A Model for Clinical Credentialing of Dental School Faculty


Abstract: Committed to the premise that the same standards of review for clinical practice may be applied to clinical teaching, The University of Texas Health Science Center Dental Branch at Houston began credentialing clinical faculty in 1997 as part of its quality assurance and risk management program, one of the first dental schools in the country to do so. Credentialing, modeled after health care institutions such as hospitals, is general and procedure-specific involving the review of qualifications such as licensure, training, education, experience, and performance of professional practitioners; measuring those qualifications against pre-established criteria; and granting of “clinical privileges” to clinical faculty to perform or supervise procedures for which they are deemed qualified, based on that review. The development process included the leadership of the Quality Assurance and Risk Management Committee who met with all interested parties, explained the rationale and justification for credentialing, and successfully gained the support of the clinical department chairs, clinical faculty, faculty senate, and the administration of the school in implementing the credentialing process. Evaluation of this process indicates that it has been useful in providing a mechanism to address a variety of patient care and clinical education issues such as faculty competency, compliance, and accommodations through a peer review process.

Credentialing has demonstrated several advantages for health care institutions, including documentation of clinical faculty qualifications, improved quality and safety of patient care, and improved quality assurance and risk management. For the University of Texas Dental Branch at Houston, the accreditation requirement of a formal quality assurance (QA) program was the original impetus for exploring clinical credentialing. At the time, few dental schools utilized a formal QA program that could serve as a model other than records review processes. And the QA models that existed in other nondental school health care environments, such as hospitals, HMOs, IPAs, and PPOs, all included a credentialing process. With the change in dental education accreditation standards in 1996 towards a more patient-centered and QA-based approach to clinical education, the rationale for including a credentialing program within a QA program was logical. And the process selected for the school was one that included those elements of the medical model: credentialing, peer review, and privileging.

Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner to provide patient services in or for a health care organization. The information gathered is usually related to the education, training, knowledge, licensure, licensure history, actions taken by licensure boards, experience, and performance of the practitioner. Peer review is a review performed by individuals who possess similar qualifications or shared experiences, goals, training, or the like. This process is well known in academia as it is utilized for decisions ranging from publications to tenure. Professional licensing boards also serve as a good example of peer review. Privileging is that portion of the credentialing process where documented qualifications (education, training, experience, performance) of practitioners are assessed and determinations regarding the actual clinical procedures the practitioner is currently competent to perform, or “clinical privileges,” are made.

Other arguments for credentialing clinical faculty in the dental school clinical environment range
from meeting accreditation standards to possible legal ramifications. The accreditation impetus begins with the mission and goals of the Commission on Dental Accreditation (CODA). The current mission of CODA is “[serving] the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental . . . education and reflect the evolving practice of dentistry.” The first reason listed beyond the commission’s emphasis on quality education is “to protect the public welfare.” Standard 3-4 states: “A defined evaluation process must exist that ensures objective measurement of the performance of each faculty member in teaching, patient care, scholarship and service.” Standard 5-1 and 5-1 b. require a “formal system of quality assurance for the patient care program,” demonstrating evidence of a review of the quality of care provided to a representative sample of patients. Credentialing of clinical faculty is an appropriate process to meet and further these CODA goals and requirements when used with information gathered in other quality assurance activities.

### Initiating a Clinical Credentialing Program

In 1995, the Dental Branch’s quality assurance officer and associate dean for clinical affairs recommended to the school’s Quality Assurance and Risk Management (QA & RM) Committee that a clinical credentialing process be considered as an enhancement to the school’s efforts in improving quality assurance and patient care. At that time, nothing was present in the literature regarding dental schools and credentialing. Additionally, we were unaware of planned or implemented credentialing programs from informal discussions with dental school QA officers and clinical deans from other schools.

The development of credentialing was formally initiated by the QA & RM Committee by appointing a subcommittee to study its feasibility. The subcommittee ultimately recommended a process, drafted a credentials application patterned after other hospitals in the medical center and adapted to a dental school environment, and devised a corrective action and appellate process for any decisions that would adversely affect a faculty member’s clinical privileges. Application forms and related documents were subsequently approved by the QA & RM Committee.

The proposed credentialing process was then presented to clinical faculty, the school’s Faculty Senate, department chairs, and administration for review and comment. As with any major change in a university, faculty “buy-in” was critical for success. All faculty input was considered and utilized, or if not, a rational explanation was given as to why not. The department chairs presented and discussed the plan with their department faculty. The Administrative Council, composed of the associate deans and department chairs and chaired by the dean, also debated the new process. The Administrative Council and the Faculty Senate ultimately approved both the process and the minimum qualifications required of all clinical faculty for credentialing. This final approval completed a development and approval process that spanned approximately two years. Today, the clinical credentialing process is fully integrated into the school’s quality assurance and clinical administrative structure (Figure 1).

Oversight of the credentialing process has been the responsibility of the faculty, department chairs, clinic administration, and a Credentials Committee. In this process, faculty members are responsible for the submission of complete and accurate documentation as required through the credentialing process.

![Figure 1. Credentialing and quality assurance oversight structure, The University of Texas Health Science Center at Houston Dental Branch](image-url)
Department chairs review documentation, attest to its accuracy and completeness, and initially approve clinical privileges. The Credentials Committee is responsible for establishing qualifications of clinical faculty, reviewing and recommending clinical privileges for faculty who perform or supervise patient care in Dental Branch clinics, and making recommendations in professional liability matters. The Credentials Committee includes faculty representatives from the clinical departments and clinic administrators, as the associate deans for patient care and for educational research and professional development, the director of QA, and the director of clinical services, all of whom serve as ex-officio members. Finally, the associate dean for patient care, as the chief clinical officer of the school, provides administrative support to the process and final approval/denial to all credentialing applications and requested privileges.

The Clinical Credentialing Process

In the fall of 1997 the school officially began the process of clinically credentialing all full- and part-time clinical faculty and those dual degree basic science faculty holding D.D.S./D.M.D. degrees. Generally, the basic science faculty had limited patient care activity and were primarily involved in research activities. Initially, a total of 197 faculty were credentialed: one-half for two years and one-half for three years to establish a two-year re-credentialing cycle.

Credentials Application

For a new dental school faculty member, clinical credentialing begins at the time of initial appointment with completion of the credentials application and assembly of supporting evidence of education, training, and experience. A complete application composed of eight pages includes:

1. Completed and signed “Application for Clinical Privileges”
2. Completed and signed “Delineation of Clinical Privileges”
3. Current curriculum vitae
4. Copies of required documentation:
   a. D.D.S./D.M.D. degree from an ADA-accredited dental school (if not from an ADA-accredited dental school, applicants follow Applicants without a DDS/DMD from an ADA-accredited Dental School in the Clinical Credentialing document);
   b. Recognized Specialty Certificate of Training from an ADA-accredited institution, if applicable;
   c. Certificate of completion in Dental Hygiene from an ADA-accredited program, if applicable;
   d. Current license to practice dentistry or dental hygiene in any jurisdiction. Faculty not licensed in the State of Texas must submit an application to the Texas State Board of Dental Examiners for either a faculty license or a full active license within six months of employment at the Dental Branch;
   e. Documentation demonstrating that the applicant is current in continuing education requirements in the state or jurisdiction of licensure at the time of application.

All credentials applications and documentation are submitted to the department chair who reviews the application and supporting documents. The chair must recommend either granting or denying each specific privilege requested by the applicant and approve or disapprove the application. This part of the process is the foundation for maintaining and monitoring the quality of patient care in school clinics. It is the department chair who has primary responsibility for the faculty who provide and oversee patient care in his or her clinical discipline. Actual denial of privileges by a chair has been infrequently observed since the process was initiated. However, credentialing has created channels for positive dialogue between chair-faculty member, chair-QA officer, chair-associate dean for patient care, and QA officer-associate dean for patient care regarding faculty members’ clinical activity and competence that did not previously exist. The application is then forwarded to the office of the associate dean for patient care, who verifies the completeness of the application. Unlike hospitals and other health care organizations, the school accepts copies of degrees and training certificates as authentic and does not verify these documents. To do so requires additional human resources that the school has elected not to dedicate to the process at this time.

Completed applications are then forwarded to the Credentials Committee to begin the formal peer review process. A committee member is assigned as a primary reviewer of the application and supporting documents to ensure that all requirements have been met, and subsequently presents the application to the full committee for discussion and action.
Accommodations

Our Credentials Application requests that faculty members provide a “declaration of satisfactory physical and mental health.” As with many professional institutions in the country, our school employs faculty who may require special or specific “reasonable accommodations” due to physical, mental, or medical conditions that may impact their ability to perform clinical dentistry. According to The University of Texas Health Science Center at Houston Handbook of Operating Procedures, a qualified disabled person is defined as any person who has a physical or mental impairment that substantially limits one or more of such person’s major life activities, has a record of such impairment, or is regarded as having such impairment and is capable of performing a particular job with reasonable accommodation.

To ensure equality of access for qualified individuals with disabilities, reasonable accommodations have been and are provided to enable the individual to perform the essential functions of his or her job and/or to participate in Dental Branch academic programs and activities. Reasonable accommodations are made unless doing so would cause undue hardship for the school or cause a direct threat to the safety of the faculty member or others.

Therefore, to grant an accommodation, the accommodation must be tailored to specifically address any functional limitations. To either initially grant or review the previous granting of the accommodation, the faculty member is usually required to submit to his or her department chair and the Credentials Committee documentation from a physician outlining the physical limitation and possible accommodations that may be made. The committee reviews the documentation provided and makes a determination about the accommodation and whether other types of tailoring may be necessary to ensure the safety of all involved—for example, limitation in specific privileges.

Once the application is complete and all requirements have been satisfied, the file is sent to the associate dean for patient care with the committee’s recommendation.

Granting and Maintenance of Privileges and Re-Credentialing

The final step in the credentialing process, the granting of clinical privileges, is based on basic education, continuing education and training, current experience, current health status, and current clinical competence and judgment. All credentials listed by the faculty member must be documented and verifiable, except where noted above. The associate dean for patient care reviews the completed application after recommendation by the department chair and review by the Credentials Committee prior to granting or denying privileges. A final letter of action(s) taken is then sent to the faculty member and his or her department chair and kept on file in the office of the associate dean for patient care.

To remain in good clinical standing, each faculty member is required to maintain credentials by:

1. Submitting renewal documents, such as annual licensure registration, DEA registration, and CPR certification.
2. Notifying his or her department chair of any change in health status that affects performance of clinical teaching or patient care duties and may require accommodation.
3. Attending annual risk management training courses.
4. Attending annual clinical updates in infection control, medical emergency management, quality assurance, HIPAA/patient privacy, and clinic policy and procedure.
5. Meeting minimum continuing education requirements.

It is an ongoing challenge to any credentialing program to collect and verify providers’ annual maintenance documentation. The Dental Branch has been no exception, and clinical faculty who fail to comply with maintenance requirements are subject to suspension or even revocation of clinical privileges. Since initiation of the program, a total of fourteen faculty have received warnings regarding suspension or revocation of privileges due incomplete documentation. Of these, three were actually suspended from clinical activity until deficiencies were corrected.

Re-credentialing of faculty is required every two years, consistent with hospitals and health care organizations. A new complete application and review process similar to initial credentialing is utilized, except that certain one-time, nonexpiring supporting documents submitted with the initial application are not required (e.g., diplomas, certificates of completion, board certification, etc.).

Corrective Action

The Dental Branch recognized that there might be a need for corrective actions with a faculty member and developed a Corrective Action and Appeals Process for Adverse Credentials Committee Deci-
sions. This allows the institution to respond immediately in instances where corrective action is recommended or imposed when the character, professional or ethical qualifications, or conduct of a faculty member would in reasonable probability adversely affect patient care or the proper operation of the clinic. The intent of the corrective action process is not to be punitive, but rather to identify the need for additional training, education, assistance, or the like designed to improve the quality of patient care. Determining the need for corrective action is typically made from information gathered through one or more of the school’s QA monitoring mechanisms, such as patient record reviews, reports of student infractions of clinic policy or standard of care, or reports of a specific or series of specific incidents. Since the inception of clinical credentialing, corrective action has been utilized at the school on two occasions.

Here is a hypothetical case of peer review corrective action mechanism for faculty.

In April 1997 the school created an oversight organization for implant placement and restoration for all of the school’s advanced education programs involved with implants. As part of this structure, two distinct committees were established:

1. An Implant Steering Committee to coordinate implant curriculum and training, policy and procedure, patient screening, and case selection. The committee and its chair reported directly to the dean of the school.

2. An Implant Review Board, as a subcommittee of the Implant Steering Committee, to review all surgical and restorative treatment plans of all school implant patients prior to the execution of any implant or pre-prosthetic surgical procedures.

At that time, implant placement was limited to advanced education programs in Oral & Maxillofacial Surgery and Periodontics. Implant restoration was limited to advanced education programs in AEGD, GPR, and Prosthodontics.

The Issue. In late 1998, the Implant Steering Committee became aware of a number of cases in the school’s AEGD program that were never presented to the Implant Review Board. The program director was notified of the deficiency by the chair of the Implant Steering Committee. Implant restoration in the AEGD program was under the supervision of “Dr. X.”

In September 1999, due to noncompliance in correcting the deficiencies identified in 1998 and multiple other cases that had come to the attention of the steering committee, the chair of the Implant Steering Committee informed the AEGD program director that all implant activity in the program should be suspended. These other deficiencies identified since 1998 involved documentation, supervision of procedures, providing care in a timely fashion, and providing appropriate follow-up.

Notification to Credentials Committee. The chair of the Implant Steering Committee referred the matter to the dean who, in October 1999, held a meeting with the chair of the Implant Steering Committee, AEGD program director, associate dean for patient care, Dr. X, and his department chair. After lengthy discussion, the dean referred the matter to the Credentials Committee.

In November and December 1999, the Credentials Committee investigated the matter, interviewing the chair of the Implant Steering Committee, Dr. X, his department chair, and the AEGD program director. The committee also reviewed patient records and “all available documents and correspondences.”

Credentials Committee Findings and Action. The Credentials Committee identified the following findings from its investigation:

1. Deficient documentation in treatment notes,
2. Deficiencies in timeliness of patient care delivery,
3. Progress of cases not monitored,
4. Acceptance of complex restorative cases in the program that were beyond the scope and ability of AEGD residents,
5. Failure to follow Dental Branch rules and procedures, specifically those involving the Implant Review Board and the Implant Steering Committee.

The Credentials Committee’s final opinion was that there was no evidence that Dr. X demonstrated any “incompetency” in knowledge or in performing the procedures. However, the committee felt the evidence supported some corrective action and recommended the following:

1. Dr. X’s department chair should place Dr. X under supervision.
2. Department chair should establish the nature and extent of the supervision for Dr. X.
3. The supervision should minimally monitor and ensure that Dr. X corrects the noted deficiencies and that Dr. X knows and complies with all school rules and procedures, including record documentation requirements when treating or supervising care for patients in school clinics.
4. The supervision should be in place for a period of one year. At the end of the period, Dr. X’s department chair should report his recommendation to the Credentials Committee as to
whether to remove Dr. X from supervisory status, extend the supervision period, revoke all implant privileges, or any other action the department chair deems appropriate.

Follow-Up. The department chair followed the Credentials Committee recommendations and instructed Dr. X that his privileges would not be reinstated until he had demonstrated the following to the satisfaction of the AEGD and GPR directors and the department chair:

1. Competence in treatment planning implant cases.
3. Residents working under his supervision are fully prepared to present cases to the Implant Review Board.
4. All implant patients accepted into the AEGD and/or GPR program are presented to the Implant Review Board.
5. Competence in supervising all clinical restorative procedures in the AEGD and GPR programs.
6. Attend and successfully complete the school’s Graduate Implant Seminar Series course.

During the one-year period, the department chair was able to arrange for other faculty to provide supervision to AEGD in place of Dr. X. At the end of the year, Dr. X had successfully demonstrated compliance and his implant privileges were reinstated.

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Evaluation and Modifications to the Credentialing Process

Formative evaluation of the process began almost immediately when credentialing was initiated and has been ongoing. With monthly meetings of the Credentials Committee and regular communication between the committee and clinic administration, problems are discussed as they arise. The process has evolved since its inception and is reviewed annually by the Credentials Committee in its report to the Faculty Senate and by the associate dean for patient care in his or her annual report to the dean. As a result of the program’s ongoing evaluation, a number of changes have been made to the process:

Prescribing Medications. Initially, there were no guidelines in the process for prescribing medication. A formal policy was later added that authorized credentialed faculty to prescribe controlled and noncontrolled substances as long as such prescriptions were related to clinical education programs and patient care activities of the school. No additional qualifications beyond clinical privileges have been required for prescribing noncontrolled substances.

Continuing Education. The original application and credentialing documents were vague in the CE standards for faculty. This requirement was clarified to require new faculty to be current in, and provide supporting documentation for, meeting continuing education requirements in the state or jurisdiction of licensure at the time of application. Additionally, faculty who were to undergo recredentialing were required to maintain a summary listing of continuing dental education during the twenty-four-month period prior to recredentialing. A recent change by the Texas State Board of Dental Examiners requiring three hours of coursework in jurisprudence every three years has also been added to the CE standards for credentialing.

Laser Dentistry. Standards for the use of the CO₂ laser equipment were developed as this technology was added to the school after the initiation of clinical credentialing. The school restricts privileges to faculty and residents who are certified in the use of the laser, have demonstrated to a designated faculty member credentialed for the laser their ability to apply their knowledge, skill, and familiarity with school policies and procedures for safe use of the laser, and who have, then, been approved by the Credentials Committee for this clinical privilege. Residents are required to work under the direct supervision of an approved faculty clinician when using lasers in clinical care.

Implant Dentistry. Clinical privileges for implant dentistry were developed based on minimum standards established by the school’s Implant Steering Committee for use by department chairs and the Credentials Committee when evaluating faculty being considered for implant-related privileges. These privileges were developed when it was determined that current and newly appointed faculty presented with a wide range of qualifications for education and experience in implant dentistry. Since the development of these standards, mishaps in implant-related procedures have decreased significantly.

Conscious Sedation/Anesthesia. Minimum standards for clinical privileges in sedation and anesthesia, based on guidelines set by the American Dental Association and the Texas State Board of Dental Examiners, were developed for use by department chairs and the Credentials Committee when evaluating faculty. The need for these standards was identified after department chairs and the committee
encountered some difficulty in assessing or confirming the competency of some faculty who requested sedation and anesthesia privileges. In one specific case, which involved one of the school’s advanced education programs, all clinical activity in sedation/anesthesia in the program was suspended by the associate dean for patient care until the problems were addressed. The school also determined through its credentialing process that the advanced education training program in sedation/anesthesia was deficient in providing adequate clinical training and supervision of dental residents. While requests by faculty for clinical privileges in sedation/anesthesia must first be approved by the faculty member’s department chair, the chair may request that the chair of Oral and Maxillofacial Surgery/Dental Anesthesiology (OMFS/DA) or his or her designee also review and evaluate the faculty member requesting privileges in sedation and/or anesthesia.

**Applicants Without a D.D.S./D.M.D. Degree from an ADA-Accredited Dental School.** The Credentials Committee developed an alternative track to clinical credentialing to provide the school’s clinical departments an option for credentialing new clinical faculty who do not have a D.D.S./D.M.D. or equivalent from an ADA-accredited dental school and who are not eligible for licensure in one of the United States. This track was especially created for individuals who were considered to be exceptional in their training, experience, and expertise. However, recent changes to the state’s dental practice act creating a new licensure category for dental school faculty will likely result in the elimination of the policy. The new “faculty license,” created in 2004 and issued by the Texas State Board of Dental Examiners, now makes licensure possible for dental school faculty who do not have a dental degree from an ADA-accredited dental school.

**Evaluation and Outcomes of the Model**

Based on seven years of experience with clinical credentialing and continuing formative evaluation, the school has identified a number of outcomes that resulted in modifications in its credentialing process. Identified outcomes have included:

**Faculty Acceptance.** The program has been generally well received by faculty. Great effort was taken during the conceptualization and implementation phases to inform and involve faculty. Although there has been overall acceptance, over the years the common complaints by faculty have been the requirement to provide annual renewal documents and submit a complete new application for recredentialing. Modifications to the timing and notification to faculty, and availability of some renewal information online, have reduced the incidence of these problems. Faculty also were concerned about the collection of clinical remakes and mishaps and how those issues might affect their clinical privileges. While this data has been collected on a regular basis since initiation of the credentialing process, it has yet to be formally tied to clinical faculty performance evaluation. Such incidents continue to be reviewed on an individual basis by the associate dean for patient care and QA officer and, if appropriate, the department chair and faculty member. However, plans are to provide this data to individual faculty members and department chairs in the future.

**Role of the Department Chair.** The school’s credentialing program places heavy responsibility on the department chair. At times, incomplete applications have been received by chairs, or documents were incorrectly filled out. As a result, a Clinical Credentialing Checklist was created to assist department chairs in submitting complete and accurate applications. The checklist includes a complete listing of all application and supporting documents required in the process and has reduced the incidence of incomplete applications received from department chairs.

**Revision of Documents.** In 1999 and again in 2003, all credentials documents and forms were revised based on weaknesses identified through formative evaluation of the process and changes in standards or qualifications for credentialing. Two examples of such revisions were the creation of formal standards for both implant dentistry and conscious sedation in response to specific clinical incidents that occurred at the school. Additionally, forms have been semiautomated to allow faculty to complete application materials online and print for signature.

**Specialists Appointed in General Practice Departments.** Departments that are generalist-based have dental specialists, such as prosthodontists and periodontists, appointed to their departments. Credentialing of these specialists has remained within their department of appointment. However, generalist department chairs have recognized the occasion where the need may exist to consult another chair about the capability of the faculty member request-
ing to be credentialed. For example, it is not unusual for a generalist chair to consult with the chair of OMFS/dental anesthesiology regarding conscious sedation privileges.

Standards for Licensure Versus Standards for Faculty Appointment. Credentialing has provided the opportunity for the Dental Branch to consider whether the standards of qualification for faculty should exceed those for licensure. Two examples have been continuing dental education and conscious sedation. In these and other instances, the Credentials Committee and clinic administration have advocated that the school maintain education and training standards for faculty that exceed the minimum established by the Texas State Board of Dental Examiners. That is, that licensure alone does not “prove” competency, and that, as educators, the skill and knowledge required to teach others are higher than the minimum established for practice. Since the initiation of credentialing, the school has maintained a higher standard for CE. However, the Credentials Committee has recently recommended reducing the standard to match that required by the state board.

Impact on Hiring and Retaining Faculty: Since the inception of the program, the Dental Branch has had no instances in which a faculty member was denied privileges appropriate to his or her training and expertise. Additionally, there have been no instances where privileges have been permanently withdrawn for a clinical faculty member or where a credentialed faculty member has been denied privileges on re-credentialing. However, department chairs have related instances in which desirable faculty candidates were not pursued due to concerns over being able to credential the candidate, such as those candidates who do not possess a dental degree from an ADA-accredited dental school (see Applicants Without a DDS/DMD Degree from an ADA-Accredited Dental School).

Future Plans

The credentialing process at the Dental Branch is now a well-established component of the school’s quality assurance program. As the process has received a number of refinements over the years, there remain a number of associated projects under consideration. These include:

Credentialing Software. The credentialing process is currently supported by a self-developed database running in Microsoft Access. A number of commercially developed credentialing software programs are available and in use by other hospitals and other health care institutions. These applications provide a wide range of credentialing management features, such as application management, tracking committee attendance, and online forms. At some point, the school intends to explore further automation of the credentialing process through one of these applications.

Appendix A

Credentialing of Allied Dental Professionals. The credentialing of allied dental professionals, such as non-faculty dental hygienists employed in graduate programs (e.g., AEGD, GPR, Periodontics), has also been discussed. In many hospitals and other health care institutions, dentists are required to credential allied dental professionals who are active with the dentist in the institution. This is particularly true for dental hygienists. However, there are no immediate plans to include residents in the credentialing process.

Residents Who Teach. The issue of whether to require residents who have teaching assignments in the predoctoral program to be credentialed has been discussed. While the school’s experience with senior-level residents in clinical teaching has generally been very positive, there has been concern that doing so without attesting to the resident’s qualifications is counter to the concept of credentialing. However, currently there are no immediate plans to include residents in the credentialing process.

Transcripts. At this time, faculty members are required to submit the following documentation to become credentialed: license to practice dentistry; current registration to practice dentistry; current CPR certification; appropriate advanced education certificate/diploma, or copy of specialty board certification or registration (if applicable); current Texas
Department of Public Safety (DPS) registration certificate and copy of current DEA registration certificate, if prescribing controlled substances. However, based upon accreditation requirements from the Southern Association of Schools, the accrediting body for The University of Texas Health Science Center at Houston, that all faculty have official transcripts on file somewhere in the university, the Dental Branch Credentials Committee official transcripts will now be required as a part of the credentialing process in addition to the above listed required documentation to be held on file at the Dental Branch.

**Conclusion**

Based on our seven-year experience with clinical credentialing, we can offer the following to institutions who may be contemplating such a program:

1. The decision to credential clinical faculty and the implementation of such a program must include faculty input from the outset.
2. The credentialing process can become a part of and enhance a school’s overall quality assurance program and its ability to meet accreditation standards.
3. Credentialing has created a mechanism to address a variety of patient care and clinical education issues, such as faculty clinical competency, local-state-federal compliance, and accommodation of special circumstances, through a faculty-driven, peer review process. Many of these benefits have been realized, and the presence of an established process provides the opportunity to expand on others, such as clinical competency.
4. Credentialing of faculty can be implemented and renewed with little burden to dental school faculty, departments, or administration.
5. The process, while now established, should continuously be evaluated to determine whether improvements or changes to the process are necessary. The process must be responsive to changes in practitioner qualification, the practice of dentistry, and the dental school’s continued pursuit of quality patient care; therefore, we will continuously undergo formative evaluation of our credentialing process.
6. Other dental schools have expressed an interest in our credentialing process. As a result of this interest, two of the authors of this article along with colleagues from Baylor College of Dentistry conducted a Faculty Development Workshop at the 2004 ADEA Annual Session to provide the rationale for such a credentialing program as well as an overview of the implementation and evaluation process for other dental faculty and administrators who are considering such a process in their schools.
7. Clinical credentialing has become a significant component of the school’s quality assurance and risk management programs, organized the documentation of clinical faculty qualifications, and provided a supportive mechanism to establish initial and continued competency for clinical faculty. However, many opportunities exist for further development and evaluation of the program’s benefit to patient care, clinical education, and clinical competency.

**REFERENCES**