practitioners in an organization is essential to ensure competence and accountability. Effective credentialing and privileging processes protect both the clients and the organization. There may be time and expense associated with the process but it is worth the investment to prevent an adverse event or outcome and the subsequent liability exposure for the organization (Cassel & Holmboe, 2006; Payne, 1999; Brott, 2001). Credentialing and privileging build a quality professional staff, not only for adherence to accreditation requirements but also to protect the public interest (Hernandez, 1998; Lumb & Oskvig, 1998). These processes should not be considered perfunctory. They are a critical form of oversight that requires active involvement of the organization's leadership with a strong connection to quality improvement (LaValley, 2006).

Accreditation and Regulation

Credentialing and privileging have long been familiar activities in hospital settings and spread to

Key Findings

- Credentialing and privileging are valuable aids in ensuring a competence workforce and client safety.
- Commonly used credentialing and privileging terms should be defined.
- An ongoing credentialing and privileging process is essential to every health care organization.

the out-patient setting with managed care in 1991 with the development of accreditation standards for ambulatory care by the Joint Commission (Brott, 2001). In the past, the Joint Commission required recredentialing once every two years. In 2007, the Joint Commission strongly rejected the pervasive "no news is good news" approach to practitioner practice oversight by health care organizations. Credentialing and privileging would now be required to be ongoing, with practitioner performance evaluated in real time (The Joint Commission, 2007). In California, the Code of Regulations, Title 22 requires that every medical



clinic have a system in place that includes credentials review, delineation of clinical privileges, and a peer review process (State of California, 1990). For public health, the Public Health Accreditation Board has proposed a set of standards for local health departments that include the responsibility to verify and document that staff meet the qualifications for their positions (Public Health Accreditation Board, 2009).

Definitions

There are many variations of definitions for the terms “credentialing” and “privileging”. An examination of the peer-reviewed literature and the consensus opinion of national health care related organization revealed the following:

Credentialing

1. Getting a doctor’s paperwork in order (Green, 2008).
2. A process of gathering information regarding a physician's qualifications for appointment to the medical staff (American College of Emergency Room Physicians, 2006).
3. A process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient care services in or for a health care organization (Payne, 1999).
4. Establishing practitioner qualifications (Brott, 2001b).
5. The process of assessing and validating the qualifications of a licensed independent (able to practice without direction or supervision [varies by state law])

practitioner to provide patient care services based on an evaluation of the individual’s licensure, training, or experience, current competence, and ability to perform requested privileges (Joint Commission, 2007).

6. To authorize an appointment (LaValley, 2006).
7. The process of assessing and confirming the qualifications of a health care practitioner (US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care, 2001 and 2002).

Privileging

1. The right to provide specific types of medical care within the organization (Green, 2008).
2. Denotes approval to provide specific services or perform specific procedures by a physician (American College of Emergency Room Physicians, 2006).
3. The specific professional activities that a staff member is permitted to perform in the facility under the jurisdiction of the governing body’s authority (Lumb & Oskvig, 1998).
4. The process whereby a specific scope and content of patient care services (i.e. clinical privileges) are authorized for a health care practitioner by a health care organization, on the basis of its evaluation of the individual’s credentials and performance (Galt, 2004).
5. Authorizations granted by the governing body of a hospital to provide specific patient care services within well-defined limits, based on the qualifications

reviewed in the credentialing process (Cooper, 1998).

6. The process that health care organizations employ to authorize practitioners to provide specific services to their patients (US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care, 2001 and 2002).

Los Angeles County Department of Public Health Definitions

The Los Angeles County Department of Public Health has chosen the following definitions for the terms

“credentialing” and “privileging”:

Credentialing is the process of assessing and confirming the qualifications of a health care practitioner.

Privileging is the process that health care organizations employ to authorize practitioners to provide specific services to their patients (US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care, 2001 and 2002).

Scope

The scope of credentialing and privileging can be structured as narrow or broad and may vary among health care organizations. For some organizations, these processes are for physicians only (American College of Emergency Room Physicians, 2006; Cassel & Holmboe, 2006; Green, 2008; Hill, 2004). In recent years, there has been a movement to adopt a broad perspective in defining which staff members would be subject to credentialing and privileg-

ing. Brott (2001a) makes the case that all who provide direct, hands-on patient care should undergo some form of credentialing. This includes those defined as “licensed independent practitioners” as explained by the Joint Commission (2007). Lumb and Oskvig (1998) describe a multidisciplinary unified approach to credentialing and privileging that includes nurse practitioners and nurse midwives who function independently as well as physician’s assistants and residents or fellows who function dependently. Pharmacists, nurse midwives, and physician’s assistants have all made their case for inclusion in credentialing and privileging systems within a health care organization (American Academy of Physician’s Assistants, 2006; Cooper, 1998; Galt, 2004). Federally, the extent of inclusion for credentialing and privileging is very broad. Any primary care site must have a process that includes any licensed or certified health care practitioner with the examples given of physician, dentist, registered nurse, social worker, laboratory technician, and nutritionists (US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care, 2001 and 2002). The Joint Commission (2007) uses the definition of “licensed independent practitioner” to define those who are subject to credentialing and privileging within a health care organization. This definition can vary from state to state depending on which practitioners are licensed to practice independently.

Processes

Certain essential elements of the credentialing and privileging process are common throughout health care organizations. The interval for the process is usually at hire and every two years thereafter. However, the Joint Commission (2007) now requires that organizations seeking its accreditation demonstrate real time, ongoing processes for the evaluation of competency to practice. Numerous credentialing and privileging checklists exist that could be adapted for use within the Los Angeles County Department of Public Health. A review of the credentialing and privileging process should be included in new employee orientation (Green, 2008). Health care organizations often contract with private organizations for the credentialing part of the process, since this is very time-consuming and requires the tracking of numerous details. Wilson and Iacovella (2000) describe several phases of credentialing conducted by a credentialing verification unit (CVU) including the inquiry phase where a credentialing application is given to the practitioner for completion. Once the application is received, the verification phase begins where the applicant's information is verified using primary source data. Once the applicant has turned in all the necessary information and it has been verified, the CVU reviews the information and determines whether to credential the practitioner for the organization. To those accepted, the CVU sends a letter acknowledging their acceptance. The practitioner is usually approved for two years.

Other Considerations

Setting up a credentialing and privileging system also includes consideration of:

- Whether to have the system within a medical staff committee structure or whether to include members of other disciplines in a professional staff organization structure with the attendant by-laws, policies, rules, and regulations.
- Determining the means by which a physician will maintain competence (skills and knowledge) and the mechanism to monitor the proficiency of each physician through a system of competency testing such as a skills lab approach or required demonstration.
- How to provide access to the process for the medical director who is overseeing the process for everyone else.
- How to tie the process into the performance evaluation system.
- How to set up peer review.
- How to ensure the process makes provision for modification, limitation, suspension, and revocation of credentialing and privileging.
- Whether to require that proof of participation in continuing education be submitted.
- How to protect confidentiality of credential decisions under peer review.
- How to ensure adherence to due process when mak-

making credentialing decisions.

- How to set up a system of experience monitoring so that data can be collected specific to a privileged person's professional activities.

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CONTRIBUTORS

Kathleen N. Smith, RN, MSN, MPH, is the Assistant Nursing Director, Administration for the Office of the Medical Director of the Los Angeles County Department of Public Health

Jeffrey D. Gunzenhauser, MD, MPH, is the Director of the Quality Improvement Division of the Los Angeles County Department of Public Health

This Quality Improvement Brief is part of a series produced by the Quality Improvement Division, Department of Public Health, County of Los Angeles. Quality Improvement Briefs present evidence-based summaries of key topic areas in quality improvement.

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- *Professional Practice*
- *Performance Improvement*
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For more information, please contact:

Kathleen N. Smith at kasmith@ph.lacounty.gov or 213-989-7247.