Credentialing and Privileging Providers at the Hospital and the Office

EXPLORE
HEALTHCARE SUMMIT

Speaker Bio

Gordon Sanders, RN, BSN, CPHRM, FASHRM, Senior Risk Consultant, MedPro Group (Gordon.Sanders@medpro.com)

Gordon has more than 35 years of experience working in clinical practice, hospital administration, risk management, and consulting. His extensive clinical leadership includes nursing supervision in both home care and acute care hospital facilities. In home care, he led the development of fee-for-service programs. In acute care hospital facilities, he served as a lead developer, clinical coordinator, and instructor of the electronic medical records system. He also advanced to director of risk management in a multihospital integrated health system.

Gordon provided risk management consulting services, including program development, education, risk reduction, survey development, and regulatory compliance (including EMTALA and HIPAA), in previous positions. He also developed risk benchmarking between facilities and a best policies repository for insured physician groups and hospitals.

Gordon received a bachelor of science degree in nursing from Youngstown State University. He is a registered nurse in the state of Ohio. He is a member of the American Society for Healthcare Risk Management, and the West Virginia Society for Healthcare Risk Management.

Gordon also has served in leadership roles in the West Virginia Society for Healthcare Risk Management and the Ohio Society for Healthcare Risk Management. Additionally, he is a certified professional in healthcare risk management, and he is a Fellow of the American Society for Healthcare Risk Management.

Objectives

At the conclusion of this program, participants should be able to:

- Define and contrast credentialing and privileging
- Discuss how the regulatory and claims environments impact credentialing and privileging
- Describe how negligent credentialing impacts the business of medicine
- Demonstrate how privileging and competency evaluations are interconnected

Do you need privileges in the office practice?

Definitely!

- If billing under the same provider number or identifier – Yes
- Some may not agree but even if these are separate – Yes
- If TJC certified – Yes - providing “medical level of care” at hospital owned ambulatory sites
- If AAAHC – Yes

Ambulatory Care Privileging

- July 2007 NY required all office-based surgery practices to become accredited (State Public Health Law Sec. 230-d)
  - Any surgical procedure requiring general, moderate, or deep sedation
    - Liposuction specified
    - Minimal sedation or no sedation excluded
  - If not accredited, no longer able to perform any of these procedures as of July 14, 2009

AAAHC 16 Accreditation Handbook For Ambulatory Healthcare, https://www.scantronassessment.com/idev/guidelines/CCNResources/AAHC%20Accreditation%20Handbook%20for%20Ambulatory%20Health%20Care%202016.pdf

5

AAAHC - Ambulatory Care Privileging

Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform.

- An accreditable organization:
  - Phase 1: The organization determines the clinical procedures and treatments that are going to be offered to patients
  - Phase 2: The organization determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege
  - Phase 3: The organization establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner

Credentialing vs Privileging - AAAHC

Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires.

An accreditable organization:

1. Establishes minimum training, experience, and other requirements (i.e., credentials) for physicians and other health care professionals
2. Establishes a process to review, assess, and validate an individual's qualifications, including education, training, experience, certification, licensure, and any other competence-enhancing activities against the organization's established minimum requirements
3. Carries out the review

AAAHC 16 Accreditation Handbook For Ambulatory Healthcare, https://www.scantronassessment.com/idev/guidelines/CCNResources/AAHC%20Accreditation%20Handbook%20for%20Ambulatory%20Health%20Care%202016.pdf

7

AAAHC – Governance 2.II.K

- If the organization is a solo medical or dental practice, the provider's credentials file is reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice) at least every three years or more frequently if required by state law or organizational policies with documentation provided to the organization….

HCPro, Verify and Comply 9th edition 2021, https://hcmarketplace.com/verify-and-comply 8

Is accreditation for every practice?

- Hospital owned – if accredited – yes
- Non-hospital owned:
  - Regulatory mandate (state specific)
  - Advertising – Quality commitment
  - Reimbursement
  - Best practice!

The Professional Liability Case

Where's the Money? "Deep Pockets"

Professional Liability Insurance—the more policies the better

- Physician's policy
  - Individual policy (purchased by physician or by employer/hospital)
  - "Additional insured" on hospital policy
- Hospital policy
  - Base policy (+patient compensation fund in applicable states)
  - Excess insurance layers

Respondeat Superior

Legal doctrine based on vicarious liability

Latin for: “let the master answer”

An employer is responsible for the actions of employees performed within the course of their employment

Wikipedia, https://en.wikipedia.org/wiki/Respondeat_superior

Corporate Liability – state specific

- The hospital owes a duty directly to the patient
- The patient looks to the hospital for treatment not an individual physician—Agency
  - Hospital based physicians—Anesthesiologists, Emergency Medicine Physicians, Hospitalists, etc.
  - Hospital clinic based physicians—Wound Care/Hyperbaric, OB/GYN, Ortho, etc.

Whitney Foster, *Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 U. Ark. Little Rock L. Rev. 321 (2009), Available at: http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

Corporate Liability: Negligent Credentialing - a cause of action

Hospital knew provider was incompetent

Hospital turned a blind eye to the incompetence

Hospital should have known

- Through the evaluation process (initial appointment)
- Through the re-evaluation process (FPPE/OPPE)

Whitney Foster, *Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 U. Ark. Little Rock L. Rev. 321 (2009), Available at: http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

Negligent Credentialing Claim

- A negligent credentialing claim may be asserted as a direct or independent claim against a hospital or as a separate cause of action within a malpractice lawsuit against a physician or a hospital's medical staff.

ECRI, Medical Staff Credentialing and Privileging, 11/20/2020, https://www.ecri.org/components/HRC/Pages/MedSt1.aspx?tab=2

15

Corporate Liability in Hospitals

- Darling v. Charleston Memorial Community Hospital, 211 N.E. 2d 253 (Ill. 1965) **- $110K**
  - Hospital is not just a work space for providers
  - Hospital assumes certain responsibilities for patients admitted upon its premises
- Johnson v. Misericordia Community Hospital, 294 N.W. 2d 501, 97 Wis. 2d 521 (Wis. 1981) **- $405K**
  - Careless selection of medical staff members
  - Allowing providers to perform procedures that the hospital knows or should know the provider is not qualified to perform
  - Failing to investigate capabilities of provider when hospital knows or should know provider does not possess said capabilities
  - Make sure medical staff is qualified for privileges granted
  - Evaluate care provided

ECRI, Medical Staff Credentialing and Privileging, 11/20/2020, https://www.ecri.org/components/HRC/Pages/MedSt1.aspx?tab=2, Whitney Foster, Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians, 31 U. Ark, Little Rock L. Rev. 321 (2009), http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

16

Corporate Liability in Hospitals

- Joiner v. Mitchell County Hospital Authority: 125 Ga. App. 1 (1) (186 S.E.2d 307) (1971)
- The governing board may delegate privileging to the medical staff
  - Credentials Committee
  - Medical Executive Committee
- Committee members are agents of the governing board
- Governing board is ultimately responsible and liable

Whitney Foster, Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians, 31 U. Ark, Little Rock L. Rev. 321 (2009), http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

Corporate Liability in Hospitals

- Thompson v. Nason Hospital Sup. Ct., 527 **Pa.** 330, 591 A.2d 703 (1991)
  - Pennsylvania Supreme Court held that a hospital has *non-delegable duties*:
    - Maintenance of safe and adequate facilities and equipment
    - Select and retain only competent physicians
    - Oversee all medical practitioners within its walls as to patient care
    - Adopt and enforce adequate rules and policies to ensure quality care for the patients
  - The hospital is viewed by the public as a “health care provider”

Whitney Foster, Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians, 31 U. Ark, Little Rock L. Rev. 321 (2009), http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

Where's the Money? "Deep Pockets"

Columbia/JFK Center v. Sangounchitte (2008) - $8.5M

- Florida hospital credential physician with marginal proven competence
- Physician performed spine surgery with "off-label" use of metal rods
- Rods migrated from spine to brain causing permanent brain damage and spinal cord injury

Columbia/JFK Medical Center v. Sangounchitte, Justia US Law, https://law.justia.com/cases/florida/fourth-district-court-of-appeal/2008/4d07-1068-op.html 19

Case law continues to evolve

Schelling v. Humphrey Ohio 916 N.E.2d 1029 (2009)

- The Ohio Supreme Court held:
- “a direct duty to grant and to continue staff privileges only to competent doctors”
- “a duty to remove ‘a known incompetent’”
- Pursuit of a negligent credentialing claim
  - Plaintiff must show “but for the lack of care in the selection or retention of the doctor, the doctor would not have been granted staff privileges and the plaintiff would not have been injured”

Schelling v. Humphrey, 123 Ohio St.3d 387, 2009-Ohio-4175, https://www.supremecourt.ohio.gov/rod/docs/pdf/0/2009/2009-Ohio-4175.pdf 20

Duty – Doctrine of corporate negligence

"If the hospital fails in its duty and knew, or should have known, that the physician is unqualified and the physician subsequently commits an act of negligence that injures a patient, the court opined, the hospital can be held separately liable for compensatory damages under what is commonly known as the doctrine of corporate negligence."

How to Avoid Negligent Credentialing Liability, https://www.jdsupra.com/legalnews/how-to-avoid-negligent-credentialing-lia-92377/#:~:text=If%20the%20hospital%20fails%20in%20its%20duty%20and,commonly%20known%20as%20the%20doctrine%20of%20corporate%20negligence

21

Breech of duty

- Failure to adopt or follow:
  - Regulations and licensing requirements (Federal/State)
  - Accreditation standards
  - Its own medical staff bylaws, rules & regulations, policies
- Failure to assess credentials and competency of practitioners
- Failure to restrict privileges of those providing substandard care or are impaired

Negligent Credentialing Developments: Impact of Recent Cases and New Joint Commission Medical Staff Standards
https://katten.com/files/20986_Negligent%20Credentialing%20Presentation%20Materials.pdf

22

Why are we talking about hospitals?

- Respondeat Superior, Corporate Liability and Case Law!
  - Its not just hospitals...remember "Medical Level of Care"
- MCOs credential their physician panels
- Most health care insurers require providers to be credentialed with their plan

Frigo v. Silver Cross Hospital (2007)

- Frigo testified that she went to Silver Cross because that is where Dr. Kirchner worked.
- $7,775,668.02 against hospital----------after Podiatrist settled for $900,000.00

Frigo v. Silver Cross Hospital And Medical Center, https://caselaw.findlaw.com/il-court-of-appeals/1331090.html 24

Who still thinks in today's legal environment that:

- Hospital employed providers, or contracted providers of hospital owned and operated medical office practices do not need credentialed and then privileged for their office practice?
- Ambulatory Surgery Centers?

Who still thinks in today's legal environment that:

- Practices with multiple providers do not need credentialed and then privileged for their office practice?
- Senior care facilities?

Employed provider – hiring evaluation and re-evaluation

- Credentials—education, experience and job history
- Performance appraisals
  - Focused Professional Practice Evaluation (FPPE) for new hires and care issues
  - Ongoing Professional Practice Evaluation (OPPE) at specified intervals

Whitney Foster, *Health Law—Negligent Credentialing and You: What Happens When Hospitals Fail to Monitor Physicians*, 31 U. Ark. Little Rock L. Rev. 321 (2009), Available at: http://lawrepository.ualr.edu/lawreview/vol31/iss2/5

Closed Claims Data

Lessons Learned

Contributing factors

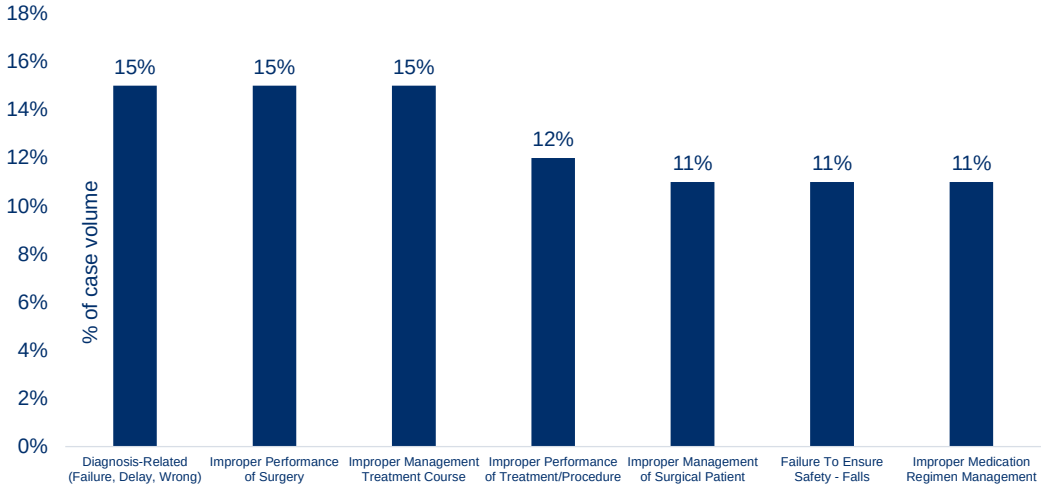
Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

> Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings and disciplines; thus, they identify opportunities for broad remediation.

CRICO Strategies. (2020). *The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss.* Retrieved from https://www.rmf.harvard.edu/Malpractice-Data/Annual-Benchmark-Reports/The-Power-to-Predict

Cases with a credentialing-related contributing risk factor



90% of all cases with a negligent credentialing risk factor fall within these allegations. 58% of these cases close with indemnity paid. Cases are distributed evenly between inpatient and ambulatory settings.

MedPro Group + MLMIC clinically coded cases, open dates 2011-2021, negligent credentialing as a contributing risk factor (N=>750)

Cases with a credentialing-related contributing risk factor

Diagnosis-related allegations are the most expensive to resolve.*

Half of all inpatient cases are associated with a senior care setting.

Failures to follow policies/procedures, and to recognize the significance of a patient's evolving clinical condition are other factors often noted in credentialing cases.

Attending/consulting physicians and organizational leadership are the roles most commonly linked to the credentialing issue.*

MedPro Group + MLMIC clinically coded cases, open dates 2011-2021, negligent credentialing as a contributing risk factor (N=>750); *closed cases, inclusive of total dollars paid (expense + indemnity); **the "role" of individual providers within a case is field available for less than one year to date so the case volume is still low (N=<130)

Examples of why a credentialing risk factor is appropriate

Rationale	Role
Surgeon not credentialed in plastics. Did not inform patient of this fact.	Attending/Consult
Physician only certified in family practice; he took a course in liposuction & attended a seminar on the subject (the credentials for liposuctions were denied due to lack of surgical background/experience).	Attending/Consult
Physician's assistant was not qualified to draw up injections.	Medical Assistant
Nurse practitioner had been deemed unsafe to provide care; yet, was allowed to continue to work for 30 days, per contract. This provider worked without any on-site physician supervision.	Nurse Practitioner
Urologist provided incomplete info in credentialing application, however, was approved by hospital.	Organizational Leadership
Many staff worked without proper credentials and/or lied about having credentials.	Organizational Leadership
Neurology tech's supervisor was listed as an MD on patient's neuro-monitoring report. He was also known as the Medical Director of the monitoring company; however, he had no medical license.	Other Allied Health
Hospital CEO mentioned "red flags" related to credentialing the cardiac surgeon. Details of concerns aren't specified in file.	Organizational Leadership
Expert questioned lax procedures related to credentialing at ambulatory surgery center.	Organizational Leadership

MedPro Group + MLMIC clinically coded cases, open dates 2011-2021, negligent credentialing as a contributing risk factor (N=>750); *closed cases, inclusive of total dollars paid (expense + indemnity); **the "role" of individual providers within a case is field available for less than one year to date so the case volume is still low (N=<130)

Credentialing and Privileging

Horror stories

- A jury in Las Vegas awarded a plaintiff more than $420,000 for a failed breast implant procedure.
- The defendant reportedly performed the procedure in his office without general anesthesia or intravenous sedation over the course of seven and a half hours.
- The incision on the patient's right breast reopened and was repaired by the defendant over an additional eight hours.
- The incision opened again, at which point the plaintiff was admitted to the hospital for removal of the implants and a regimen of intravenous antibiotics. (Bernstein & Poisson, LLC)

Office-Based Surgery and Anesthesia – Guidance, ECRI, 1/1/2013, https://www.ecri.org/components/HRC/Pages/OutPt3.aspx?tab=2#tabs-2 34

Horror stories

- In a case presented to the medical board in Oregon, a physician administered a fatal overdose of local anesthetic to the patient, an employee of the practice, during an after-hours procedure.
- The board found that the physician, an internal medicine specialist, failed to perform a patient evaluation before the procedure; performed the surgery alone, with no support staff or crash cart; failed to recognize the symptoms of a drug overdose; and failed to have the necessary drugs available to address such an emergency.
- The board determined the physician had improperly performed surgeries and treatments for friends and had administered treatments with no medical justification. (Budnick)

Office-Based Surgery and Anesthesia – Guidance, ECRI, 1/1/2013, https://www.ecri.org/components/HRC/Pages/OutPt3.aspx?tab=2#tabs-2 35

Horror stories

- Another case of death following a liposuction procedure involved a fatal overdose of lidocaine.
- The office where the procedure was performed was not registered as a surgical center, and a news article about the case warns that lax state regulation may lead some smaller practices to branch into cosmetic procedures because of the potential for larger profit margins.
- The practitioner in this case did not have hospital privileges. He was found to have attempted to remove too much fat and to be lacking the support staff or equipment necessary in the event of a life-threatening emergency.
- A restriction was issued against him to prevent additional surgeries from taking place in his office or under his supervision. (O'Donnell)

Office-Based Surgery and Anesthesia – Guidance, ECRI, 1/1/2013, https://www.ecri.org/components/HRC/Pages/OutPt3.aspx?tab=2#tabs-2 36

For physicians: what about midlevels/allied health practitioners/advanced practice providers

?

PAs and NPs *independently* billed Medicare over 4M office based procedures (2012)

- Forms of training
  - Formal Training
    - Physicians average 10,000 clinical hours in residency
    - NP (doctorate)/ PA (masters) average 500—900 hours
  - Seminars/weekend training programs

Scope of Physician Procedures Independently Billed by Mid-Level Providers in the Office Setting, http://archderm.jamanetwork.com/article.aspx?articleID=1895673&utm_source=Silverchair%20Information%20Systems&utm_medium=email&utm_campaign=ArchivesofDermatology%3AOnlineFirst08%2F11%2F2014

38

Cosmetic surgery in the office – laser surgery

Medical malpractice judgements from 1985-2012

- 174 cases
- 120 cases with public decisions
- 61% plaintiff verdict
- $5000 to $2,145,000
- *Mean=$380,700 Median=$350,000*
- **-34% physician extenders**

Common Causes of Injury and Legal Action in Laser Surgery, http://archderm.jamanetwork.com/article.aspx?articleid=1654904

39

Cosmetic surgery in the office

"Physicians are offering or supervising laser skin treatments outside the scope of their specialty"

Common Causes of Injury and Legal Action in Laser Surgery, http://archderm.jamanetwork.com/article.aspx?articleid=1654904

Botched on E!

- *Botched* is a Hollywood reality TV show
- Dr. Terry Dubrow and Paul Nassif “remedy extreme plastic surgeries gone wrong”

Botched on E!, https://en.wikipedia.org/wiki/Botched_(TV_series)
http://www.eonline.com/shows/botched

41

Doctor's offices are doing more surgeries

- Historically:
  - In the 1980s, hernia repairs were done with long hospital stays
  - Now done in the office due to minimally invasive techniques and advances in anesthetics
- 44 states (+DC) now regulate office-based surgery (2020)

Federation of State Medical Boards (FSMB) – OBS, https://www.fsmb.org/siteassets/advocacy/key-issues/office-based-surgery.pdf 42

Credentialing and Privileging

Part II

Credentialing

1. All hospital employed physicians and midlevels (AHPs/APPs), whether they practice at the hospital or not must have a credentials file, which resides at the hospital
2. All contracted providers in hospital owned/operated practices must have a credentials file

- Examples:
  - Hospital employed NP that staffs PCP office in Timbuktu
  - *Most* any employed PCP where the hospital has a hospitalist program
  - Hospital owned practice with contracted physician
  - Independent clinic physicians practicing in hospital building

Privileges

- Granting clinical privileges must be facility specific for each individual
- Clinical privileges are based on:
  - Applicant's qualifications
  - Care that can be provided within the specific facility
- Because an organization may credential its practitioners for several facilities within the organization that offer varying services, a practitioner's clinical privileges must clearly specify the sites for which privileges are granted.

Medical Staff Credentialing and Privileging – Guidance, ECRI, 11/20/2020, https://www.ecri.org/components/HRC/Pages/MedSt1.aspx?tab=2#credentialing 45

Privileging

The process whereby a specific scope and content of patient care services (that is clinical privileges) are authorized for a healthcare practitioner by a healthcare organization, **based on an evaluation of the individual's credentials and performance.**

A "privilege" is defined as an advantage, right, or benefit that is not available to everyone; the rights and advantages enjoyed by a relatively small group of people, **usually as a result of education and experience.**

Credentialing Resource Center - https://credentialingresourcecenter.com/resources/core-privileges-physicians

Privileges

- Core
  - Should reflect current practice of majority of providers in that specialty (what they were trained to do – residency, fellowship)
- Criteria-based
- Core plus – not quite laundry list
  - Criteria-based core (well defined core)
  - Criteria-based non-core (this is the plus)
    - Require additional training/experience beyond core

Credentialing Resource Center - https://credentialingresourcecenter.com/resources/core-privileges-physicians

47

Privileges

- Temporary – use with caution (red flag)
  - Limited duration for a specific care/service need
  - Locum tenens

HCPro, Verify and Comply 9th edition 2021, https://hcmarketplace.com/verify-and-comply
Credentialing Resource Center - https://credentialingresourcecenter.com/articles/locum-tenens-and-temporary-privileges#

48

Privileges

- Just because you credential them, doesn't mean you need to grant hospital privileges
- Refer and follow privileges
- If they do not intend on seeing patients in the hospital, maintain a credentials file, but do not privilege for hospital practice.
- If employed and do not need hospital privileges – privilege for office practice only.

Credentialing Resource Center - Refer-and-follow privileges and beyond for low- and no-volume practitioners, https://credentialingresourcecenter.com/articles/refer-and-follow-privileges-and-beyond-low-and-no-volume-practitioners

49

Privileges for office practice

Additional resources

- https://www.migrantclinician.org/resource/application-clinical-privileges-physician-specialty-family-medicine.html
- https://www.healthstream.com/resource/blog/introduction-to-privileges-understanding-privilege-form-components-and-best-practices
- https://www.veritystream.com/resources/white-papers
- https://www.umc.edu/Medical%20Staff%20Services/files/afm---family-medicine-clinical-privileges.pdf
- https://atriumhealth.org/-/media/chs/files/for-employees/medical-staff-services/clinical-privileges-update-forms/enterprise-ob-family-practice-dop.pdf?la=en&hash=F9311931495A3E62514F8E445F2A7F4CFFA7FF7A
- http://info.greeley.com/hs-fs/hub/252233/file-2431333108-pdf/White_Papers/crd_whitepaper_taking_the_fear_out_core_privileges.pdf

Hospital oversight

Risk management 101

Support for owned/operated practices

- Documentation
- Regulatory
- Training/Competencies
- Quality and Oversight
- Acquisitions

Documentation

- EMR
  - Compatibility—how many systems do you have?
  - Meaningful use / MIPS
  - Alerts for test results?
  - Alerts for referrals?
  - Alerts for recurring tests?
  - Alerts for screenings?

Documentation as evidence of compliance with privileges

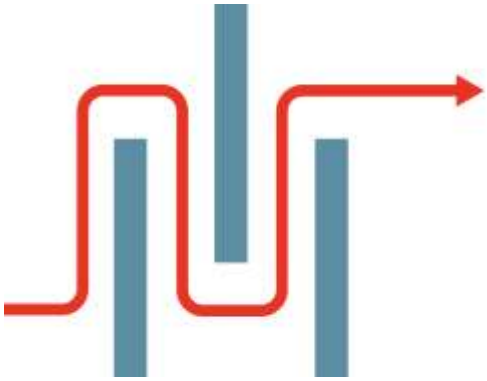
- Forms
  - Consent forms
    - Procedure specific consent forms
    - Anesthesia consent forms
  - Informed refusal forms

Training/competencies

- Physicians
- Midlevels (AHPs/APPs)
- Clinical office staff (RN, LPN, MA)
- Non-clinical office staff (Secretary, Billers, Managers)

Training/competencies

- Policies and Procedures
- Regulations (HIPAA/OSHA, etc.)
- Infection Control
- Use of equipment (Bio-Med)
  - Laser safety
  - Cautery
  - Cryo



Training/competencies

- Drills
- Fire
- HazMat Spill
- Infectious diseases
- Violence/Shooter
- Abduction
- Medical emergencies

Quality oversight and peer review

- Based on granted privileges:
- FPPE – include proctoring for procedures
- OPPE
- Case review – 360 degree review (hospital and office case reviews)
- Quality Indicators

Quality oversight and peer review

- **Midlevels/Allied Health Providers/Advanced Practice Providers**
  - FPPE – include proctoring for procedures
  - OPPE
  - Case review – 360 degree review (hospital and office case reviews)
  - *Collaborative/Supervisory agreements – compliance
  - Scope of Practice
  - Quality Indicators

* As applicable according to state

Quality oversight and peer review

- Office Practice Data
- Appointment – National Indicators
- Reappointment – National Indicators + System Specific

Risk management – office practices

- Risk Management is foreign to most office practices
- Acquisitions – due diligence
- Pro-active risk assessment
- Rounding
- Education
- Reporting

Questions

What questions do you have?

Thank You!!