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New guideline represents 'processed-oriented' approach for ISO 9000

ISO 9000 and JCAHO can run in tandem

Hospitals that have been tracking the development of ISO 9000 in the health care industry should pay close attention to a new guideline about to emerge that experts say will be the system's next leap forward.

Many hospitals know about the ISO 9000 standard series but not about its requirements. The International Organization for Standardization's Technical Committee (TC 176) produces the international quality management and quality assurance standards known as the ISO 9000 series of standards. The Geneva, Switzerland-based ISO establishes common sets of manufacturing, trade, and communication standards.

> *"What we found was that the [Joint Commission] designation really has zero meaning to the people that we take care of."*

According to **Laura Preole**, health care services manager of SGS International Certification Services based in Rutherford, NJ, the new guideline is the latest step in an effort to establish a more "process-oriented" method of looking at the health care environment from the moment a patient walks into a facility to the moment he or she is discharged.

The new guideline will be the product of a meeting co-hosted last month by the Standards Council of Canada and Canadian Standards Association

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International. The goal is a published guideline to help health care organizations understand how to interpret the existing standard for their businesses, explains Preole, who has been an active participant in its development.

The current standard for ISO is only 20 pages long and lays out 20 requirements that define a quality management system.

"It gives you a set of end results so that standard can be applied to a variety of industry sectors," explains Preole. "It talks about quality management systems rather than health care accreditation standards."

According to **Joe McMahon**, senior program officer for the ISO Standards Council of Canada in Ottawa, which was instrumental in the meeting, the ISO health care division felt it was important to take the existing standard one step further while also providing additional guidance on ISO 9004:2000. The new standard is called 9004:2000, even though hospitals pursuing certification would be using ISO 9001:2000.

"Where this goes from here will be determined at the workshop itself," explains McMahon. "This is not a training session in any respect; it is a working session."

Questioning value of JCAHO surveys

Among the hospitals that have already moved in the direction of ISO is Memorial Medical Center of West Michigan, a 95-bed facility in Ludington. Roughly six years ago, the hospital became dissatisfied with the survey process and objectivity of the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations, says **Robert Marquardt**, Memorial's CFO.

"We really questioned the value that we were getting from the Joint Commission," he recalls. But the hospital was concerned how its patients would respond if it made a change.

To address those concerns, Memorial implemented a novel survey. "We went out to the real world and called about 400 households in our county and asked them a series of questions related to this topic," Marquardt reports.

He says the survey showed that only about six households out of 400 even knew what the Joint Commission was, and only a few of them placed any value on the process.

"What we found was that the [Joint Commission] designation really has zero meaning to the people that we take care of." Among the hospital's large payers there was even less interest in

the Joint Commission, he adds. At the same time, Marquardt says, the hospital felt rudderless without some type of external assessment to gauge the quality of its services. "We were less concerned with who that external body was than having somebody outside the organization to provide an effective assessment."

After briefly tapping an outside consultant to fulfill that role, Marquardt says, Memorial opted to use ISO for two primary reasons:

1. **Memorial wanted to be able to relate its quality experience to the manufacturing community.** That made the ISO process immediately attractive because many employees at the hospital already understood what is involved with that certification process.

From a marketing perspective, that created a powerful tool, Marquardt says. As the process unfolded, however, he became even more interested in what the process could do for the hospital internally. "It had a very powerful impact on the manufacturing community, but the result we were most excited about was what it did for us internally."

According to Marquardt, those improvements included documenting processes that were already occurring in the organization but had never been tracked. "The strength of the process for us has been the internal auditing," he says. "We have been able to document our strategic planning process and our quality improvement process along with the results of that process."

Marquardt says the ISO process not only gauges improvements against the ISO standard itself but broader areas that take into account actual performance areas, such as customer services expectations, corporate compliance training, and safety and security. "The tool and the framework it provides are just very powerful," he says.

2. **Memorial wanted to save money on survey fees.** The savings were immediate, Marquardt says. At the time Memorial disengaged from the Joint Commission, those survey fees were going to run $35,000 to $40,000. By contrast, initial ISO survey fees amounted to less than $5,000.

Most of the hospitals that so far have moved in the direction of ISO have been similar in size to Memorial, and it is difficult to know how rapidly larger hospitals will follow. Marquardt says the limiting factor at the present time in Michigan is that Blue Cross and Blue Shield of Michigan will allow only small rural hospitals to forgo Joint Commission accreditation. "To the extent that Michigan and other states modify that requirement, things may start to break loose a little bit," he predicts.

Marquardt maintains that ISO is a substantially more powerful tool for improving quality and focusing management activity in key areas. But he adds that every hospital must make that assessment for itself. "We don't necessarily advocate that everybody follow our lead and sever their ties with the Joint Commission," he says.

Hospitals that are not affected by deemed status have more opportunity to shift to ISO, notes **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI. In certain parts of the country, hospitals have no choice but to attain Joint Commission deemed status. But even in those instances, she says, ISO may prove useful in maintaining accreditation.

According to Preole, some organizations use the ISO program and then subject themselves to initial annual visits by the Health Care Financing Administration (HCFA) where they are reviewed for Medicare and Medicaid compliance. When another body comes in and performs the assessment, she says, the organization still gets Medicare and Medicaid status apart from the Joint Commission.

ISO: Compliment or replacement?

Preole says one issue that has been heavily discussed is what role ISO 9000 can play as a compliment or a replacement to existing accreditation programs. When ISO first came out, she says, Joint Commission representatives were reluctant to embrace it because they felt it was being promoted as a replacement. But that antagonism has faded, she reports.

In fact, Preole contends there can be "quite a nice marriage" between the two processes. Now she says not only providers but also other accreditation bodies are viewing ISO 9000 as an excellent complement to existing standards.

Marquardt agrees that the two processes can run in tandem. "If nothing else, I suspect some hospitals will choose to run them together as a means of differentiating themselves from their competitors."

According to Homa-Lowry, there are a lot of similarities between ISO and the Joint Commission — namely that both programs are interested in good systems and processes that lead to good outcomes.

One advantage of ISO is that hospitals get to design their own systems and processes to determine outcomes, she adds.

She says it is going to be interesting to monitor what impact payers and the government have on the Joint Commission. She says the organization recently has aligned itself more closely with the HCFA on core measures as well as managed care organization mandates.

"Even if you are ISO-certified, you still have to pay attention to the dictates of HCFA as well as managed care contracts," she warns. That means organizations must develop good systems and processes for patient care outcomes and evaluate which process is going to be the most helpful in evaluating good patient care outcomes. ■

Final privacy rules create more questions

Changes will have impact on quality departments

Buried in the final patient privacy regulations released by the Clinton administration are a host of changes from the proposed regulations that will directly affect quality assurance managers, according to experts who have been sifting through the 1,500-page document since its release Dec. 21.

"I expected to see a significant rewrite, and there were a lot of changes," says **Dan Mulholland**, JD, a partner with Horty Springer & Mattern in Pittsburgh. "I think the costs of this, just at first glance, are going to be enormous." That is because hospitals will have to change almost any policy that deals with patient care and the release of information, in addition to establishing a host of new procedures, he warns.

"From a practical standpoint, apart from the computer systems and the general policies, I don't see how you police this," he adds.

Concerns with verbal communications

According to Mulholland, it probably makes sense for most hospitals to vest these new responsibilities with the compliance office. However, in some areas, responsibilities will have to be shared with other departments, including quality assurance, and that will lead to problems associated with dual accountability.

Mulholland says that quality assurance managers should be especially concerned with the expansion included in the final regulation to cover oral communications. He says that is especially true if hospitals are dealing with an outsourced quality assurance or utilization review entity.

"If you are giving them information over the telephone, that could come under the scope of this," he explains. "You always have to know the parameters of the patient's consent, because patients are allowed to put restrictions on what can be disclosed from their records."

Mulholland also points to a requirement in the final regulation that requires patient-specific consent for certain routine disclosures. He says that happens routinely when a health plan comes in and audits patient records.

"That seems to suggest that every time a health plan wants to perform an audit on a patient record, it has to have specific consent for the release of that information," he explains. "That would seriously compromise the ability to perform quality assurance and utilization review."

But not all the news is bad news. "The main thing that I liked is that it applies to more than just electronic medical records," says **Paul DeMuro**, JD, a partner with Latham Watkins in San Francisco. The final regulations cover paper records as well as electronic records. They also require that most providers acquire patient consent for even routine use and disclosure of health records.

Disease management affected

Another major change from the proposed rule is that business partner agreements do not have to give patients direct rights over the information that they have, adds DeMuro. "In other words, the notion of business associates declaring patients to be third-party beneficiaries is no longer necessary."

Mulholland adds that the final regulation includes a provision that allows providers to use the patient record for any purpose. "The rule regarding the minimum necessary to disclose does not apply for the purposes of treatment," he says. "That is good news because providers would have been hamstrung."

For example, if an elderly person entered the hospital with a broken hip and the hospital

learned he had a drinking problem, it might have been at risk if staff passed that information to another provider such as a home health agency.

"All the other problems regarding substance abuse aside, that principle could have seriously compromised the ability to provide adequate continuous care," explains Mulholland. But he says that requirement seems to have gone by the boards, at least with respect to transfer of records for the purposes of treatment.

According to **Karen Ignani,** president of the American Association of Health Plans (AAHP) in Washington, DC, one potential victim of the final regulations could be emerging disease management programs. "We are very worried that these activities could be heavily impacted in a negative way," she says.

For example, Ignani says, routine notifications to women in certain age cohorts that remind them about mammograms could be threatened under the final rule. Routine notification sent to diabetics reminding them to get retinal scans and regular examinations also could be jeopardized, she argues.

Reminders sent to individuals who have suffered a heart attack and require drugs to prevent another also are an example, according to Ignani. That is because that activity can be considered health care promotion, disease management, or simply care for the chronically ill. How this change in policy affects these programs will depend on how they are interpreted, she argues

Rick Smith, vice president of public policy and research at AAHP, argues that under the proposed rule it was clear that the intent was to facilitate this type of activity. "There was a recognition that this was a core activity," he argues. "We think that should have been sustained." ■

HHS database is risky source for credentialing

Federal report finds NPDB riddled with problems

Hospitals are running a considerable risk if they rely too heavily on the National Practitioner Data Bank (NPDB) as a source of information throughout their credentialing process.

"The data bank is a useful tool," asserts **Carol Ostermann**, CMSC, CTCS, manager of medical staff services at St Mary's Medical Center in Long Beach, CA. "But it is certainly not the answer to all the questions that we have to answer when we are credentialing."

A report recently released by the General Accounting Office (GAO), which found the data bank riddled with problems, only underlines that point. The government watchdog agency says problems of underreporting to the NPDB make it a questionable source of information regarding disciplinary actions taken against health care practitioners by hospitals and other health care providers.

Worse yet, the Department of Health and Human Services (HHS) has no plan to fix the problems, even though the HHS Office of Inspector General has long considered that the weakest link in the entire process, according to the GAO.

Other resources available

The problem facing hospitals is that the NPDB is the only national repository of this information nationwide that is accessible to hospitals.

"Unfortunately, it is the only mechanism that exists nationally that has this kind of data," says health care attorney **Mark Kadzielski** of the Los Angeles-based Akin Gump. He notes that the Healthcare Integrity and Protection Data Bank holds five times the information included in the NPDB, but hospitals remain locked out of that resource.

"The problem in credentialing is that just because you don't get any information from the data bank it does not automatically mean that the doctor is a qualified professional," he says. "There may be many reasons that information is not in there."

That creates a challenge for hospital staff who are responsible for credentialing. "Quality management people look at themselves as patient advocates," says **Marie Pears**, RHIA, CPHQ, quality coordinator at Meadville (PA) Medical Center. "This first place you start is with a qualified practitioner, which makes this information very important."

But that is easier said than done, she adds. "We can access information on licensure actions for most of the states, but you don't always know which states a practitioner may be licensed in," she explains.

For example, a practitioner may have been

licensed in a state where an event occurred that affected his or her license. "However, if it was not reported to the practitioner database, you miss that piece," she explains.

While hospitals must rely on the information reported to the NPDB on a national level, it is not the only resource available. "You can never be too thorough in credentialing a practitioner by looking in various places," adds Pears. "We are always trying to double-check information and find areas where we can look for additional information."

Earlier this year, legislation was introduced that would open the NPDB to public scrutiny via the Internet and give the public access to disciplinary information about adverse actions in its current form along with additional information to compare physicians within a particular specialty or a given state. But that legislation died.

According to **Vi Griffin**, director of quality management at Craig Hospital in Denver, while it is important to have this information centralized in a timely fashion, the safest route for hospitals is to make the data bank only one component of a much broader credentialing process.

Lynn Buchanan, CHSC, CPCS, president of Buchanan & Consultants in Morrison, CO, takes a similar view. "I think hospitals are only semireliant on the data bank," she says. "We use the data bank as a backup or in addition to licensing boards, medical associations, and malpractice carriers."

According to Buchanan, hospitals may be able to get additional information from the licensing board, the hospital, or the malpractice carrier that might not have been reportable to the data bank because it did not meet the data bank's criteria. In some cases, hospitals are not as diligent in reporting information as they should be, she adds.

In the malpractice arena, Buchanan says one reason for going beyond the NPDB is that the data bank only includes information about malpractice cases that have been settled, not those still pending.

According to Ostermann, the only method that is entirely reliable is talking to the institution where the event occurred.

"The best information in this area is directly from the source," she argues. "I still think the human aspect is the most important database that we have."

Buchanan also points out that not all the problems associated with the data bank are internal. "Everybody is always looking for loopholes to keep from reporting to the data bank, which is unfortunate. The data bank can only be as good as the information that is sent to it."

According to the GAO, HHS's efforts to quantify or minimize underreporting have been largely unsuccessful. For example, GAO says that HHS has focused on the underreporting of malpractice payments even though government-sponsored studies conclude that underreporting of clinical privilege restrictions by hospitals and other health care providers is a far more pressing issue.

The GAO also points out that HHS has failed to implement a 13-year-old law that expanded NPDB to include information on nurses and other health care practitioners. "As a result, disciplinary actions taken against nurses and other practitioners are not reported to the NPDB, despite these individuals' increasing importance in the delivery of health care," says the agency.

Going beyond NPDB

HHS concurs with the GAO that it must improve compliance with reporting requirements. But it balks at the agency's recommendation to develop procedures to ensure the accuracy and completeness of NPDB information. HHS is also resisting the GAO's recommendation that it should revise its notification to users regarding limitations in the data.

Unfortunately, Congress will not be able to rectify these problems until next year at the earliest. Earlier this year, legislation was introduced that would open the NPDB to public scrutiny via the Internet and give the public access to disciplinary information about adverse actions in its current form along with additional information to compare physicians within a particular specialty or a given state. But that legislation died.

The Chicago-based American Medical Association says the solution lies in going beyond the NPDB. It says individual states have made significant progress in their ability to collect and disseminate the same information.

The association points out that information about physician credentials and disciplinary action already is available through state-based systems. ■

THE QUALITY - CO$T CONNECTION

Part 2 of a 2-part series

Use XmR charts to better understand performance

A guide to individual and moving range charts

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

When people don't understand what is causing variation in performance measure data, many things can happen:

- Trends are identified when there are no trends.
- Trends are not identified when there are trends.
- People blame or credit others for things over which others have no control.
- Past performance can't be understood.
- Future plans can't be made.

By plotting performance measurement data on control charts, quality management professionals can help prevent people from misinterpreting results. There are several types of control charts. However, one that can be used for many of the performance measures commonly used in health care organizations is the individual (X) and moving range (mR) chart.

Commonly referred to as the XmR chart, this type of control chart can be used to plot both measurement and count data, making it appropriate to use in most situations.

Setting up the chart

As with all control charts, average values are determined, control limits are established based on +/- 3 standard deviations from the process average, and points are plotted and examined for signals of an out-of-control process.

The XmR chart has two sections:

- a moving range control chart;
- an individual values control chart.

The data in the chart below show the weekly number of incomplete medication orders received by the hospital pharmacy department that cannot be filled without clarification.

The following steps are used to create a moving range chart from the data:

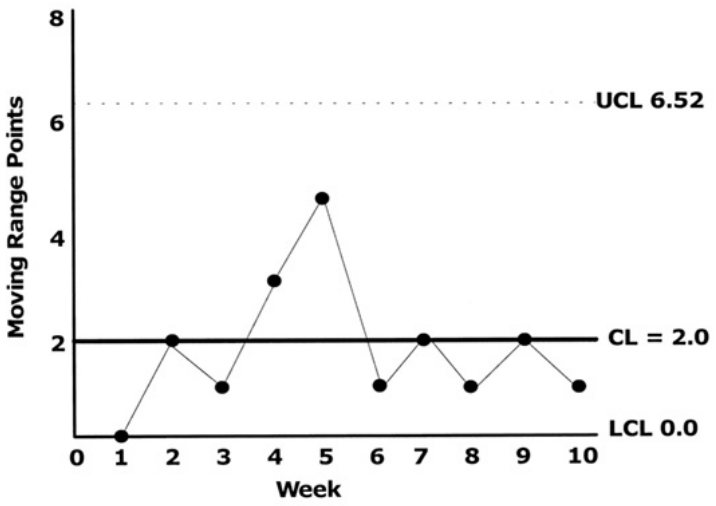
1. Calculate the average moving range using the following formula:

Weekly Number of Incomplete Orders

	# Incomplete Medication Orders (X)	Moving Range (MR)
Week 1	4	N / A
Week 2	16	2
Week 3	15	1
Week 4	18	3
Week 5	13	5
Week 6	12	1
Week 7	10	2
Week 8	11	1
Week 9	9	2
Week 10	10	1
Average	12.8	2

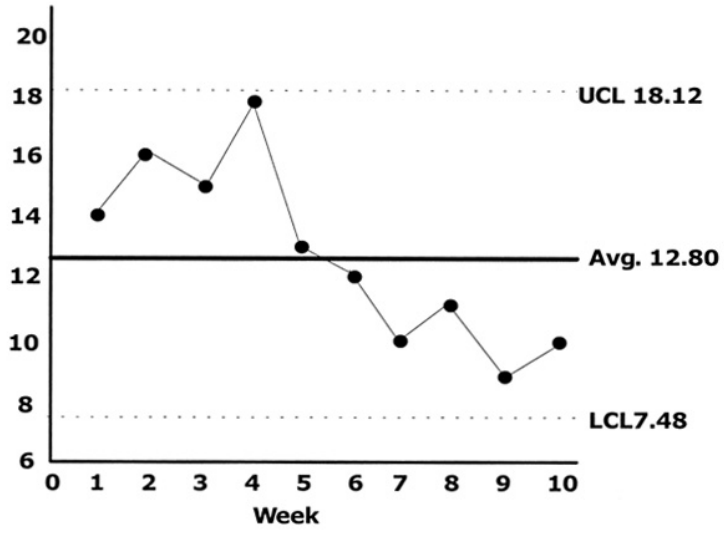
Source: Patrice Spath, Brown-Spath & Associates, Forest Grove, OR.

Moving Range Control Chart
Incomplete Medication Orders



Source: Patrice Spath, Brown-Spath & Associates, Forest Grove, OR.

Individual Control Chart
Incomplete Medication Orders



Numbers on left indicate incomplete medication orders.

Source: Patrice Spath, Brown-Spath & Associates, Forest Grove, OR.

Average MR = ∑ MR + (n-1) = 18 + 9 = 2

2. At the value of 2 on the Y axis of the moving range chart, draw a horizontal line. This represents the average moving range or the center line (CL).

3. Calculate the upper control limit (UCL) for the moving range chart using the following formula:
   UCL = 3.26 x Average MR = 3.26 x 2 = 6.52
   Note: 3.26 is always the multiplier for R for the individual moving range chart.

4. At the value of 6.52 on the Y-axis of the moving range chart, draw a horizontal line. This represents the upper control limit.

5. The lower control limit for the moving range chart will always be "0". (Differences between values can't be smaller than "0".)
   Before calculating the values for and plotting the individual values chart, first interpret the moving range chart. Look for differences — changes from week to week — that exceed the three standard deviation control limit and thus signal a "special cause" variation. **A completed moving range for the data illustrated in the Weekly Number chart is shown in the Moving Range Control chart, above left.**

   If the upper control limit is exceeded in any week, ask the people involved in the process to reflect on what was different that week. Understanding what caused the process to become unstable should lead to elimination or correction of undesirable influences.

Next, the individual values chart is created using these steps:

1. Calculate the average number of incomplete medication orders for the time period using the following formula:
   Average = sum of data points + number of subgroups
   X-bar = $\sum$ X + N = 128 + 10 = 12.8

2. Draw a horizontal line at a value of 12.8 on the Y-axis of the individual values chart. This represents the individual values average and is the center line (CL) on the chart.

3. Calculate the upper control limit for the upper control limit (UCL) for the individual values chart using the following formula:
   UCL = average number of incomplete orders (2.66 x the average range)
   12.8 + (2.66 x 2) = 12.8 + 5.32 = 18.12
   Note: 2.66 is always the multiplier of the individual values chart for calculating the upper and lower control limits.

4. At the value of 18.12 on the Y-axis of the individual values chart, draw a horizontal line and label it UCL.

5. Calculate the lower control limit (LCL) for the individual values chart using the following formula:
   LCL = average number of incomplete orders – (2.66 x average range)
   12.8 – (2.66 x 2) = 12.8 – 5.32 = 7.48

6. At the value of 7.48 on the Y-axis of the individual values chart, draw a horizontal line and label it LCL.

7. Plot the weekly count data on the chart **(see completed chart, p. 24, bottom box)**.

Interpreting the chart

Now it's time to interpret the set of graphs that comprise the XmR chart. As noted, the differences in the ranges are examined first.

This is done because the average range is used to determine the control limits for the chart.

If one or more ranges is out of control, the reasons for the unstable process should be identified and eliminated (if possible) before the individual values chart has any meaning.

Once the change in the weekly number of incomplete medication orders consistently falls within the upper and lower control limits, then the process is considered to be in control.

The values displayed on the individual values chart then can be used to reliably track the performance of the process.

The data points on the individual values chart that fall within the upper and lower control limits can be assessed using statistical methods.

When the measurement results are plotted, observe the values in relation to the center (median) line.

Eight consecutive points above or eight consecutive points below the center line signal the presence of a special cause that is forcing a shift in level.

Six consecutive points, each of which is larger (or each of which is smaller) than its preceding point, are the statistical signal of a trend.

Identify, eliminate the problem

When signals of special causes are identified, the process owners need to get involved in eliminating the problem.

When no signals of special causes exist, the process is operating at its best. If further improvements are desired, fundamental changes in the process will be necessary.

People who understand variation can see from the XmR chart that the process of medication order writing is a controlled process.

However, it may not be operating at a level that is satisfactory to everyone.

Without significant changes to the process, the number of incomplete orders received by the pharmacy will likely continue to range from a low of nine to a high of 18 each week.

To further reduce variation in the process, the underlying system of how orders are written must be improved.

Recommended reading

• Kelley, D. Lynn. *How to Use Control Charts for Healthcare.* Milwaukee: American Society for Quality; 1999. Telephone: (800) 248-1946. Web site: www.asq.org.

• Carey R.G, Lloyd R.C. *Measuring Quality Improvement in Healthcare: A Guide to Statistical Process Control Applications.* Milwaukee: American Society for Quality; 2001. Telephone: (800) 248-1946. Web site: www.asq.org

• Wheeler D. *Understanding Variation: The Key to Managing Chaos.* Knoxville, TN: SPC Press Inc.; 1993. Telephone: (800) 545-8602. Web site: www.spcpress.com/. ■

JCAHO alert on infusion pumps raises concern

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a Sentinel Event Alert Nov. 30 that says human and medical errors involving the use of infusion pumps have led to several deaths and near-fatal drug overdoses. But industry representatives fault JCAHO for failing to provide adequate guidance for ongoing assessment.

Russell Massaro, MD, JCAHO's executive vice president, says the Joint Commission is especially concerned about the use of pumps that do not provide protection from the free-flow of intravenous fluid / medication into the patient. "Joint Commission surveyors will inquire about use of these pumps during on-site surveys in 2001," he warns.

JCAHO maintains that improper use of infusion pumps already has led to several deaths and near-fatal drug overdoses. While experts say human and mechanical error are factors, the main problem is the use of pumps that do not provide protection from the free-flow of intravenous fluid / medication into the patient, according to the Joint Commission.

As evidence, JCAHO cites reports by U.S. Pharmacopeia in Rockville, MD, about six cases between October 1991 and November 1999 in which patients died and four others almost died because an intravenous pump did not provide protection from free-flow of intravenous solutions.

Charlene Hill, a JCAHO spokeswoman, says that when surveyors visit health care organizations next year, they will be inquiring whether the organization is aware of the information in the sentinel event alert.

"If not, surveyors will be educating them about those issues," she says. "If they are, surveyors will be asking the organization what they have done to ensure the safety of these pumps."

Organizations that say they are aware of the alert but have not addressed potential problems and could be cited for being out of compliance under one of JCAHO's performance standards, Hill explains. "They could get a Type I or a recommendation for improvement," she says.

According to **Rad Dillon**, national pharmacy manager with Apria Healthcare, the infusion industry is suffering under an "accreditatory yoke" imposed by the Joint Commission.

"Technically, it is a voluntary organization," he says. "But what [JCAHO] has done is create a monopoly that Bill Gates would be proud of," he argues. He says that is why some people in the infusion industry are examining potential legal avenues on the basis that JCAHO is effectively restraining trade.

As things stand, he says the Joint Commission more or less forces service providers to become JCAHO-accredited in order to work with hospitals. "I would like to be in a position to tell JCAHO to peddle its wares elsewhere because we have convinced payers that we have an effective alternate route with other accrediting bodies."

According to Dillon, the ORYX project is a case in point. He says anybody would be hard pressed to find an infusion provider that has derived any benefit from that project because the data are collected without adequate controls.

"[JCAHO] can't do it right, but for a variety of reasons, [it is] not going to let it die," he asserts. "Yet, all of us are being forced to spend large sums of money to do this." Even if the data were more accurate, this should not be JCAHO's role responsibility, Dillon argues. He says that's why the infusion industry is trying to establish its own standards through voluntary efforts such as the operational benchmarking project sponsored by the National Home Infusion Association.

(JCAHO's Sentinel Event Alert on infusion pumps can be found on-line at http://www.jcaho.org/sentinel/sentevnt_frm.html.) ■

Conference targets quality, cost in case management

Experts will share their proven ideas for successful case management at The 6th Annual Hospital Case Management Conference: Blueprint for Case Management Success: Information, Accountability and Collaboration, to be held March 25-27, 2001 in Orlando, FL.

The conference is sponsored by American Health Consultants, publisher of *Hospital Case Management*.

The timely topics offer something for every hospital-based case manager or quality professional. A variety of speakers will address issues including:

- New avenues for community case management
- Knowledge-driven care coordination
- Creating a heart service line report card
- What you can teach your CEO about managed care
- Values, ethics, and legal parameters in case management
- The ABCs of the Balanced Budget Act
- Reimbursement: An ever-changing process
- Key concepts in case management
- An interdisciplinary practice model for acute-care case management
- Better case management through denial management
- Measuring the impact of case management interventions

Each session sets aside time for you and your peers to ask the experts your most burning questions. Nineteen contact hours of continuing education will be offered. The conference fee includes a cocktail party to network with speakers and other registrants, continental breakfasts, lunches, a course manual, and a form exchange for attendees.

For more information, contact American Health Consultants, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. ■

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