Redefining Peer Review: Current Challenges and Future Directions

Presented by

Robert J. Marder, MD, CMSL, Vice President

Mark A. Smith, MD, MBA, CMSL, Director, Credentialing and Privileging Services
Target Audience:
• Members of the Greeley Medical Staff Institute
• Medical staff officers
• Medical staff department chairs
• Medical executive committee members
• Developing medical staff leaders
• Senior hospital managers
• Governing board members
• Medical staff professionals
• Credentials Committee Chairs
• Credentials committee members
• Medical staff quality committee members
• Vice presidents for medical affairs/Chief medical officers
• CEO’s
• COO’s
• Governing Board Members

Statement of Need:
This audio conference program is to educate and train members of The Greeley Medical Staff Institute, physicians and administrative healthcare leaders to stay current in their understanding of the evolving approaches to evaluating physician competency through peer review.

Educational Objectives:
- Understand the implications for your peer review program of the expanding areas physician competency measurement and ongoing professional practice evaluation.
- Create tools to evaluate and report the effectiveness of your peer review program to the MEC and the Board
- Implement a peer review rating system that incorporates patient harm.
- Define strategies to obtain perception data to evaluate non-technical competencies
The “Redefining Peer Review: Current Challenges and Future Directions” audio conference materials package is published by The Greeley Medical Staff Institute, 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945.

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III. Reporting peer review to the Board

IV. Evaluating harm in case review

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About your sponsors

About The Greeley Company

The Greeley Company's consultants and educators are physician leaders and senior healthcare professionals with hands-on experience in hospital, ambulatory, physician practice, and managed care settings. Our approach is to provide consultation, education, and training that is timely and cost-effective and to partner with our clients to produce high-impact results that serve the best interests of your organization, your patients, and the communities you serve.

We’re dedicated to helping healthcare leaders succeed in the face of today’s toughest challenges. We know how hard your job is. We have years of experience doing your job and helping others across the country do their jobs. From that experience, we know you don’t always have all the talent, resources, or time available within your organization to tackle the issues most important for your success and sometimes even for your organization’s survival. So when you need help, we’ll be there with just the customized, effective solution you need.

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The Greeley Medical Staff Institute is a unique membership organization dedicated to serving the needs of hospital and medical staff leaders who recognize the importance of effective physician relationships to their hospital’s success. Members of the institute receive exclusive access to high-level, nationally renowned consulting experts—all physicians and former hospital leaders—who work closely with you and members of your staff to develop and implement a multifaceted relationship-building program. Each customized program is designed to reduce hospital costs, build effective medical staff leadership, develop a succession strategy, comply with regulatory requirements, meet public accountability for quality, and train staff members to practice safe and effective medicine.
Robert J. Marder, MD, CMSL, Vice President

Robert Marder serves as vice president at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. He brings more than 25 years of healthcare leadership and management experience to his work with physicians, hospitals, and healthcare organizations across the country.

Marder’s many roles in senior hospital medical administration and operations management in academic and community hospital settings make him uniquely qualified to assist physicians and hospitals develop solutions for complex medical staff and hospital performance issues. He has consulted, authored, and presented on a wide range of healthcare leadership issues, including effective and efficient peer review, physician performance measurement and improvement, hospital quality measurement systems and performance improvement, patient safety/error reduction, and utilization management.

Prior to joining The Greeley Company, Marder served as assistant vice president for quality management at Rush-Presbyterian-St. Luke’s Medical Center and vice president for medical affairs at Holy Cross Hospital. He also served as the national project director for indicator development and use at The Joint Commission from 1988 to 1991. He is a board-certified pathologist and was assistant director of laboratories and director of clinical immunology at Northwestern Memorial Hospital and associate clinical professor at Northwestern University Medical School.

Marder is a graduate of Rush Medical College and received his residency training at Rush-Presbyterian-St. Luke’s Medical Center in pathology with a fellowship in microbiology/immunology.
Mark A. Smith, MD, MBA, CMSL, Director, Credentialing and Privileging Services

Mark Smith is director of credentialing and privileging services and a senior consultant at The Greeley Company. He brings 25 years of clinical practice and hospital management experiences to his work with physicians and hospitals across the United States.

Smith’s clinical practice as a surgeon and multiple roles in senior hospital administration make him uniquely qualified to assist Greeley clients develop solutions to their complex staffing and managerial problems. He is an expert in peer review, focused professional practice evaluation, and criteria-based privileging.

He is a fellow of the American College of Surgeons, Southwest Surgical Society, International Society of Endovascular Surgeons, and the American Board of Quality Assurance and Utilization Review Physicians. He is also a member of the American College of Physician Executives and the American College of Healthcare Executives.

Smith is a board-certified surgeon. He practiced as a vascular and general surgeon in Palm Springs, CA, and is currently a part-time vascular surgery faculty member at the University of California, Irvine. His previous positions include president, chief of surgery, chair of the peer review committee, and medical director of cardiac surgery at Desert Regional Medical Center.

He is a graduate of Jefferson Medical College. He received his residency training at the University of Kansas Medical Center and had a fellowship at the Hospital of the University of Pennsylvania. He holds an MBA from the University of Phoenix.
Exhibit A

presentation by

Robert J. Marder, MD, CMSL, and
Mark A. Smith, MD, MBA, CMSL
Redefining Peer Review: Current challenges and future directions

Presented by:
Robert J. Marder, MD, CMSL
Mark A. Smith, MD, MBA, CMSL

Redefining Peer Review

- Traditional definition:
  - Evaluation of patient charts to determine the quality of care provided by individual physicians
Redefining Peer Review (cont’d)

- Contemporary definition:
  - Evaluation of a physician’s professional performance for all defined competency areas using multiple data sources

- Case Review is only a part of Peer Review

The Joint Commission Terms
Defining Peer Review

- General Competencies
  - The framework that defines the competency expectations to be measured and evaluated

- Ongoing professional practice evaluation (OPPE):
  - Routine monitoring of current competency for current medical staff members

- Focused professional practice evaluation (FPPE):
  - Establishing current competency based on:
    - concerns from OPPE (focused review) or
    - new medical staff members or new privileges, (proctoring)
The Joint Commission General Competencies Framework

- Patient care
- Medical/clinical knowledge
- Interpersonal and communication skills
- Professionalism
- Systems-based practice
- Practice-based learning and improvement

Greeley Physician Performance Pyramid Dimensions

- Technical quality
- Service quality
- Relations
- Citizenship
- Patient safety/patient rights
- Resource use
OPPE and FPPE: How will it affect your peer review program?

OPPE and FPPE for Current Members: What does TJC really want?

- MS.4.15: Privileging decisions have an objective evidence-based process
  - *That means use relevant data*

- MS.4.30: A clear process for focused review
  - *That means use defined methods and accountabilities*

- MS.4.40: OPPE data is factored into privileging decisions prior to or at the time of renewal
  - *That means implement integrated systems*
How Will This Affect Your Peer Review Program?

- It's not just looking at the same data more often
  - More than just case reviews
  - Data for all competencies
  - Policies for when to look further
  - Accountability systems to assure follow-up

Effective OPPE and FPPE (Current Members) =

Systematic measurement
  +
Systematic evaluation
  +
Systematic follow-through
What Will You Need To Do Differently?

- It may be a lot, or a little.
  - Depends on how you are performing peer review today

- Use it as an opportunity to design better systems
  - Focus the system on helping physicians provide better patient care
  - Focus on how the standard will be surveyed in two years, not how it is surveyed today

How Can You Get There?

- Design fair and efficient measurement systems

- Collect credible data - accurate, risk adjusted

- Create data evaluation systems that improve physician performance and accountability
Reporting Physician Competency Measurement: What Should the MEC and the Board Know?

What Keeps the Board and MEC Up at Night?

- Is peer review working?
  - Case review
  - Rule and rate measures

- Are there medical staff wide concerns?

- Are there individual physician concerns?
Principles for Oversight Reporting

- Aggregate data on mutually agreed upon measures
- Consistent format
- Easy interpretation
  - Current period
  - Trends
- Provide detail only if need for action

Is Peer Review Working?

- Case Review Process and Results
- Aggregate Rate and Rule Indicator Results
Greeley Case Review Effectiveness Indicators

- Case identification effectiveness:
  - Cases reviewed by QM per 1000 hospital D/Cs

- Screening effectiveness:
  - % cases requiring physician review

- Review process efficiency:
  - % physician review cases with final decision within 90 days

- Review system effectiveness:
  - Cases with physician care issues per 1000 D/Cs

Source: The Greeley Company
% Cases Screened by QM Requiring Physician Review

Source: The Greeley Company

% cases with final determination within 90 days of physician reviewer assignment

Source: The Greeley Company
Cases Rated < Appropriate per 1000 DCs

Source: The Greeley Company
### Sample Medical Staff Indicators Board Report

<table>
<thead>
<tr>
<th>Performance Data</th>
<th>Indicator Type</th>
<th>Results</th>
<th>Excel Target</th>
<th>Accept Target</th>
<th>Curr Score</th>
<th>Prev Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Adj. Mortality Index: All DRGs</td>
<td>Rate</td>
<td>0.95</td>
<td>&lt;0.9</td>
<td>&lt;1.5</td>
<td>G</td>
<td>G</td>
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<tr>
<td>Risk Adj. Complication Index</td>
<td>Rate</td>
<td>0.88</td>
<td>&lt;0.9</td>
<td>&lt;1.5</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>% CHF Patients D/C on ACEI</td>
<td>Rate</td>
<td>93%</td>
<td>&lt;90%</td>
<td>&gt;75%</td>
<td>G</td>
<td>Y</td>
</tr>
<tr>
<td>Service Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% ED page response w/in 30 mins</td>
<td>Rate</td>
<td>70%</td>
<td>&gt;95%</td>
<td>&gt;80%</td>
<td>R</td>
<td>Y</td>
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<tr>
<td>Patient Satisfaction with MD %tile</td>
<td>Rate</td>
<td>65%</td>
<td>&gt;75%</td>
<td>&gt;50%</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Resource Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity Adj. LOS Index: All DRGS</td>
<td>Rate</td>
<td>0.9</td>
<td>&lt;0.9</td>
<td>&lt;1.5</td>
<td>G</td>
<td>G</td>
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<tr>
<td>Delayed Starts in OR/Procedure Area</td>
<td>Rule</td>
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<td>&lt;4</td>
<td>&lt;8</td>
<td>G</td>
<td>G</td>
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<td>Peer and Coworker Relationships</td>
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<td></td>
</tr>
<tr>
<td>Physician Behavior Incidents</td>
<td>Review</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>Y</td>
<td>G</td>
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<td>Citizenship</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H&amp;P/OP report not dictated w/ 24 hrs</td>
<td>Rule</td>
<td>0</td>
<td>0</td>
<td>&lt;3</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Medical Records Suspensions</td>
<td>Rule</td>
<td>0</td>
<td>0</td>
<td>&lt;3</td>
<td>G</td>
<td>Y</td>
</tr>
</tbody>
</table>

### What If You Identify Trends or Outliners?

- □ Provide explanation or status of inquiry
- □ Provide more detailed data if needed for a requested action or decision
Is the Report the Same for the MEC and the Board?

- Same aggregate measures
- MEC may have more detail, but not to micromanagement
- Board report would have MEC interpretation or recommendations

Evaluating Harm in Case Review
Greeley Categorical Case Rating System (See Case Rating Form)

- Single-aspect categories:
  - Overall physician care (three levels):
  - Physician issue identification
  - Documentation
  - Physician contribution to harm (optional)

- Exemplary care nominations

- Nonphysician care issues

---

Greeley Harm Ranking System: Physician Contribution to Patient Harm

Definitions of Harm Levels (Actual or Potential)

0 = No Harm
1 = Minor Harm: minor loss of function, brief temporary effects or slightly prolonged stay
2 = Moderate Harm: loss of major organ function, additional major procedures or significantly prolonged stay
3 = Severe Harm: death, irreversible vegetative state, or institutionalization
Greeley Ranking System: Physician Contribution to Patient Harm (cont’d)

TOTAL HARM RANKING (0 – 6) =

ACTUAL HARM due to physician care (0 to 3) + POTENTIAL HARM due to physician care (0 to 3)

Potential harm scored as equal or greater than actual harm

Would Evaluating Harm Due to Physician be of Benefit for Your Medical Staff?

☐ Pro
  ■ Establishes the importance of the case
  ■ Makes the final rating more meaningful
  ■ Prioritizes need for improvement actions

☐ Con
  ■ More difficult decision - implies causality
  ■ Takes additional committee time
How Do You Measure Non-technical Physician Competencies?

- Using perception data to measure physician competency

  The “brave new world” of physician competency measurement

What is Perception Data?

- Views of others regarding our performance:
  - Peers
  - Coworkers
  - Supervisor
  - Patients
Types of Perception Data

- **Passive**
  - Incident reports
  - Complaints and compliments

- **Active**
  - Evaluation forms
  - Surveys

When is Perception Data a Valid Form of Evaluation?

- When the perceiver is asked a question that they can have the ability to evaluate
  - Technical skills vs communication skills

- When the perceiver has a reasonable opportunity to observe performance
  - OR Nursing director vs Chief of Surgery
Which Expectations Lend Themselves Best to Using Perception Data?

- Patient care:
  - Compassion
  - Education and counseling
- Interpersonal and communication skills:
  - Clarity
  - Collegiality/cooperation
- Professionalism
  - Behavior
  - Responsiveness
  - Sensitivity to diversity

Impact of Survey-based Perception Data on Bias

- Minimizes personal reporting bias
- Allows for normative interpretation to decrease interpretation bias
### Four Steps to Implement Use of Perception Data for Your Medical Staff

1. Engage medical staff leaders in a discussion about perception data to obtain buy-in
2. Involve physicians in the design
3. Pilot test any new approaches
4. Educate the medical staff prior to roll-out
Exhibit B
Peer Review Case Rating Form
Peer Review Case Rating Form (Alternate Draft 7/08)

MR #:_______________  D/C Date: ___________ Referral Date: __________ Provider #: __________

Referral Source: Check the corresponding box
[ ] Screen [ ] Risk [ ] HIM [ ] Nursing [ ] Pharm [ ] Pt. Relations [ ] Med Staff [ ] Other _____

Review Criteria/Referral Issue:__________________________________________________________

Quality Screener/Date_________________________ Date Submitted for Physician Review ____________________

Case Summary ___________________________________________________________________________________
___________________________________________________________________________________________

Key Questions for Physician Reviewer: _______________________________________________________________
______________________________________________________________________________________________

To be completed by Physician Reviewer

Physician Reviewer:_________________________________________ Review Date: ___________

Note: If Overall Care = 1, then Issue must = (A); If Overall Care = 2, 3 or 0, then Issue must = (B) through (O)

<table>
<thead>
<tr>
<th>Overall Physician Care: Check one</th>
<th>Physician Care Issues: Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Appropriate</td>
<td>A No issues with physician care</td>
</tr>
<tr>
<td>2 Questionable</td>
<td>B Diagnosis</td>
</tr>
<tr>
<td>3 Inappropriate</td>
<td>C Clinical Judgment/Decision-making</td>
</tr>
<tr>
<td>0 Reviewer Uncertain, needs Committee discussion</td>
<td>D Technique/Skills</td>
</tr>
<tr>
<td></td>
<td>E Knowledge</td>
</tr>
<tr>
<td></td>
<td>F Communication/Responsiveness</td>
</tr>
<tr>
<td></td>
<td>G Planning</td>
</tr>
<tr>
<td></td>
<td>H Follow-up/Follow-through</td>
</tr>
<tr>
<td></td>
<td>I Policy Compliance</td>
</tr>
<tr>
<td></td>
<td>J Supervision (House Physician or AHP)</td>
</tr>
<tr>
<td></td>
<td>O Other:</td>
</tr>
</tbody>
</table>

Documentation Issue Description:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Physician Contribution to Patient Harm
Definitions of Harm (Actual or Potential)
1. Minor Harm: minor loss of function, brief temporary effects or slightly prolonged stay
2. Moderate Harm: loss of major organ function, additional major procedures or significantly prolonged stay
3. Severe Harm: death, irreversible vegetative state, or institutionalization

Check one each for Actual and Potential (Potential rating must be at least as high as Actual rating)

<table>
<thead>
<tr>
<th>Actual Harm from Physician Care</th>
<th>Potential Harm due to Physician Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 No actual patient harm from physician care</td>
<td>0 No potential patient harm from physician care</td>
</tr>
<tr>
<td>1 Actual minimal patient harm from physician care</td>
<td>1 Potential minimal patient harm from physician care</td>
</tr>
<tr>
<td>2 Actual moderate patient harm from physician care</td>
<td>2 Potential moderate patient harm from physician care</td>
</tr>
<tr>
<td>3 Actual severe patient harm from physician care</td>
<td>3 Potential severe patient harm from physician care</td>
</tr>
</tbody>
</table>

PHYSICIAN CONTRIBUTION TO PATIENT HARM RANKING: Actual ___ + Potential____ = Total____

If Overall Physician Care rated Appropriate, provide a brief description of the basis for reviewer findings:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

If Overall Physician Care rated Questionable, Inappropriate, or Uncertain, please complete the following:
A. Brief description of the basis for reviewer concerns:___________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

B. What questions are to be addressed by the physician or the Committee?____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Exemplary Nominations: __Physician Care___ Physician Documentation ___Non-Physician Care

Brief Description:______________________________________________________________

Non-Physician Care Issues: ____Potential System or Process Issue __ Potential Nursing/Ancillary Care Issue

Issue Description:______________________________________________________________

Redefining Peer Review: Current Challenges and Future Directions
**Committee Review**

Is physician response needed? _____Y _____N

**Practitioner response:** __Discussion with chair __Letter __Committee appearance

**Committee Final Scoring:**

Overall Physician Care _____ Issue Identification:____ Documentation:____ Harm Actual____ + Potential____ = Total_____

<table>
<thead>
<tr>
<th>Committee Recommendation/Action (Check One)</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>No action warranted</td>
<td></td>
</tr>
<tr>
<td>Physician self acknowledged action plan sufficient</td>
<td></td>
</tr>
<tr>
<td>Educational letter to physician sufficient</td>
<td></td>
</tr>
<tr>
<td>Dept. Chair discussion of informal improvement plan with physician</td>
<td></td>
</tr>
<tr>
<td>Dept. Chair develops formal improvement plan with monitoring</td>
<td></td>
</tr>
<tr>
<td>Refer to MEC for formal corrective action</td>
<td></td>
</tr>
</tbody>
</table>

___System Problem Identified – forward to PIC  Date sent: ________ Date Response______

Describe system issue:______________________________________________

___Referral to Nursing Review  Date sent: ________ Date Response______

Describe nursing concern:______________________________________________

___Referral for CME/Dept M&M  Date sent:________________________
Peer Review Monthly:
Why use a scoring system for peer review?
"Peer Review Monthly: Why use a scoring system for peer review?"

Published July 2008

Dear Medical Staff Leader,

At a recent Greeley Company national seminar, a physician leader asked me why peer review committees should use a case review scoring system. She had attended another organization’s program, which advocated eliminating final case scoring and simply classifying cases with care issues as “referrals.” When the physician leader asked the previous speaker to justify this approach, the speaker in turn asked why one would use a scoring system in the first place.

The Greeley Company has consistently advocated for scoring case reviews, but we are certainly open to new ideas that may help medical staffs perform effective peer review. In that spirit, I thought it would be useful to review our justification for using our scoring system to be sure it is still relevant. This scoring system is based on following three action points:

1. Rate each case using categories that focus on a single aspect of evaluation. Doing so makes scoring easier and more reliable. It is better to have one category that evaluates the potential clinical outcomes and a second category that evaluates the appropriateness of physician care rather than a single category that tries to combines both (e.g., a category such as “Moderate effect on the patient but no physician care issues”). Likewise, it is important to have a separate category for documentation deficiencies because they are different from technical quality of care issues.

2. To rate appropriateness of care, use at least three levels:
   - Appropriate
   - Questionable (or controversial)
   - Not appropriate

   Otherwise, even when a physician reviewer disagrees somewhat with the approach taken by the physician under review, the reviewer will score care as “appropriate” if the only other option is “not appropriate.”

3. Define the reasons why care might not have been viewed as appropriate. The Greeley Company uses a separate category to identify physician care issues (e.g. skills, knowledge, judgment, communication, planning, etc.). Systematically defining physician care issues at the time each case is decided allows the medical staff to get to the root cause of physician
performance concerns and identify patterns for improvement despite differences in the diseases, procedures, or circumstances of the individual case.

The main reason for using a scoring system for case reviews is fairness. A scoring system lends itself to more clearly defined thresholds for focused review and allows the medical staff to set prospective targets and address different levels of concerns. As a result, scoring systems make the decision to look more closely at physician performance less arbitrary and more fair. Typically, a medical staff will set a threshold to automatically review a physician’s performance if more than two cases per year are rated inappropriate or four cases per year are rated questionable or inappropriate.

An additional benefit of using a categorical scoring system is that it lends itself to database tracking and easier pattern recognition. Leaving cases rated as referrals requires going back and defining the issues that were apparent on the initial review.

There may be reasons for eliminating scoring based in legal concerns to minimize documentation for peer review. However, to do fair and effective peer review, we believe case scoring is still well justified if a good system is used.

Regards,
Robert Marder, MD, CMSL
Vice president
The Greeley Company
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- Physician practice
- Quality/patient safety
- Safety
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attended

“Redefining Peer Review: Current Challenges and Future Directions”

a 60-minute audio conference

Rick Sheff
Chairman and Executive Director
The Greeley Company