Dear Dr. Jeff:

I have been asked to coordinate “credentials and privileges” at our nursing home. I’m not sure what the difference is or what standards we should use. What do you suggest?

Dr. Jeff responds: Credentialing and privileging are the linked processes by which we protect our residents against unqualified health care professionals and inappropriate or substandard procedures. Essentially, credentialing confirms that practitioners have the training and licenses they claim to have, while privileging defines the abilities for which they are authorized within a facility.

For example, let’s say your facility is contacted by a wound-care team consisting of a surgeon and a nurse practitioner who is also a certified wound care nurse. They say they are prepared to come to your facility to participate in care, and assure you that they will bill third-party payers, so the facility and its residents will benefit from their expertise at no cost. They also inform you that they use a tracking form that enhances documentation and assures regulatory compliance. What would you want to know about them before you leap at the opportunity? That is the essential question that credentialing and privileging is intended to answer.

We live in an era of identity theft and inflated or frankly falsified resumes. Most of us have read about Frank Abagnale Jr. and his teenage exploits pretending to be a physician in Georgia (popularized in the Leonardo DiCaprio movie “Catch Me If You Can”). Many have thought this case was unique, but a simple Internet search identified cases of bogus physicians caught within the last few months treating patients in New York, Florida, New Jersey, Connecticut, Michigan, Nevada, and California. In one news account, a New York official estimated that more than 100 unlicensed practitioners were treating patients in New York alone.

A tech-savvy 12-year-old with a decent computer and color printer can create almost any document you might wish, so even a file with copies of licenses and malpractice insurance certificates may be insufficient to protect the facility against fraud.

Some individuals who practice fraudulently may be fairly easy to spot. For example, a would-be doctor in Coconut Creek, Fla., was arrested going door to door in one town offering free breast exams. Another was arrested when a patient died after she was injected in her buttocks with plastic cement by a “plastic surgeon” offering cosmetic surgery performed at home. But others, such as Michigan’s “Doctor” William Hamman who posed as a cardiologist, have obtained hospital and medical school appointments, lectured widely, and participated in multi-million-dollar grants.

Some of these bogus practitioners have gained entry into the medical system by becoming junior partners in established practices. They rarely scrutinize employees as thoroughly as most institutional employers would. Then, when providing “coverage” for a known practitioner, the fraudulent doctor gets into health care facilities.

A large visiting-doctors agency in Toms River, N.J., used identity theft to allow unlicensed staff to make home visits billed under the legitimate credentials and insurance numbers of former employees. These phony physicians ordered diagnostic tests, wrote prescriptions, and authorized Medicare and Medicaid home care services for hundreds of seniors.

It’s important to note that many of the pseudodoctors appear quite plausible. They may have attended nursing school or even completed some medical school. They may have experience working in medical facilities. They dress professionally and speak medicalese.

The Credentials

Consequently, a certain level of paranoia is appropriate. The Joint Commission (previously known as JCAHO) has quite high standards for hospital credentialing procedures. Relatively few long-term care facilities are accredited through the Joint Commission.

Although the Joint Commission schedules surveys at times convenient to the facility and does not require that deficiencies be posted in the lobby or placed on a website for consumer review, it does require primary source verification for hospital certification. This means that hospitals are expected to verify documents with the issuing source, not simply place them in files.

Medical school graduation must be verified with the school, state licensure, the state licensing agency, board certification with the certifying board, etc. Thus, while not an absolute guarantee, possession of full privileges at a local accredited hospital is a powerful argument that a practitioner actually has the background that he or she claims to have. Most hospitals will release this information to you if the practitioner signs a release form.

An increasing number of hospitals are turning to hospitalist models, raising barriers to independent physicians, and purchasing physician practices to create salaried subspecialists. As a result, many physicians have chosen to practice outside the hospital structure. This places the onus of credential verification back on you.

To return to our hypothetical wound-care team, what would you wish to know about these practitioners before they work in your facility? At a minimum, you would wish to confirm that they have valid licenses to practice in your state. For the protection of your facility, you would also need to confirm that their malpractice insurance is in force and meets your minimum coverage requirements (most facilities are requiring $1.1 million/$3.9 million policies, which might be more than some independent practitioners maintain). You would need to confirm that neither individual has been barred from Medicare or Medicaid. This is important not only because they would need to bill for their services (which is their problem) but also because they may be ordering services to be reimbursed.

Most of the necessary information is available online. The American Board of Medical Specialties website can confirm board certification by specialty. The Federation of State Medical Boards maintains a website through which licensure by state can be confirmed directly from the state licensure agency. Many states have available other significant information regarding training and certifications.

The AMA website has information regarding training and certification. The National Practitioner Data Bank is a repository of information regarding malpractice payments or judgments, state licensure agency penalties, and adverse peer review findings by hospitals or professional societies. Information from this databank is not publicly available by individual practitioner, but is available to health care institutions that register with the website. Since information regarding the adverse findings of professional and peer review organizations, such as being suspended by a hospital or censured by a professional board, must be reported by law, this databank is quite complete and contains information not available anywhere else. While an individual malpractice settlement may not reflect any particular quality issue regarding the practitioner, particularly in fields like orthopedics and neurosurgery where never being sued suggests a lack of experience, a pattern of negative findings might suggest a problem.

Also, many facilities rely heavily on letters of reference from peers. In my opinion, this is largely a waste of time. Doctors have very little notion of how their peers practice medicine. Any practitioner who can’t find a couple of friends prepared to write a letter stating that they are a fine human being and a paragon of professional excellence is really in trouble.

Privileging goes beyond general credentials to look at specific functions. For example, is this wound-care team approved to be the primary physician for a patient in your facility, or are they approved only as consultants? Is the surgeon approved to perform bedside debridement of wounds or needle aspiration? Even a simple bone biopsy might be possible in the home to exclude osteomyelitis. If the surgeon is being given privileges to perform some or all of these procedures, do they extend to the associated nurse practitioner? Importantly, credentialing and privileging is for individuals, not for a team.

Most facilities wish to be as welcoming as possible to professionals willing to practice within our walls. Residents benefit from continuity of care when practitioners who cared for them before their institutionalization can add their knowledge of and experience with the resident and the family to the team’s care plan. Certainly, many residents feel reassured by the familiar face of a trusted professional. And, of course, our census depends largely on the willingness of others to refer patients to us for care.

But that does not mean, most emphatically, that just anyone is competent to provide care in a nursing home. As our residents become sicker and their multiple medical problems become more complex, and as hospitals discharge patients to subacute care when they might have been in the ICU or cardiac step-down when I was a resident, the need for highly skilled and trained professionals to work in our setting can only grow. The American Medical Directors Association has been exploring the creation of a new designation tentatively called “SNFist” (pronounced sniffist) to describe this new specialty. We need to struggle to ensure that our residents’ care is being provided by first-rate, fully qualified professionals.

By Jeffrey Nichols, MD

Dear Dr. Jeff:

I’ve Got to Have the Right Stuff

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. You can comment on this and other columns at www.caringfortheages.com, under “Views.”