The Compliance Arms Race: How Healthcare Lost Sight of Evidence-Based Credentialing

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I've spent more than 20 years in healthcare. The first part of my career was in direct patient care, practicing both oncology and emergency nursing at two major academic institutions in New York City. For the past 17 years, I've worked in contingent workforce operations, overseeing the placement and compliance of thousands of healthcare professionals across the country at a national staffing agency. During that time, I've watched medicine evolve in remarkable ways. Clinical practice has become increasingly evidence-based, technology has transformed patient care, and quality metrics have become more sophisticated than ever before. Yet one area of healthcare seems to have moved in the opposite direction, at least from my perspective: the compliance process for contingent healthcare workers.

To be clear, compliance is essential. The alternative is not one I would support. Background investigations, license verification, occupational health screening, competency validation, immunization records (especially in the, hopefully short-lived, vaccine-skeptical environment we live in), and related credentialing requirements all play an important role in protecting patients, clinicians, and healthcare organizations. No reasonable person would argue that these safeguards should disappear. The problem isn't compliance itself. The problem is that over the past two decades, compliance has quietly evolved from an evidence-based safety process into an administrative competition where more requirements are often mistaken for better protection. Two condoms are not better than one.

Today's contingent staffing environment looks very different than it did twenty years ago. Most large health systems no longer contract directly with dozens, or even hundreds, of staffing agencies. Instead, they outsource workforce management to Managed Service Providers (MSPs) or Vendor Management Systems (VMS), organizations responsible for recruiting, credentialing, and managing temporary clinicians. Competition among MSPs is fierce and fiery. Winning a large health system contract can represent hundreds of millions of dollars in labor spend, and virtually every RFP emphasizes the organization's ability to deliver the highest level of compliance.

On paper, that's exactly what hospitals should want. In reality, however, this competitive environment has unintentionally created what I consider a compliance arms race. Every new client seems to add another form, another laboratory test, another attestation, another competency assessment, another verification. Rarely does anyone stop to ask the most important question: does this additional requirement measurably improve patient safety enough to justify its cost?

Many of these core requirements are unquestionably evidence-based. Beyond those fundamentals, however, the process often becomes inconsistent and difficult to justify scientifically. One hospital requires Hepatitis C screening while another does not. Some require annual competency assessments that duplicate nationally recognized certifications clinicians already maintain. Others require additional laboratory testing with little explanation or supporting evidence. The inconsistency itself raises an important question. If these requirements are truly essential to patient safety, why do they vary so dramatically between hospitals treating similar patient populations?

Tuberculosis screening provides perhaps the clearest example of how compliance has drifted away from evidence-based practice. Many healthcare professionals working in the United States were born in countries where the Bacille Calmette-Guérin (BCG) vaccine is routinely administered. Current CDC guidance recognizes that healthcare personnel with documented prior positive tuberculosis testing should not undergo repeated TB testing. Instead, they should receive a baseline symptom evaluation and maintain documentation of a prior chest radiograph, with additional imaging recommended only if symptoms develop or clinical circumstances warrant further evaluation. Routine serial chest radiographs are not recommended for asymptomatic individuals with documented prior positive testing.

Despite these recommendations, many contingent clinicians who travel every 13 weeks between assignments continue to obtain repeat chest radiographs simply because each hospital maintains its own occupational health policy. In many cases, credentialing specialists are not empowered to question client-specific requirements, even when those requirements exceed nationally accepted recommendations. Although the radiation exposure from a single chest radiograph is relatively small, roughly equivalent to ten days of natural background radiation according to the American College of Radiology, the issue isn't that one X-ray poses significant danger. The issue is that repeated imaging without medical indication offers no clinical benefit while increasing costs, delaying onboarding, and exposing workers to unnecessary procedures. If an evidence-based symptom questionnaire satisfies CDC recommendations, why should a clinician be subjected to repeat imaging simply because they crossed a state line or accepted a new assignment?

The same lack of consistency extends to laboratory testing. Some organizations require Hepatitis C screening for incoming contingent workers while others do not. Nearly every hospital requires documentation of Hepatitis B immunity (and some active infection, as well) because it directly relates to occupational exposure under OSHA's Bloodborne Pathogens Standard. But why Hepatitis C and not HIV? Why one bloodborne pathogen but not another? These questions aren't meant to minimize the importance of infectious disease screening. Rather, they highlight the absence of a clearly articulated, evidence-based standard that is applied consistently across organizations. Too often, compliance policies appear to evolve through institutional habit rather than occupational medicine supported by scientific evidence.

These decisions are not without consequences. Every additional requirement carries a cost. Staffing agencies absorb increased occupational health expenses, administrative labor, and delayed placements. Clinicians lose valuable time scheduling appointments, repeating laboratory work, obtaining duplicate documentation, and delaying the start of assignments that hospitals urgently need to fill. Hospitals themselves ultimately bear much of the financial burden through

prolonged vacancies, higher staffing costs, and slower onboarding. More importantly, patients bear the consequences as well. Every unnecessary delay in onboarding means another shift left unfilled, another unit operating short-staffed, another operating room schedule constrained by staffing shortages, and another emergency department searching for qualified clinicians. Administrative inefficiency is not merely a staffing problem; it ultimately becomes a patient care problem.

The American Hospital Association has estimated that administrative complexity contributes hundreds of billions of dollars annually to healthcare spending in the United States. While contingent workforce compliance represents only one piece of that enormous administrative burden, it reflects a larger systemic problem: processes tend to expand far more readily than they are ever simplified.

Perhaps the greatest inefficiency is the absence of any meaningful standardization. A nurse who completes a thirteen-week assignment at one hospital may possess a current background investigation, verified licensure, occupational health clearance, competency assessments, and nationally recognized certifications. Yet when that same nurse begins an assignment at another hospital only days later, much of the process begins all over again despite the documentation being only weeks old. It is difficult to imagine another highly regulated profession operating this way. Commercial airline pilots do not repeat credentialing every time they land at a different airport. Attorneys do not undergo background investigations every time they appear in a different courtroom. Yet healthcare routinely requires highly qualified clinicians to restart administrative processes that have already been completed.

Ironically, many state licensing boards remain so backlogged that primary source verification may lag behind real-world events. A clinician who incurs disciplinary action during an assignment may not appear differently in a verification system for weeks, or even months. This illustrates another reality: administrative burden does not necessarily translate into better oversight.

In many ways, the current system reflects a shift from risk management toward risk avoidance. Perhaps this, in the face of the professional plaintiff. Every additional requirement creates the appearance of increased diligence, but appearance should never be confused with effectiveness. Medicine has spent decades embracing evidence-based clinical practice. New medications, diagnostic tests, and procedures are expected to demonstrate measurable benefit before becoming standard of care. Administrative compliance should be held to the same standard. If a requirement cannot be shown to improve patient safety, reduce occupational risk, satisfy a regulatory mandate, or improve clinical outcomes, organizations should carefully reconsider whether it belongs in the onboarding process at all.

Healthcare does not need less compliance. It needs smarter compliance. Nationally standardized credentialing guidelines developed collaboratively by the CDC, OSHA, The Joint Commission, specialty nursing organizations, occupational medicine experts, healthcare systems, MSPs, and staffing organizations could dramatically reduce unnecessary duplication while maintaining rigorous safety standards. A universally accepted digital compliance passport could allow verified documentation to travel with clinicians between assignments rather than forcing them to

repeatedly prove the same qualifications every few months. Digital credential wallets, interoperable workforce platforms, and secure verification technology already exist. The barrier is no longer technology; it is the willingness of healthcare organizations, regulators, MSPs, and accreditation bodies to agree on a common evidence-based standard.

After nearly two decades working in contingent workforce operations, I have watched an essential patient safety function evolve into an increasingly fragmented administrative exercise. Hospitals, MSPs, and staffing agencies often compete over who can require the most documentation rather than who can create the safest and most efficient workforce. Compliance should protect patients, not reward redundancy. Healthcare has embraced evidence-based medicine in nearly every aspect of clinical practice. It is time to embrace evidence-based compliance as well. Every credentialing requirement should answer a simple question: Does it measurably improve patient safety? If the answer is no, we should have the courage to eliminate it. Smarter compliance, not simply more compliance, is how we strengthen both patient safety and the healthcare workforce.