Commonwealth of Massachusetts
Board of Registration in Medicine

Report of the Expert Panel on Credentialing

Guidelines for Competency-Based Hospital Credentialing

February 2008

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II. Expert Panel Report and Recommendations

A. Introduction

The Massachusetts Board of Registration in Medicine (BORM) through its Patient Care Assessment Division and Committee (PCA) has statutory and regulatory authority over quality improvement, patient safety and medical error prevention activities at Massachusetts health care facilities. While it may seem unusual that the Massachusetts Legislature placed oversight of institutional quality assurance in an agency that licenses physicians, but not health care facilities, the rationale is compelling: institutional quality and safety assurance will not succeed without meaningful physician leadership and participation.

Health care facility initial and biennial credentialing processes are subject to oversight by PCA. PCA monitors these processes through the review of reports submitted by health care facilities describing their quality assurance activities and findings, including the results of their reviews of serious unexpected patient outcomes. Through examination of these reports and communication with health care facility leadership, PCA determined that the credentialing process in many hospitals is burdensome, making it difficult to achieve the purpose of assuring that all physicians on the medical staff are providing safe and competent patient care.

In September, 2006, BORM created the Expert Panel on Credentialing. The Panel's purpose was to develop the specifications for credentialing physicians that all hospitals would be expected to meet in the biennial process. The Panel was also charged to create a standardized framework that healthcare facilities might utilize during initial credentialing and re-credentialing. This includes a broad array of methods, such as evaluation of patient outcomes through case reviews, analysis of data, review of accomplishments, complaints, certifications, and other competency assessments as recommended by specialty boards, professional societies, or regulatory agencies. The following proposal for hospitals is the first of several that seek to ensure the sustained competency of the Commonwealth's licensed physicians. Further deliberations will focus on assessing competency in the extended care setting and in non-hospital based practices.

B. History

Modern medicine remains challenged in its quest to reliably ensure that physician competency is sustained throughout the entire duration of a professional career. Over the span of several centuries, and in different cultures, various means were implemented in an attempt to enhance the quality and safety of medical practice.[1] For the ancient Mesopotamians, the Code of Hammurabi punished incompetence by summarily amputating the hands of physicians whose intervention resulted in a poor outcome. Medieval European universities began to identify core competencies by structuring formal curricula. Using medical texts from Byzantium and the Arab world, the degree of Doctor of Medicine was first granted at Salerno in the Eleventh Century. According to De Renzi in his "Storia della Medicina in Italia," it took three years of college work, then four years of medical study, followed by a year of practice with a physician, and possibly another year of anatomy for surgery,

to earn licensure, with a doctoral degree and teaching privileges granted after the four years of medical study.[2] 12th Century Italian physicians were required to be publicly examined by the masters in Salerno for licensure; practicing without such a license resulted in imprisonment and loss of property. During the 13th Century, lay barber-surgeons were required to pass examination by the clerical barber-surgeons, both members of the Collège de Saint Côme, the presiding medical guild in Paris. In the United States, the first specialty board, the American Board for Ophthalmic Examinations, was incorporated in 1917 and became the de facto competency overseer for that specialty. In 1934, with the addition of other boards, the Advisory Board for Medical Specialties was formed, subsequently to become the current American Board of Medical Specialties (ABMS).[3] At present, 24 boards certify satisfactory completion of training programs in 36 areas of specialization and in 88 areas of added qualifications. However, no claim is made that satisfactory completion of the training program assures sustained competency. The current board examination process first tests a physician's fund of relevant medical knowledge by utilizing written objective examination within a designated period of time during or immediately following training. With successful completion of this initial exam, candidates are then required to have their clinical judgment evaluated through the formulation of treatment plans during an oral exam component. This two-part examination process occurs only once at an early stage in a career.

With rapidly emerging medical advances, continuing medical education (CME) requirements and voluntary ABMS written re-certifying exams were added in the 1970's. While these validated a current fund of knowledge, they once again failed to provide ongoing assessment of the full breadth of clinical competence. As stated by the ABMS,

> *"…..member Boards realized that, in addition to medical knowledge, other skills and competencies are necessary for doctors to close the quality gap in the practice of specialty medicine and surgery in the 21st century. Enter the Maintenance of Certification (MOC) process."*[4]

MOC defines a process through which specialty board certified physicians can maintain their board certificate by demonstrating specific competencies.

In 1999, the Institute of Medicine (IOM) report "To Err Is Human" heightened awareness and renewed interest in patient safety initiatives. One area of focus is clinical competency.[5] Until recently, "competency" has been narrowly defined, often ignoring interpersonal relationships, the environment in which physicians practice, their relationship to the expanding team of providers and their degree of professionalism. These have typically been assumed to be adequate rather than be objectively assessed. What is needed is consistent real-time evaluation of all of a physician's specialty-specific skills, as is the routine in the airline industry. For pilots, such assessments are carried out through direct observation by a colleague and with the use of simulators.

In response to this deficiency, the ABMS, American Council on Graduate Medical Education (ACGME) and the Joint Commission have embraced a series of six core competencies.[6, 7] Together with the Federation of State Medical Boards (FSMB), these groups are seeking to establish standardized, comprehensive, and continuing methods for assessing physician competencies, both for physicians in training and, at the hospital level, for physicians in practice. The objective is to

assure physicians and the public that every licensed and certified physician is competent to provide care at the time it is provided.

C. Overview

The Expert Panel on Credentialing began its deliberations in September of 2006 and formulated proposed guidelines that provide a set of core criteria for credentialing. Furthermore, the guidelines establish a baseline for assessing competency in the six major areas embraced by the ACGME, Joint Commission, and the Federation of State Medical Boards. On October 17, 2007, BORM approved this report, including the proposed guidelines.

It is the expressed intent that the BORM and the facility will establish a working dialogue in implementing these guidelines that are consistent with a non-punitive, constructive process to improve physician performance. Mechanisms will also be proposed for remediation in the event that competency is questioned. It is recognized that in order to facilitate widespread acceptance and utilization of remediation programs, the BORM needs to incorporate new language in their regulations. Specifically, health care facilities must be allowed to initiate remedial action without a statutory obligation to report the physician in question to the BORM if the lack of a competency has not resulted in patient harm.

It is also recognized, however, that pursuant to its authority to oversee health care facility credentialing processes, PCA may request information from the health care facility concerning any remedial action taken to improve or monitor physician performance. Information provided pursuant to such requests would only be used by PCA to assess the quality of the health care facility's credentialing processes. PCA would not require that physicians be identified and the information would not be shared with those Divisions or Units of BORM responsible for reviewing and investigating mandated reports concerning individual licensees, (e.g., the BORM Enforcement Division and Data Repository Unit).

The responsibility for measuring competency rests with the hospital or other institution(s) where the physician practices. Several assessment measures are suggested for each of the competencies. The science of measuring competency is in its early stages of development, so these metrics will undoubtedly be modified and expanded over time. However, the currently available broad array of assessment methods is more than adequate to permit meaningful competency measurement.

The issue of granting privileges, once a physician has satisfied the criteria for credentialing, is also not addressed in this document. It is recognized that a number of issues, such as practice volume, emerging technology and the type of supervision provided to the privileged physician have significant impact upon the quality of care and needs to be addressed.

D. Guidelines

An initial survey of health care facilities was conducted to understand the current spectrum of credentialing criteria. (**Attachment A**) Based on this survey, the Panel recommends the **Core Credentialing Criteria** listed in **Attachment B**. Primary Criteria are those typically used by

facilities to meet mandatory credentialing requirements, while the Secondary Criteria are suggested as elective depending upon the needs of the specific facility.

The proposed elements of **Core Competencies** parallel initiatives by the ABMS, ACGME, Joint Commission and the FSMB. They are designed to standardize expectations through the professional development of a medical career from medical student to senior physician. Our intent is to provide guidelines for facilities to incorporate within their credentialing process, along with suggested metrics where available and applicable. (**Attachment C**). We have also provided a sample template based upon the six core competencies to facilitate the annual or biannual evaluation (**Attachment D**).

While these guidelines are provided without intent to regulate, institutions must be held accountable for implementing a sustainable process for ensuring competency. **The proposed core competencies and associated measures represent a spectrum of options, of which some may not be applicable to a specific healthcare facility or specialty practice. However, the measures listed provide several alternatives from which a facility can select those deemed most appropriate.**

III. Core Competencies

Definition: "Competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served." [8]

1. Patient Care
Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.

All medical and invasive procedures must be patient-focused and performed competently. In addition, health care services must include prevention strategies developed collaboratively with health care professionals from other disciplines.

Assessment, diagnosis, treatment, and effective referral of patients are contingent upon up-to-date record keeping and adherence to specialty principles & practice including osteopathic principles. Access to successful treatment in emergencies is dependent upon clinical timeliness, competency in procedures, effective use of resources, pain management, and utilization of end of life care.

- Access
  - Is reasonably accessible to patients in all health care settings
  - Assumes appropriate responsibility for patients
  - Arranges appropriate coverage when unavailable for patients

  Measures 3, 6, 13, 17, 18.

- Assessment
  - Communicates effectively and demonstrates caring and respectful behaviors when interacting with patients and their families

- Gathers essential and accurate information about patients
- Listens and responds to patients' questions, concerns and preferences

Measures 6, 11, 12, 14, 16, 17

✶ Diagnosis
- Selects diagnostic tests appropriately
- Critically assesses diagnostic information and communicates results to patients in a timely manner
- Makes accurate diagnoses following consultation
- Makes informed decisions about diagnostic and therapeutic interventions based on patient information and preferences and reasonable clinical judgment founded on evidence-based medicine, best practices and best available objective evidence
- Communicates diagnosis in a compassionate and sensitive manner

Measures 1, 11, 12, 14-16, 17, 18

✶ Treatment
- Develops and carries out patient management plans
- Educates patients so they can make informed decisions about their care
- Involves and counsels patients in their treatment decisions
- Uses information technology to support patient care decisions and education
- Pays attention to details
- Selects appropriate evidence-based treatments
- Prescribes medications in accordance with evidence based guidelines
- Demonstrates good judgment
- Manages patients with complex problems effectively
- Manages health care resources efficiently
- Performs competently all medical and invasive procedures within his/her scope of practice
- Manages pain appropriately
- Provides compassionate and effective end of life care
- Provides preventive health care services
- Demonstrates commitment to patients over personal concerns
- Advocates for patient rights for appropriate treatment

Measures 1, 3, 6-17

✶ Coordination of care
- Co-ordinates care effectively with other health care professionals
- Ensures continuity of patient care during absence and hand-offs
- Respects right of patients to seek a second opinion
- Keeps patients informed of progress in their care
- Handles transfer of care appropriately
- Provides relevant and timely information to referring physicians about mutual patients

Measures 3, 6, 11-13, 17

✶ Referral
- Refers patients to other specialists when indicated

- Refers patients to other health care institutions for specialized care or for alternate levels of care when indicated
- Works with health care professionals to provide patient-focused care
- Keeps referring physicians informed about patient's progress

Measures 3, 6, 11-13, 17, 18

✶ Record Keeping
- Maintains accurate, legible and relevant medical records
- Documents medical information in medical records in a timely manner
- Makes medical records accessible to patients

Measures 11, 12

2. Medical Knowledge

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

This is accomplished by demonstrating an investigatory and analytic thinking approach to clinical situations. Clinicians are expected to know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

Keeping up to date with new advances is accomplished through continuous certification by engaging in CME/Continuing Professional Development (CPD). Knowledge acquisition is measured by accessing and evaluating information and by mastery of practice specific competencies. Clinicians must be aware of best practices, guidelines, consensus documents in specific areas of practice and understand limits of knowledge.

- Keeps aware of best practices, guidelines, consensus documents in specific areas of practice
- Demonstrates an investigatory and analytic thinking approach to clinical situations
- Knows and applies the basic and clinically supportive sciences that are appropriate to their discipline
- Keeps up to date
- Understands limits of his/her knowledge

Measures 1, 7, 8

3. Practice Based Learning and Improvement

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practice.

This takes place through analyzing practice experiences and performing practice-based improvement activities using systematic methodologies. Specifically, the clinician must locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems. They should obtain and use information about their own population of patients and the larger population from which their patients are drawn. Knowledge of study designs and statistical methods are then applied to the appraisal of clinical studies and other information on diagnostic and

therapeutic effectiveness. Information technology is then used to manage information, access on-line medical information, and support their own education.

Clinicians must be able to facilitate the learning of students and other health care professionals. This is done by collecting and maintaining data about their practice, analyzing and learning from data collected, and improving practice based on what is learned. This includes understand norms, best practices, and benchmarks specific to their area of practice. Feedback should be sought from patients regarding their expertise with the practice.

- Learning and investigation
  - Collects and maintains data about his/her practice
  - Reports adverse events and errors to facilitate learning
  - Seeks feedback from patients, staff and professional colleagues regarding their experience with the practice
  - Incorporates results of peer-review processes
  - Understands norms / best practices / benchmarks specific to area of practice
  - Locates, appraises, and assimilates evidence from scientific studies related to his/her patients' health problems
  - Applies knowledge of study designs and statistical methods to assess clinical studies and other information on diagnostic and therapeutic effectiveness

  Measures 5-7, 8, 9, 19, 20

- Evaluation
  - Analyzes personal practice experience to improve
  - Uses information technology to manage information, access on-line medical information; and support his/her own education
  - Facilitates the learning of students and other health care professionals

  Measures 3, 7-9, 17, 20

- Improvement
  - Improves personal practice based on what is learned
  - Sets goals for improvement
  - Leads and/or participates in quality improvement and team-based practice improvement

  Measures 3, 8, 17, 18

4. Interpersonal and Communication Skills

Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, non-physician co-workers, physician colleagues and others.

This is realized by creating and sustaining a respectful, therapeutic and ethically sound relationship with patients using effective listening skills and eliciting and providing information using effective nonverbal, explanatory, questioning, and writing skills.

Communicating effectively entails demonstrating caring and respectful behaviors and gathering essential and accurate information from patients. Informed decisions can then be made regarding diagnostic and therapeutic interventions based on patient information and preferences, up-to-date

scientific evidence, clinical judgment, informed consent, and cultural sensitivity. Clinical management plans can then be carried out and communicated to the patient through counseling, education, and the use of information technology.

Information provided must be understandable to patients, families, non-physician co-workers, physician colleagues and others. This includes informing patients of errors, communicating in a timely fashion critical results, business and financial issues, and timely and comprehensive discussion with other colleagues involved in care. The latter includes seamless pass-ons during transitions in care (e.g., end of shift, etc.) Listening to patients and respecting their views can be measured through patient surveys.

- ✶ Communicates effectively with patients and their families
  - Listens to patients and respects their views
  - Provides information that is understandable to patients, families, and others
  - Shows compassion for patients and their families
  - Is courteous to patients and their families
  - Maintains confidentiality of patients and families
  - Respects the rights of patients

  Measures 6, 13, 14, 17, 18

- ✶ Involves patients actively in their care
  - Communicates treatment options to patients
  - Creates and sustains a therapeutic and ethically sound relationship with patients
  - Uses effective listening skills and elicits and provides information using effective nonverbal, explanatory, questioning, and writing skills

  Measures 6,13,14,17

- ✶ Communicates honestly and openly when things go wrong
  - Acknowledges complications and errors with patients and families when they occur
  - Fully explains what is known about the mishap and what will be done to discover, understand, and correct the causes
  - Accepts and communicates responsibility for complications and continuing care
  - Provides feedback of information from investigation of the event to its conclusion
  - Apologizes sincerely for errors and systems failures that harm patients
  - Provides continuing emotional support for injured patients
  - Responds promptly and openly to patient complaints, including apologizing when appropriate

  Measures 6, 13, 17, 19

- ✶ Communicates effectively with non-physician co-workers
  - Works effectively with others as a member or leader of a health care team
  - Respects non-physician co-workers as valued members of the team
  - Is courteous to non-physician co-workers
  - Listens to co-workers and responds to their concerns and input
  - Collaborates well with non-physician co-workers
  - Communicates effectively orally and in writing with non-physician co-workers

  Measures 3, 13, 17

- ✶ Communicates effectively with physician colleagues
    - Exhibits professional and ethical behavior towards physician colleagues
    - Is available for communication about mutual patients
    - Is courteous to physician colleagues
    - Collaborates with physician colleagues
    - Effectively manages transitions in care (end of shift, etc.)
    - Supports colleagues when things go wrong

  Measures 3, 17, 18

5. Professionalism

Practitioners are expected to demonstrate integrity with behaviors that reflect a commitment to continuous professional development, personal health, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

Professionalism is evidenced by a commitment to clinical excellence, self-awareness, and diligence with respect to personal physical and emotional health. Physicians need to recognize the signs and symptoms of burn out, the effects of aging and illness on clinical competency, work-family disequilibrium, the hazards of maladaptive coping strategies such as excessive alcohol or drug use, and where to go for confidential assistance if the physician or a colleague manifests signs of impairment with respect to their ability to practice medicine.

Physicians must be committed to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, the need for continuity of care, and sound business practices such as truth in advertising, unambiguous billing, and the avoidance of conflicts of interest. Clinicians must demonstrate understanding of the need to maintain professional boundaries and in order to avoid discrimination and prejudice, sensitivity to diversity in terms of a patient's culture, age, gender, and physical or mental special needs. Responsible attitudes are seen in honesty and compassion and a responsiveness to the needs of patients, the profession, and society that supersedes self-interest.

- ✶ Demonstrates personal integrity
    - Is honest and trustworthy
    - Demonstrates respect, compassion, and integrity
    - Holds self accountable to patients, society, and the profession
    - Is committed to excellence and on-going professional development
    - Demonstrates self-awareness and diligence with respect to personal physical and emotional health

  Measures 17, 18

- ✶ Maintains personal competence
    - Pursues continuous professional development
    - Participates in self- and others' assessment of competency
    - Displays intellectual curiosity
    - Works within limits of competence

  Measures 1, 3, 4, 5, 7, 8, 11, 12, 17, 18

- ✶ Places patients' interests first
    - Is responsive to the needs of patients and society that supersedes self-interest
    - Treats patients with respect regardless of their life choices and beliefs
    - Avoids financial conflicts of interest when possible; fully inform patients if they exist
    - Observes ethical principles when providing or withholding clinical care
    - Does not allow personal views of patient's circumstances or life choices to affect the treatment recommended or provided
    - When patients wishes conflicts with physicians convictions, physicians must be transparent and offer care with an alternative health care provider
    - Maintains confidentiality of patient information
    - Ensures patients are fully informed for consent to recommended treatments
    - Is committed to ethical principles pertaining to business practices
    - Is sensitive and responsive to patients' ethnicity, culture, age, gender, and disabilities
    - Provides competent and compassionate care without regard to patients' ethnicity, culture, age, gender, and disabilities
    - Provides for continuity of patient care during absence or termination of care
    - Scrupulously observes ethical boundaries
    - Avoids expressing to patients personal political, religious or moral beliefs
      Measures 3, 6, 13, 17, 18

- ✶ Ensures competency and professionalism of colleagues as applicable
    - Participates in teaching and training of physicians and students
    - Participates in assessment of competency of colleagues
    - Challenges colleagues when their actions are inappropriate or unsafe
    - Takes action as necessary to protect patients from unsafe acts of colleagues
    - Provides support for colleagues' improvement
    - Facilitates the learning of colleagues and co-workers
    - Facilitates the learning of residents and students
      Measures 3, 5, 17-20

6. Systems-Based Practice

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, as well as the ability to apply this knowledge to improve and optimize health care and patient safety.

This requires an understanding of how their care of patients and other professional practices affect other health care professionals, the health care organization, the larger society, and how these elements of the system affect their own practice. Physicians must understand how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.

Physicians should practice cost-effective health care and resource allocation that does not compromise the quality of care. They must advocate for quality patient care and assist patients in dealing with system complexities. This includes knowledge of how to partner with health care managers and health care providers to assess, coordinate, and improve health care and an understanding of how these activities can affect system performance.

Within a physician's sphere of control is attention to the environment of care, participation in teamwork, Continuous Quality Improvement (CQI)/Quality Assurance (QA)/audits, assuring that there are adequate systems to support the quality of practice and patient safety, clearly defined policies and procedures, compliance with public health and other regulatory reporting, and continuity and coordination of care across delivery settings.

- Understand the contexts and systems in which health care is provided
- Demonstrates familiarity with financing structures, the organization and capacities of provider entities and delivery systems, including methods of controlling health care costs and allocating resources
- Understands how personal practices affect other professionals and the health care organization, and how these elements of the system affect their own practice
- Participates with health care managers and other health care providers in quality and safety audits and assessments
- Partners with health care managers and other health care providers to redesign systems as needed to improve and optimize health care
- Partners with health care managers and other health care providers to provide coordinated high quality care
- Takes personal responsibility to identify hazardous practices and correct them by system redesign when possible
- Practices cost-effective health care and resource allocation that does not compromise quality or safety of care
- Advocates for quality patient care and assists patients in dealing with system complexities
- Works cooperatively to meet responsibilities associated with working within delivery systems, e.g., hospitals, nursing homes
  Measures 3, 17-19.

IV. References

1. In Garrison FH; An introduction to the history of medicine, 4th Edition. W.B. Saunders Company, Philadelphia 1929.

2. In Porter R: The Greatest Benefit to Mankind: A medical history of humanity from antiquity to the present. Harper Collins 1997

3. http://www.abms.org/About_ABMS/who_we_are.aspx Accessed April 4, 2007.

4. http://www.abms.org/Who_We_Help/Physicians/improving_quality.aspx#trans Accessed April 4, 2007.

5. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human; building a safer health system. Institute of Medicine. Washington, DC: National Academy Press; 1999.

6. Joyce B. Introduction to competency-based residency education: 2006 ACGME. A Product of the ACGME Outcome Project. Chicago, IL: Accreditation Council for Graduate Medical Education; 2006. p. 19-20.7. Comprehensive Accreditation Manual for Hospitals: *The Official Handbook.* The Joint Commission Resources, Inc. March, 2007: 407-8.

7. Comprehensive Accreditation Manual for Hospitals: *The Official Handbook*. The Joint Commission Resources, Inc. March, 2007:407-8.

8. Epstein RM, Hundert EM. Defining and Assessing Professional Competence. *JAMA* 2002; 287(2):226-35.

Attachment A

Spectrum of Core Credentialing Criteria

Checklist Data	Academic Medical	Community	Long Term Care	Health	Liability
Application	YES	YES	YES	YES	YES
Photograph	9	YES			
Copy of the License	YES	YES	YES	YES	YES
Other State License	YES	50%	YES	50%	YES
License Application	YES	YES	YES		
Visa Status if applicable	YES	YES	YES		
NPI/UPIN Numbers	YES	YES	YES	50%	
Federal Drug Enforcement Agency (DEA)	YES	YES	YES	YES	
Narcotics Waiver, when no DEA	2				
State Control Substance Certificate	50%	YES	YES	50%	
Curriculum Vitae (CV)	YES	YES	YES	YES	YES
Verification of Education/Training	YES	YES	YES	YES	YES
Educational Commission for Foreign Medical Graduates (ECFMG®)	YES	YES	YES	50%	YES
Verification of Board Certification* **	YES	YES	YES	YES	YES
Verification of other Hospital Appts	YES	YES	YES	YES	YES
Description of Clinical Responsibility Form*	YES				
Delineation of Privileges	YES	YES	YES	50%	YES
Privileges at Other Institutions		15%	50%		YES
No. Procedures at Other Institutions		50%	50%		
Privileges from former Hosp	1				
Authorization/Release	YES	YES	YES	YES	YES
Reference Letters	YES	YES	YES		
Explanation of Gaps		YES	YES	YES	YES
Quality Data	2				
American Medical Association (AMA) Profile	2	75%		YES	
Teaching Title Verification	2				
Criminal Background Check - Initial/Reapp/Both	Initial	85%	YES		
NPDB/HIPDB	YES	YES	YES	YES	YES
Verification of Medicare Sanctions	8	YES		YES	
Malpractice Face Sheet	YES	YES	YES	YES	YES
10 Year Claim History	YES	YES	YES	YES	YES
Patient Complaint Data	0				
Member Complaints from Health Plans	2				
Clinical Competence Form	1				
Declaration Health	2	YES	YES	YES	YES
Substance Abuse Test	2				
Tbc Test	1	30%			

Signed Confidentiality Agreement	5	30%			
Computer Key Statement - confidentiality	1				
Infection Control Paperwork	3				
Child Abuse Check	1				
Point of Care Course	1				
Physician Impairment Course	1				
Occupational Safety and Health Administration (OSHA) Regulations					
CME Requirements met		1			
Attestations:					
Bylaws		YES			
Advanced Cardiac Life Support (ACLS)		85%			
Intravenous Conscious Sedation (IVCS)	YES	BY DEPT / 85%			
Code of Conduct policy	YES	30%			
Corporate Compliance Policy		30%			
Orientation Form		15%			
National Patient Safety Goals		15%			
Medicare Attestations	**7**	30%			
Quality Improvement (QI)/Patient Care Assessment (PCA) orientation		15%			
Orientation Manual		15%			
Federation of State Medical Boards (FSMB) Reports	?				
MassPRO acknowledgement statement					
Massachusetts Department of Public Health (DPH) Volunteer Registration for Disasters					
Incident Command System (ICS) 100					
Incident Command System (ICS) 200.HealthCare					
IS-800.A National Response Plan (NRP)					

Attachment B

Primary Criteria
Application
Photograph
Copy of the License
Other State License
License Application
Visa Status if applicable
National Provider Identifier (NPI)/ Unique Physician Identification Number (UPIN)
Federal Drug Enforcement Agency (DEA)
Narcotics Waiver, when no DEA
State Control Substance Certificate
Curriculum Vitae (CV)
Primary Source Verification of Education/Training
Educational Commission for Foreign Medical Graduates (ECFMG®)
Primary Source Verification of Board Certification***
Primary Source Verification of other Hospital Appts
Description of Clinical Responsibility Form*
Delineation of Privileges
Privileges at Other Institutions
No. Procedures at Other Institutions
Privileges from former Hospital
Authorization/Release
Reference Letters
Explanation of Gaps
Quality Data
American Medical Association (AMA) Profile
Teaching Title Verification
Criminal Background Check - Initial/Reapp/Both
National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Data Bank (HIPDB)
Verification of Medicare Sanctions
Malpractice Face Sheet
10 Year Malpractice Claim History
Patient Appreciation and Complaint Data
Member Complaints from Health Plans
Clinical Competence Form
Declaration Health

Attachment B
(continued)

Secondary Criteria
Substance Abuse Testing
Tbc Test
Signed Confidentiality Agreement
Computer Key Statement - confidentiality
Infection Control Paperwork
Child Abuse Check
Point of Care Course
Physician Impairment Course
Occupational Safety and Health Administration (OSHA) Regulations
CME Requirements met
Attestations
Bylaws
Advanced Cardiac Life Support (ACLS)
Intravenous Conscious Sedation (IVCS)
Code of Conduct policy
Corporate Compliance Policy
Orientation Form
National Patient Safety Goals
Medicare Attestations
Quality Improvement (QI)/Patient Care Assessment (PCA) orientation
Orientation Manual
Federation of State Medical Boards (FSMB) Reports
MassPRO acknowledgement statement
Massachusetts Department of Public Health (DPH) Volunteer Registration for Disasters
Incident Command System (ICS) 100
Incident Command System (ICS) 200.HealthCare
IS-800.A National Response Plan (NRP)

Attachment C

Measures Applicable to Assessment of Clinical Competence

1. ABMS Specialty Board certification, re-certification and/or MOC
2. Malpractice Claims
3. Co-worker or peer recognition of excellence or complaints
4. Academic recognition of excellence or complaints
5. Professional society recognition of excellence or complaints
6. Patient/Family recognition of excellence or complaints
7. Outcomes analysis
   a. Deaths
   b. Complications
   c. Readmissions
8. Portfolio analysis of outcome data and 360 reviews for performance improvement
9. Appropriateness analysis (unnecessary surgery, imaging, etc….)
10. Process indicators (core measures, e.g., eye exams, B-blockers, etc)
11. Peer review record (American Board of Internal Medicine [ABIM] tool, etc….)
12. Retrospective record review
13. Communication assessment (Kalamazoo and other instruments)
14. Observation assessment of a “standardized patient”
15. Observation of a video or CD of actual case and presentation to experts
16. Participation, observation and assessment in high fidelity simulation
17. Multisource (360) evaluation
18. Department chairman assessment
19. Reports to Risk Management
20. Attendance and participation in departmental meetings and conferences

Attachment D

EVALUATION FOR MEDICAL STAFF APPOINTMENT

Assessment of Current Clinical Competence

Applicant's Name _____

Evaluating Institution _____

Current Status Active __ Affiliate __ Fellow __ Resident __

Dates of Appointment From _____ To _____

Competency	Characteristic	Measures used	Excellent	Good	Fair	Poor	Unknown
1. Patient Care	Access						
	Assessment						
	Diagnosis						
	Treatment						
	Coordination of care						
	Referral						
	Record keeping						
2. Medical Knowledge	Aware of best practices						
	Keeps up to date						
3. Practice-Based Learning And Improvement	Learning and investigation						
	Evaluation /Improvement						
4. Interpersonal and Communication Skills	Communicates effectively with patients and families						
	Involves patients in care						
	Communicates honestly and openly when things go wrong						
	Communicates effectively with non-physician coworkers						
	Communicates effectively with physician colleagues						
5. Professionalism	Demonstrates personal integrity						
	Maintains personal competence						
	Places patients' interests first						
	Ensures competency and professionalism of colleagues						
6. Systems-Based Practice	Understands systems of care						
	Participates in quality audits						
	Partners with others to redesign systems as needed						
	Practices cost-effective care						

Goals /Objectives for Next Year: 1.

2.

Signature of Evaluator _____ Signature of Applicant _____