HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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IN THIS ISSUE

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ED case managers keep patients from falling through the cracks

Goal is to ensure timely follow-up care

Before Jackson Health System in Miami had case managers in the emergency department (ED), the average waiting time for patients who needed to be seen for follow-up was six months, and only about 22% of patients showed up for their appointments.

As a result, many of the patients who were sent home with a month's supply of medicine for diabetes, hypertension, or other chronic illnesses, returned to the ED for treatment before their follow-up appointment because they ran out of medicine and their condition became exacerbated.

"One of our main concerns was to reduce recidivism in the emergency room," says **Genise Harrelson**, RN, BSN, emergency care center case manager. "We recognized that there was a huge problem and one that we needed to focus on. We didn't want these patients to return to the emergency room because they had no access to health care."

Harrelson is one of three ED case managers at Jackson Health System's ED in Miami. The first case manager was a registered nurse who primarily collected data but didn't really have a defined role.

In late 1998, the ED case management model was redesigned, and by mid-1999, there were three case managers — two who deal with the adult population and one who focuses on pediatrics.

"At first, there was a lot of confusion because, within the ED, we had case managers, a social worker, and a patient representative. Nobody really understood who played what role. We worked with the others to develop a referral list, delineating what each professional would handle," Harrelson says.

The case managers also surveyed the ED staff to identify their needs and how case managers could help them work more effectively. The survey helped identify ED case managers' priorities, roles, and responsibilities.

The case manager's first priority is to decrease the number of patients who return to the ED repeatedly by improving the method and consistency

Case Management Definition

"Emergency service case management is a dynamic collective process designed to assure timely and appropriate follow-up care to patients presenting for emergency services. Our goal is to increase continuity, quality of care, and decrease recidivism through emergency services."

Source: Jackson Health System, Miami.

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Editorial Questions

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of referrals from ED services to other services.

"Our mission was to improve the coordination of care when the patient was discharged, making it more appropriate and easier for the patient," Harrelson says.

The case managers communicated their findings to the ED staff and started doing inservices to teach them about the case management role in early 2001. Later on that year, they started meeting with the hospital medical director to address physician and case management issues and get physician input.

The case managers make frequent rounds in the ED, discussing patients with the staff.

Since the trio of case managers schedule appointments for follow-up care and ensure that patients no longer fall through the cracks, waiting time for follow-up is two to four weeks, and compliance with appointments is about 80%.

Jackson Health System is a county hospital affiliated with the University of Miami. More than 90,000 patients a year are treated in the ED. Many of the patients who come to the ED are publicly insured or have no health care coverage.

The hospital operates more than 450 general medical and specialty clinics.

Among the clinics is an ED follow-up clinic that provides primary care follow-up care to patients who are treated in the ED but do not have funding for their health care.

For instance, patients who come in for a broken limb or as a result of an automobile accident and are diagnosed with diabetes or hypertension are followed up at the ED follow-up clinic.

The three case managers are in the ED 13 hours a day, from 6:30 a.m. to 7:30 p.m. They don't work on weekends or major holidays.

Patients who are discharged when the case managers are not on duty are instructed to call the case managers to set up an appointment.

The case managers originally tried to establish outcomes by looking at recidivism in the ED but found that the information didn't give the full picture, says **Christine Ruschmeyer**, RN, BSN, adult ED case manager.

For instance, a patient might come in with out-of-control diabetes and a few weeks later show up with an injury.

Now, they track compliance with follow-up clinic visits as proof that the case management initiatives are making a difference.

"One of our goals is to reduce unnecessary emergency room visits by ensuring that patients get the follow-up care they need. We let them

know that keeping an appointment with a doctor helps them avoid another illness and is easier and less time-consuming than sitting in the emergency room," Harrelson says.

The first step the case managers took in 2000 when they established their current ED initiative was to take over setting appointments for follow-up care for ED patients. **(For a definition of ED case management, see box, p. 66.)**

At the time, appointments for follow-up, whether for the ED follow-up clinic or a specialty clinic, were scheduled by the ED secretaries.

The secretaries did not know how to decipher the information as to which HMOs had contracts with the hospital, so they routinely gave every patient a follow-up appointment. The case managers developed an educational letter that is given to HMO patients upon discharge from the ED so they know to get in touch with their providers for the appropriate referral and authorization.

"It wasn't that we didn't want to take them or treat them, but since they have HMOs, they have to follow up with their primary care physician," Harrelson says.

The case managers also started routing patients to community clinics affiliated with the hospital that was closer to their homes. Many of them already are going to community clinics for care.

"We get a lot of patients who are not funded or on Medicaid and they don't have transportation. Coming back to the hospital is a long trip for them. They can walk or take the bus to the community clinics," Harrelson says.

If the patient already has a medical appointment at a community clinic, the case manager prints out the information and gives it to the patient. "In the past, if a patient had an appointment with a doctor in a clinic in two weeks, he still was given a follow-up appointment in six months because the secretaries were not trained to do a thorough screening for existing appointments until the case managers trained them," Harrelson says.

Patients who need comprehensive follow-up, such as a neurological evaluation, a stress test, or

Pediatric CM interventions improve care for patients

Family education is a key intervention

The first year that **Christopher Chevalier**, BSN, pediatric emergency department (ED) case manager at Jackson Health System in Miami, began referring young asthma patients to the hospital's new asthma center, ED visits for asthma decreased by 22%.

"Everything came together because we had case managers who could flag the patients, let them know the resources of the clinic were available, and see that they got one-on-one disease management," Chevalier says.

Before the asthma center was established, juvenile asthma patients came to the ED over and over because their families had no knowledge of how to handle the disease and no resources to help them cope. Now, if a child has two or more ED visits for asthma within a year, the child and the mother are directed to the asthma center where they are evaluated and taught how to handle the disease. For instance, the mothers are taught how to look for triggers to asthma attacks and what conditions in the home may contribute to an attack.

"We were able to identify the consistent return to the emergency room because of lack of resources within our facility of getting patients with asthma direct disease management," Chevalier says.

Among pediatric patients at Jackson Health System, 85% to 95% have HMOs, mostly with Medicaid, he says.

Before the case managers were involved, the appointment setters had no clue who was covered by an HMO. As a result, many parents brought their children in for clinic appointments but were turned away because their insurance company had not approved the visit.

"Many of the population we serve are poor and treat their children's health care like their own. They bring them in only when they're sick. They are not big on preventative care because they are afraid of having to pay out of pocket," Chevalier says.

He works to help educate parents on the value of preventive checkups and helps them find community resources that can subsidize the cost. "We put out fires here and there. For instance, Medicaid in Florida stopped approving a certain medication. We call and get an override for each child who needs it."

The case manager helps remove any obstacles that may be in the way of patients getting the post discharge care they need.

Chevalier follows up, especially with chronically ill children who do not show up for appointments. He keeps a record of the appointments and calls the parents the day before to remind them, and again the day after to make sure they kept the appointment.

The third time a parent fails to bring the child in for a follow-up visit, he contacts the state Department of Children and Family Services for investigation of medical neglect. ■

a magnetic resonance imaging test, are referred to a hospital specialty clinic for follow-up.

Ruschmeyer coordinates setting appointments for the specialty clinics and makes sure the patient keeps their appointments. **(For more details on her job, see box, below.)**

Patients covered by HMOs or other insurance receive a letter suggesting that they see their primary care physician for follow-up and telling them how to find out who their primary care physician is if they don't know.

Christopher Chevalier, RN, pediatric ED case manager, follows up on high-risk patients in the ED, working with parents, educating them about the disease process, and stressing the importance of follow-up care.

"I don't work with parents on every earache or sore throat. I follow up on patients diagnosed with chronic illnesses such as juvenile diabetes, asthma, sickle cell disease, and neurological seizure disorders," he says. **(For more information on pediatric ED case management, see related article, p. 67.)**

The case managers notify the HMO that the patients are in the ED and give them the required clinical information. If those patients are admitted to the hospital, the ED case managers start giving the HMO patient information up front.

When the patient has a chronic illness, the case managers refer them to the hospital's disease management classes for diabetes, asthma, congestive heart failure, and other chronic conditions. The classes are available at the hospital and some outlying clinics and are conducted in English, Spanish, and Creole.

"If there is a new-onset diabetic and the doctor wants the patient in a disease management class, I find out when and where the next class is being held and get the patient into that class so he can start learning about his disease," Harrelson says. ■

CMs smooth path for referrals to specialty clinic

Patients referred to care in most appropriate setting

When patients at a busy emergency department (ED) are referred to a clinic for specialty care, they may fall through the cracks if no one follows up.

That's where **Christine Ruschmeyer,** RN, BSN, adult ED case manager at Jackson Health System in Miami comes in.

Ruschmeyer follows ED patients who are referred to one of the hospital's numerous specialty clinics by ED physicians who see more than 90,000 patients a year. Her job is to make sure that all patients get the care they need in the setting that best fits their needs.

"I make sure that I get a copy of the consults the emergency room doctors make to the specialty clinic and make sure the patients get an appointment in the most appropriate place," she adds.

For instance, if patients are covered by an HMO or other private health insurance plan, they can't see the specialty clinic without prior authorization.

In other cases, a patient may not need to go to a specialty clinic but can receive care from a primary care physician at one of the hospital's community clinics.

Each specialty clinic has its own criteria for the types of patients it will see. For instance, a patient with a new diagnosis of diabetes doesn't necessarily need to be seen at the endocrinology clinic.

A patient with Bell's palsy often can be treated by a primary care physician rather than a neurologist.

Before Ruschmeyer began tracking the patients, they might show up for a specialty clinic and be turned away because they didn't meet the criteria for specialty care or because the specialty clinic didn't have enough information.

Because the ED physicians are busy, the consults may have sketchy information. For instance, when a patient comes in with a migraine headache and the physician orders a neurological consult, the physician may just write "headache" on the form. The neurological clinic is likely to refuse to see the patient because there's not enough information.

Ruschmeyer collects all the consults, looks at the chart, and adds patient history, information from the labs, and other pertinent data so the clinic will have as full a picture as possible. Instead of faxing the referrals or sending them in intraoffice mail, Ruschmeyer delivers them in person and presents them to the attending physician.

The specialty clinics meet only half a day, one day a week. Ruschmeyer waits until that clinic is in session to present the consult and set up an appointment.

The specialty clinics automatically mail appointments to the patients. If time is of the essence, she contacts the patients herself to let them know about their appointment.

All patients who are referred to specialty clinics get a letter telling them they may or may not be accepted for specialty care, depending on whether they meet clinic criteria and urging them to seek follow-up care in the meantime with a primary care physician or clinic. ■

Reorganization improves efficiency, cuts LOS

Case management is a three-pronged approach

Following a comprehensive redesign of its case management department, the average lengths of stay (LOS) on some medical services at the University of Alabama in Birmingham (UAB) Medical Center's University Hospital have declined. For instance, the average LOS for the trauma patient population has declined by one day, while the average LOS for the burn patient population has dropped by three days.

"The UAB case management process was restructured two years ago by a design team that identified how the various disciplines could work together to better manage patients," says **Donna R. Lawson**, MSHA, MBA, director of quality and care management.

The hospital takes a triangular approach to case management. The core members of the team include master's level registered nurses (RN care managers) who handle clinical care coordination and clinical resource management; social workers who deal with psychosocial needs of the patients, and execute discharge plans; and licensed practical nurses who handle telephonic utilization review.

"This core team works closely with the physicians, ancillary departments, and bedside nurses to expedite the patient's transition to the next level of care, ensure appropriate clinical resource usage, and facilitate payment for services provided," Lawson says.

The role of the RN care managers changed the most following the redesign. They monitor the care plan and intervene as necessary to make sure patients receive the services they need in a timely manner.

"The RN care manager is the one constant person who deals with each patient. The patient may have several nurses during the course of their stay, but the RN care manager sees that person from beginning to end," Lawson says. For instance, the RN care managers in the trauma/burn service are on call 24 hours a day, seven days a week. Whoever is on call has an alert pager that notifies him or her when a trauma patient enters the emergency department (ED). Those care managers respond to every trauma alert and begin their involvement when the patient arrives in the ED.

They make daily rounds with the clinical team and coordinate a weekly multidisciplinary case conference to review the patient's progress and make sure the patient is moved through the acute care facility to the next level of care in a timely manner. They also work with the social worker to identify what the patient is likely to need after discharge.

The trauma/burn care managers attend follow-up clinic twice a week to see their patients after they are discharged from the acute care hospital. ■

Worried? HIPAA privacy regs should change little

You're probably doing what you need to comply

When the privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 went into effect on April 14, they probably didn't mandate changing anything that you as a hospital case manager have been doing for years, says **Sara Kraus**, JD, an attorney practicing in the health care department of Proskauer Rose LLP in New York City.

"HIPAA just formalizes the procedures that are already established by some states, institutions, and health care providers for preserving patient rights," she adds.

When the rules first came out, a lot of people in the health care industry panicked, interpreting some provisions as onerous regulations that would make it more difficult for them to treat patients. For instance, some decided hospitals couldn't put patient names on the door, have a sign-in sheet at clinics, and staff couldn't have a discussion about a patient in the hall or a room with an open door.

"HIPAA was never meant to apply to incidental disclosure of health care information. Everybody went a little nuts when the rules first came out. The government guidance issued in August 2002 has retreated a little from the original restrictions," Kraus says. HIPAA restrictions shouldn't disrupt the delivery of health care, she says.

But while you don't have to go in a room and shut the door to ask a physician a question about one of your patients, you do need to make sure that you discuss patient information in a quiet voice, Kraus says.

Consider training your staff to not to talk loudly when they discuss patients and take other reasonable measures to make sure the patient information

is kept confidential, she advises.

Kraus reminds case managers that complying with HIPAA doesn't necessarily mean that you are complying with state or local laws. If you are working with outside case managers, you should make sure your hospital regulations will allow you to share the information without an authorization, she adds.

One of the biggest differences that HIPAA is likely to make is the requirement that providers make a good-faith attempt to give their privacy notice to patients in person and to get their acknowledgement that they received it. The exception is for emergency treatment.

For hospitals, it's a one-time requirement for every new patient. If your hospital has a computerized record system that can track whether or not a patient has received a privacy notice and acknowledged receipt of it, you don't have to give it again. "If you don't have a way of knowing whether or not the person has gotten your privacy notice before April 14, it will be easier to give them another one," Kraus says.

The privacy notice should include patients' rights under HIPAA, including their right to access their medical records and propose an amendment to them, a right to an accounting of nonroutine disclosures, such as information given as the result of a government inquiry, and a right to make a complaint if they think their privacy has been violated.

A patient's information can be disclosed only for treatment, payment, and health care operations. If your hospital is going to use patient information for other purposes, such as fundraising or clinical research, the patient must give permission.

"There is still confusion among people. The way a provider uses patient information must be disclosed in the privacy notice, but it's a limited universe. If a particular use is not permitted, the provider still can't do it, even if it is included in the privacy notice," she adds.

Some other tips for making sure that you are in compliance with the HIPAA regulations:

- Make sure that everyone on your staff is trained in your hospitals' HIPAA privacy obligation.
- When in doubt about something, check with your privacy officer. "It's better to assume you can't do something," Kraus says.
- Make sure your patient records that contain individually identifiable health information are in a secure location and are not readily available to those who do not need them. ■

GUEST COLUMN

A better way to consider information technology

IT isn't always beneficial

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

Information technology (IT) has brought many changes to the job of the hospital case manager, but does that mean that IT always is beneficial? The simple answer is no. In many ways, IT can cause higher costs and inefficiencies. At times, it is easy to be persuaded of the benefits of technology. For example, automating the coding of diagnoses and procedures is expected to improve accuracy and consistency. However, when the system actually is installed, sometimes the anticipated beneficial features actually slow the work process or require more staff support.

Before investing in IT that could fail to deliver promised benefits, case managers should thoroughly evaluate work systems and the potential impact of IT. This evaluation involves understanding work activities and then determining if IT will improve performance.

The first step in determining the value of IT in case management activities is to understand the "what and why" of case management performance as a system. For example, if you want to automate the discharge planning process, first get a thorough understanding of the "what and why" of the current discharge planning system. In simple terms, this means looking at the process from end to end. Questions to answer during this assessment:

- What is the purpose of this process?
- What are its core activities?
- What is the process capability (e.g., what can be predictably achieved)?
- Why does the process behave in this way?

When you know the "what and why" of performance in the discharge planning, you can see two things: What is possible, and what is stopping you from achieving it. Now it's time to look for inefficiencies and the causes. Questions to

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CRITICAL PATH NETWORK

Asthma pathway treats and teaches patients

Program returns patients to normal living

An asthma pathway was implemented at Children's Hospitals and Clinics in Minneapolis because this chronic disease is the No. 1 hospital admission.

The pathway creates a plan for the course of the patient's hospitalization that helps to get the asthma under control, educates the patient and family members, and gets the patient back to a normal lifestyle quickly.

The average length of hospital stay is 2.4 days, and during this time patients undergo intense education.

The teaching is a collaborative effort between nursing staff, respiratory therapists, and pharmacists, says **Diane Alexander**, RPh, a clinical leader with the department of pharmacy.

The nurses get the patients and their families started by distributing a packet of educational materials. Nurses discuss things that may trigger the patient's asthma and what to avoid.

The respiratory therapist teaches about peak flow meters and how to use them to monitor lung capacity and administer medications accordingly. He or she also teaches about the use of a nebulizer and the metered-dose inhalers.

Pharmacy teaches a class Monday through Friday that families are to attend before the child is discharged. Children are encouraged to attend the class if they are old enough to understand the information.

"We usually figure that if they are using a metered-dose inhaler, they can understand their treatment. If they are 7 or older, we would like them to come with their parent to the class," says Alexander.

The pharmacist knows what medications the patient is going home on, tailors the teaching to these specific medications, and answers any questions the family has. The pharmacists try to limit the class size to two patients, because any more than that makes the classes too long with so much of the information individualized.

It usually isn't difficult to keep the class size down because the hospital admits about two asthma patients a day.

If a family can't make the class, a pharmacist tries to do the teaching session in the patient's room, but that request is harder to accommodate, Alexander says.

Class curriculum covers inflammation, triggers and what to avoid, how the different prescribed medications are used to control asthma and their importance, and compliance.

A flip chart is used to guide the educational session to ensure that all pharmacists cover the same information with all families. About seven pharmacists teach on a routine basis. During the class, patients receive a red / yellow / green zone sheet that the pharmacist fills out so patients know which medications to take when their peak-flow meter readings indicate that they are in a yellow or red zone. The respiratory therapist has filled in the peak flow meter numbers at the top of the sheet.

"They know by their peak flow numbers if they are going into that zone and they start adding therapies if they need to depending on what their red, green, and yellow zone tell them to do," Alexander says.

The main goal of the pathway is to reduce the number of readmissions, and the health care system has accomplished this. With the education program, patients and their parents recognize the signs and symptoms of an asthma problem early and know what they should be doing next, she says. ■

Check mental status or risk missing problems

Quick assessment checks for neurological deficit

When a 57-year-old man walked into the emergency department (ED) at North Broward Medical Center in Fort Lauderdale, FL, with slurred speech and left facial drooping, his wife told nurses that the symptoms had started about 30 minutes earlier. "We immediately assumed the worst case scenario: that it was a stroke," says **Sharon S. Cohen**, RN, MSN, CEN, CCRN, trauma clinical nurse specialist.

According to the ED's stroke protocol, nurses immediately took steps to determine if the man was a candidate for thrombolytics. "We asked his wife if he was taking any anticoagulant medication; because if so, he wouldn't qualify for treatment. We started IVs and checked his blood sugar at the bedside," Cohen says. "Within 10 minutes, we were ready to send him to CT [computed tomography] scan."

At that point, the patient's blood sugar came back with a level of 33, far lower than the normal range of 80 to 100. "It turned out that he was a new-onset diabetic and had an acute glycemic reaction," says Cohen.

"Once we fixed his blood sugar, all his symptoms subsided. He was able to tell us that he felt weak and dizzy but never had a headache." If nurses hadn't intervened rapidly, the patient's blood sugar would have kept dropping, and he could have gone into an irreversible coma, she explains.

Always do a quick check

Triage nurses at her facility always perform a quick assessment to check for any neurological deficits, says Cohen. "We do a basic neuro check for every patient who walks in the door, like taking vital signs," she says.

This can identify life-threatening conditions that might otherwise go undetected, Cohen adds. (**See the facility's Emergency Department Record/ Adult assessment form, p. 73.)**

Cognitive assessments usually reveal a change in neurologic function before physical signs such as pupil changes, adds **Patricia Carroll**, RN, BC, CEN, MS, former ED nurse at Manchester (CT) Memorial Hospital and founder of Educational Medical Consultants, a Meriden, CT-based consulting company specializing in educational programs for health care professionals.

You should add a "D" for disability caused by neurological deficits to the "A, B, C" tenets of airway, breathing, and circulation, recommends Cohen. Your goal is to determine if the patient is awake, alert, and oriented, she says. "If not, you need to go back and figure out why."

Here are items to consider:

- **Use the information to determine the accuracy of the history.**

Doing a quick neuro check allows you to assess if the information provided by the patient can be relied on to provide clinical care, says Cohen. "If the patient has delusions or goes off on tangents, you have to question his history and look for additional sources, or do a different style of work-up."

- **Check all patients with a history of trauma.**

These patients always should have regular neurological checks as long as they are in the ED, even if their initial assessments are perfectly normal, says Carroll. This includes motor vehicle crashes, falls, bicycle accidents, and assaults, she says.

In addition, patients at risk for neurologic impairment from conditions such as high blood pressure, cardiac dysrhythmias and myocardial infarction, electrolyte imbalances, and illnesses that can cause hypoxia should have an initial neurological assessment, says Carroll.

Even if their initial assessment is normal, they should have follow-up assessments to determine if their underlying medical condition is affecting their neurologic status, she adds.

In overcrowded EDs that also face nursing shortages, it may not be practical to perform neuro checks on every patient, acknowledges Carroll. "Remember, in legal circles, your care will be held up to the standard of what another 'reasonably prudent' nurse would have done in the same circumstances," she says.

'Differential diagnosis is huge'

To determine if a patient needs a neuro check, you need to consider mechanism of injury and pathophysiology of disease, says Carroll.

She gives the example of a 30-year-old man who tells you he cut his hand when he accidentally grabbed the sharp edge of a dog food can to pull it off the magnet on the can opener. "If the

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Date:

Patient Name: Last First | D.O.B.: M/D/Y / / | S.S.#: | TRIAGE LEVEL

Allergies: | Mode of Arrival ☐ Police ☐ Ambulated ☐ W/C ☐ EMS _____ | PRESENT MEDICATION/DOSAGE

TRIAGE TIME | PRE-HOSPITAL TREATMENT | TRIAGE INTERVENTION

TRIAGE NOTE: CHIEF COMPLAINT | PMD

PMH

T | P | R | BP | PULSE OX | LMP | T.D. - UTD ☐ Yes ☐ No | PAIN INTENSITY SCALE | NURSES SIGNATURE:

PSYCHOSOCIAL

AFFECT: ☐ Normal ☐ Flat **BEHAVIOR:** ☐ Cooperative ☐ Agitated ☐ Restless ☐ Anxious ☐ Other: _____ **SPEECH:** ☐ Normal ☐ Abnormal

LANGUAGE/CULTURAL: ☐ English ☐ Spanish ☐ Creole ☐ Other _____ Interpreter utilized ☐ No ☐ Yes Name: _____

ENVIRONMENTAL: ☐ Lives alone ☐ Family/Significant other ☐ Minor ♀ parent ☐ Minor ♂ parent ☐ Nursing home ☐ ACLF ☐ At large ☐ Other: _____

AMBULATION: ☐ Independent ☐ Assist Type _____ **Suspicion of abuse** ☐ Yes ☐ No

TIME TO TX RM:

RM#

RESPIRATORY EFFORT
☐ N/A
☐ Normal ☐ Tachypnea
☐ Dyspnea ☐ Accessory Muscles
☐ Stridor

L BREATH SOUNDS R
☐ Clear ☐
☐ Rales ☐
☐ Rhonchi ☐
☐ Wheezing ☐
☐ Diminished ☐
☐ Absent ☐
☐ Other _____

Comments: _____

☐ Cardiac Monitor
Rhythm _____

CIRCULATORY CAPILLARY REFILL
☐ N/A
☐ Normal ☐ Delayed

PULSES

L		R
☐	Radial	☐
☐	Pedal	☐

SKIN COLOR
☐ Normal ☐ Pale
☐ Cyanotic ☐ Mottled
☐ Jaundiced ☐ Flushed
☐ Warm ☐ Dry
☐ Cool ☐ Diaphoretic

TURGOR
☐ Normal ☐ Decreased

EDEMA
☐ Absent ☐ Present
Location _____

MUCOUS MEMBRANES
☐ Moist ☐ Dry

PAIN
Location: _____
Duration: _____
Quality: _____
Radiation _____

NEURO (GCS)
☐ N/A

EYE OPENING
4. ☐ Spontaneous
3. ☐ To Voice
2. ☐ To Pain
1. ☐ No Response

L ☐ **PUPIL REACTION** ☐ R

VERBAL RESPONSE
5. ☐ Oriented
4. ☐ Confused
3. ☐ Inappropriate words
2. ☐ Incomprehensive sounds
1. ☐ None

MOTOR RESPONSES
6. ☐ Follows commands
5. ☐ Localizes pain
4. ☐ Withdraws pain
3. ☐ Flexes to pain
2. ☐ Extends to pain
1. ☐ None

_____ SCORE

GI/GU/GYN
☐ N/A

ABDOMEN
☐ Soft ☐ Distended
☐ Guarding ☐ Rigid

TENDERNESS
☐ Yes _____ ☐ No

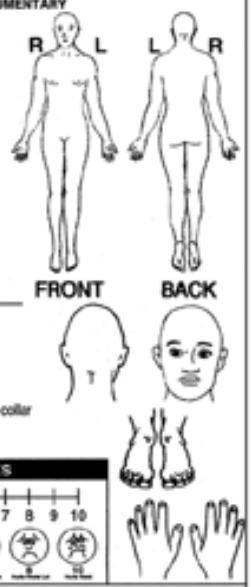
BOWEL SOUNDS
☐ None ☐ Present
☐ Vomiting x _____
☐ Diarrhea x _____

GU
☐ Flank pain L R
☐ Dysuria
☐ Hematuria
☐ Frequency

GYN
Pregnant
☐ Yes ☐ No
☐ Vaginal bleeding
☐ Amount _____
☐ Vaginal discharge

☐ **N/A ORTHO/INTEGUMENTARY**

A - ABRASIONS
B - BRUISE
C - BURNS
D - FOREIGN BODY
E - LACERATION
F - PUNCTURE
G - DEFORMITY
H - C/O PAIN
I - REDNESS
J - HEMATOMA
K - AVULSION
L - OTHER _____
M - SWELLING
N - LIMITED MOVEMENT



☐ Back Board ☐ Stiff collar

PUPIL REACTION:
S – SLUGGISH
B – BRISK
N – NON-REACTIVE

PUPIL SIZE

FHT

Pain Assessment SCALES

0-10 Numeric Pain Distress Scale

VISION: ☐ N/A ☐ GLASSES ☐ CONTACTS ☐ BLIND ☐ VISUAL ACUITY: _____ OD _____ OS _____ OU ☐ CORRECTED ☐ UNCORRECTED

ENT: ☐ N/A ☐ EPISTAXIS ☐ SWELLING ☐ PAIN ☐ DRAINAGE ☐ HEARING DIFFICULTY ☐ DIFFICULTY SWALLOWING ☐ FOREIGN BODY

NURSING DIAGNOSIS: (ACTUAL PROBLEMS)

☐ Ineffective airway clearance/impaired gas exchange
☐ Alteration in tissue perfusion
☐ Alteration in skin integrity
☐ Infection
☐ Knowledge Deficit
☐ Pain ☐ Anxiety
☐ Other _____

Planned Outcome/Evaluation

☐ Improved respiratory status
☐ Improved tissue perfusion
☐ Clean Wound
☐ MD TX for infection
☐ Verbalizes understanding of TX/Discharge Instructions
☐ Pain free
☐ Copes with anxiety, by _____
☐ Abuse report called to 1-800-96-Abuse
☐ Other _____

Assessment Completed by: _____ **Time:** _____

North Broward Hospital District

EMERGENCY DEPARTMENT RECORD / ADULT

ADDRESSOGRAPH

Source: North Broward Hospital District, Fort Lauderdale, FL.

location and nature of the laceration is consistent with his description of the mechanism of injury, a neuro examination is not essential," says Carroll.

However, if his story does not match the injury you see, you smell alcohol on his breath, his speech is slurred, or he has an ataxic gait, you'll need to do a more comprehensive neuro assessment, and follow up with repeat assessments to determine if any impairment is getting better or worsening, she says.

- **Determine the cause of the patient's altered mental status**.

Possible causes for altered mental status include cardiac dysrhythmias, electrolyte imbalances, anemia, stroke, brain tumor, and hypoxia, says Cohen. "There are many things that could alter somebody's mental status. The differential diagnosis is huge," she says.

It also could be a normal status for the patient, she notes. "If the patient doesn't speak clearly, it could be due to a stroke from three years ago. But if I don't know that, I have to assume the abnormal speech is of a new nature," says Cohen.

You must treat any patient who presents with a change in mental status or slurred speech as a stroke until proven otherwise, stresses Cohen.

"This is especially important with an ischemic or embolic stroke, because we can give anticoagulants to treat that," she says. ■

CE questions

17. The first CM in Jackson Health System's ED was a social worker responsible for triage.
    A. true
    B. false
18. Define the first step the ED case managers at Jackson Health System took in 2000 when they established their current ED initiative.
    A. They took over all discharge planning responsibilities.
    B. They began overseeing the admitting process.
    C. They took over setting appointments for follow up care for ED patients.
    D. none of the above.
19. Among pediatric patients at Jackson health System, what percentage have HMOs?
    A. 85% to 95%
    B. 65% to 75%
    C 45% to 55%
    D. 25% to 35%
20. Which of the following is not included in the "triangular approach" to case management at the UAB's University Hospital?
    A. RN case managers
    B. social workers
    C. licensed practical nurses
    D. physician's assistants
21. The final security standards under HIPAA become enforceable on what date?
    A. Nov. 1, 2003
    B. April 14, 2004
    C. April 21, 2005
    D. May 6, 2006
22. According to Patrice Spath, RHIT, a misconception regarding IT is that installing new software will reduce staffing needs.
    A. true
    B. false

Answer Key: 17. B; 18. C; 19. A; 20. D; 21. C; 22. A

AHRQ launches web site to aid in quality measure

The Agency for Healthcare Research and Quality (AHRQ) has launched a web-based National Quality Measures Clearinghouse (NQMC) designed to be a one-stop shop for hospitals, physicians, health plans, and others interested in quality measures.

It contains evidence-based quality measures and measure sets available to evaluate and improve the quality of health care. The clearinghouse should be helpful as hospitals work to identify scientifically valid quality measures for hospitals as part of the National Hospital Quality Information Initiative, according to **Nancy Foster**, the American Hospital Association's senior associate director for health policy.

The initiative will start with 10 common measures approved by the Centers for Medicare & Medicaid Services; the Joint Commission on Accreditation of Healthcare Organizations; and the National Quality Forum. Each domain of measurement in NQMC, access, outcome, patient experience, and process, offers a different insight into health care quality, according to information on the site. An access measure, for example, assesses the patient's attainment of timely and appropriate health care, while a patient experience measure aggregates reports of patients about their observations of and participation in health care.

For information, go to: www.qualitymeasures.ahrq.gov. ■

ACCESS MANAGEMENT
QUARTERLY

LOS reduced as system hones case management

Bed management, discharge initiatives cited

It's been more than a decade since Lehigh Valley Hospital and Health Network in Allentown, PA, took its discharge planning and utilization management functions and created a resource utilization department with a single director, says **Susan Lawrence**, MS, CPHQ, administrator of quality and case management.

The "forward thinking" exemplified by that move — unusual for its time — continues to the present, she adds, paying off in continually decreasing lengths of stay (LOS) for the 750-bed system, which includes two hospital campuses in Allentown and another in Bethlehem.

Such present-day initiatives as daily bed alerts, emergency department (ED) case management, and an express admit unit for direct admits from physician offices continue to streamline health system operations, Lawrence explains.

Medicare patients at Lehigh Valley have an average LOS of 5.3 days, she notes, while the average medical-surgical LOS is 4.5 days. The latter figure becomes more impressive, Lawrence points out, when you consider that it includes level-one trauma patients, and those in the neonatal intensive care (NICU) and burn units. Babies in the NICU, she adds, can have stays of from 20-40 days.

After the creation of the consolidated department in 1990 — now known as the case management department — the next pivotal move, Lawrence says, was the decision in 1994 to combine the roles of the discharge planner and utilization management (UM) nurse, so that each could perform the other's duties.

"We were implementing patient-centered care, and we began looking internally at how we could adopt some of those principles and have less people interacting with the patient and the medical records," Lawrence says. "We looked at the job descriptions of the discharge planner and the UM nurse, and thought we could put those roles together completely."

The department conducted a three-month pilot, with two discharge planners and one utilization nurse performing the blended function. The findings, she says, were that the discharge planners were able to review the medical record, assess severity of illness and intensity of service, evaluate the clinical information, and report all that to the insurance company to get authorization.

Conversely, Lawrence says, the UM nurse was able to assess patient needs at the time of discharge and develop plans for post-hospital care, whatever those might be. "It took about 12 months to cross-train everyone, so it was the end of 1995 by the time that was fully implemented," she notes. "We began to see some improvements in LOS, and we did not see an increase in denials."

With the combining of the two functions, Lawrence adds, the person handling the case is "constantly aware of whether the patient meets the criteria to be in the hospital and can immediately act to implement the plan. You're not repeating, so you save time."

The health system has used that model ever since, she notes, and in 1999, began an additional focus on decreasing LOS. "We tried to refine the role of case manager and increased the recognition of that role throughout the organization."

With LOS reduction identified as an important priority, Lawrence says, the health system began holding weekly multidisciplinary meetings, pulling in representatives from such areas as respiratory therapy, pharmacy, and radiology. "We were able to bring to the surface what some of the delays were."

In response to those findings, she notes, the health system implemented Saturday thallium stress testing and weekend physical therapy, among other changes.

"We have also done some studies to evaluate what's affecting LOS, and we've identified a lack of short-term skilled nursing facility (SNF) beds,"

Lawrence says. "We happen to have a hospital-based SNF unit, but it was only staffed for 32 beds. Once we demonstrated the need, it was opened up to 42 beds. It's licensed for 55, so the data are evaluated periodically to see if we need to recruit more staff to open more beds."

Daily bed alerts instituted

Because Lehigh Valley's registration process is fairly decentralized, there is no admitting department, Lawrence explains. Direct admits are sent from the front door to the nursing floor, and staff there perform registrations, she adds. ED registrars report directly to the ED management, Lawrence notes, and there is a person with the title of director of support services who supervises registrars in certain areas.

The director of bed management — a function that, in many hospitals, is part of access services — handles one of Lehigh Valley's LOS initiatives, she says. That individual, who supervises a department that is staffed 24 hours a day, seven days a week, issues daily bed alerts when the hospital gets to certain occupancy levels.

"They will send pages, messages out to various members of the staff, including case managers," Lawrence says. "What that tells us is how many people are awaiting beds and what kind of beds they need. It helps the staff to prioritize."

Like many other providers, Lehigh Valley has looked closely at ED operations in its efforts to relieve overcrowding and increase bed capacity, she notes.

Case management in the ED was instituted after a pilot program showed that it avoided a significant number of inappropriate admissions, Lawrence says. The ED case manager is able to arrange SNF admissions for non-Medicare patients directly from the ED, she adds. "Even the placement of Medicare patients can be facilitated if they don't need acute care."

The ED case manager also has helped a great deal in placing patients in assisted-living homes, setting up home care, and ordering durable medical equipment, Lawrence adds. "[The case manager] has been a really good resource."

A project called Clockwork ED "implemented a lot of processes to improve ED efficiencies, but we realized that many of our inpatient operations were impacting [the ED's] ability to send patients to the floor, she says. "If a patient is not discharged from the bed, [another patient] can't move up from the ED," Lawrence adds, "so we created a large group called 'Growing Organizational Occupancy,' which we call GOC."

That team, which began meeting in October 2002, has chartered a number of subgroups, she says, to focus on various parts of the hospitalization process.

The team's first mission was to look at the mechanics of discharge, Lawrence notes. "If you're being discharged and going home with your family, how do we get you to the front door?"

"Then we had a group that looked at how to get a bed cleaned as quickly as possible," she says. "We identified that the patient may have left the building, but we were unable to turn around [the room] quickly enough. Part of it is the nurses are busy with other patients, and cleaning the bed is not a top priority."

A number of recommendations have been made to streamline the process, she notes, including a proposal for automating discharge paperwork. Under this plan, Lawrence explains, physicians would generate orders on the eve of discharge that would notify physical therapy, radiology, and other pertinent areas to move toward getting the patient out by 11 a.m.

"We're trying to increase the percentage [of early discharges] from 8% to 20%," she says. "To make that happen, we're working on a communication campaign targeting patients' families, all caregivers. We want to communicate a consistent message that — like a hotel — once you're discharged, it's time to go."

The idea, Lawrence says, is to eliminate such scenarios as telling a patient at 9 a.m. that she's been discharged and having her say, "I'll call my husband and have him pick me up. He gets off at 4 p.m."

"It's about changing everyone's mindset — informing patients that as soon as they're discharged, our goal is to make the bed available for the next patient," she says.

Another plan has to do with establishing centralized dispatch for external transport, Lawrence says. At present, individual case managers call various ambulance companies to secure arrangements for their patients, she notes. "We're proposing they call a central number and have [a dispatcher] call and make arrangements."

Although case managers still would be making the same number of calls, Lawrence says, this method gives the hospital more control over the time that a patient is being picked up and allows prioritizing.

"If we need an ICU [intensive care unit] bed more quickly," she adds, "we could prioritize an ICU transfer out earlier in the day. If case managers are making arrangements independently, they're all vying for the same time." ■

Committee seeks ways to enhance hospital revenue

Grass-roots effort leaves no stone unturned

When **Donna Madlener** agreed to lead the revenue enhancement committee for the James Cancer Hospital, which is part of The Ohio State University Health System (OSUHS) in Columbus, she signed on for "a unique experience" that went to the heart of such issues as financial responsibility and internal customer service.

"We interviewed the managers of every cost center in the James Hospital and brought back the information they provided to us," says Madlener, who is manager of the hospital's apheresis unit. "There were suggestions for revenue enhancement and the problems they saw in any processes we had in place. The underlying purpose was to evaluate all processes and systems to identify opportunities for revenue enhancement and recommend strategies for improvement."

The James committee began work in May 2001 and presented its recommendations in January 2002, sometimes meeting as often as twice a week, she says. "It was a long, involved process."

The nine-member committee also included OSUHS director of revenue manager Joe Denney, who spearheaded the effort for the entire health system, and representatives from administration, nursing, outpatient services, and pharmacy, among other hospital areas, Madlener notes. "A multitude of backgrounds were represented."

The committee developed a questionnaire and embarked upon the interviewing process, dividing up the cost centers according to the expertise of individual members, Madlener says. "Through the grass-roots effort of interviewing each manager, we looked at the information we had and defined the purpose and goals we wanted to focus on."

When it came to registration, "a process with huge financial ramifications," the committee looked at, among other things, "different people's roles and job descriptions," she explains. "Did we have people responsible for doing certain things, or were there holes in the system? Were there people in the same role [at different centers] but doing things differently?"

In addressing its task, Madlener adds, the committee used an existing model that looks at how patients go through the continuum of services in a hospital. The first phase, for example, is pre-encounter, which includes inpatient precertification, outpatient precertification and authorization, and scheduling, she says. "We divided the issues into the different phases and from there made recommendations."

Looking at inpatient precert, for instance, the committee found that there was no real policy development, Madlener says. "Everyone was doing their own thing," she notes. "[Employees at physician offices and clinics] were not really part of our hospital, but were responsible for precert. There was no fallout if they didn't do it."

Regarding the registration software program, Madlener points out, the committee's recommendation was that the flow and storage of information be enhanced so the hospital could monitor processes for compliance and determine how many accounts were getting through without precerts being obtained.

When it came to centralized scheduling, she adds, the need was for more information systems resources. "There was no one to call to help you."

Another recommendation had to do with the need for registration personnel — who perform a critical function — to be trained and paid accordingly, Madlener says. "They're doing probably the most important job. When the bill is not correct, [the hospital] spends lots of money correcting it, paying people to figure out what was going on. We thought that was crucial."

Cost center accountability probably was the biggest issue confronted by the committee during the "encounter phase — what happens when the patient is already here," she points out. This had to do with "things like reconciling billing. After you put the charge in, did someone check to see if it was put in correctly? Did you pick the right procedure to charge for? Is the fee schedule updated? Are the CPT [current procedural terminology] codes current? Is the cost of the procedure more than what you're charging? Do the managers know how to read performance and productivity reports?"

Much of the problem, Madlener adds, had to do with the attitude that "it's somebody else's job. As a state institution, [the hospital] didn't really have a culture of financial responsibility

and internal customer service."

As a sideline of the committee, members sat down with each of the hospital's nurse managers and went over the fee schedule item by item, she notes. "It was very laborious. On some of the fee schedules there were, for example, 10 different catheters to charge for, and two were identical. A lot of cleaning up and updating of CPT codes was done."

One cost center was charging for drawing blood from a central line, and another wasn't charging for the same procedure, Madlener points out. "They didn't know they could."

Staff turnover was identified as a huge expense with a tremendous impact on the hospital's bottom line, she notes. The negative effects ranged from the cost of formal training and education of new hires to the problems caused by new employees' lack of knowledge, Madlener adds. "A lot of money was spent on staff turnover."

Although the committee's role was to look at the situation and make recommendations, she adds, in many cases it took a more proactive role. "When we would identify things — fee schedules, charge entry — that were huge issues, we would correct the problem right on the spot. In the case of some drugs that were not being billed correctly, we went right to the source and fixed it." ■

Registrars' cash incentive raises hospital collections

Brown County General Hospital more than doubled its upfront cash collections over the past year by offering incentives to both registrars and their bosses, says **Barb Dailey**, patient access director at the Georgetown, OH, facility.

Fifteen registrars who cover the admitting, outpatient, and emergency areas at the 50-bed hospital had collected close to $15,000 by mid-November 2002, compared to $7,000 for the year 2001, and $5,000 during 2000, Dailey says. The goal for 2002 was $10,000, she adds.

In January 2002, the hospital began offering registrars 3% of whatever they collect in upfront copays and deductibles, she explains. Dailey and a supervisor each get 1.5% of the total collected. Clinic fees charged by the specialty physicians in the hospital's outpatient pavilion are included, she says. "We keep track of it through the business office. Receipts are printed out in the system and added up at the end of each quarter. [The business office staff] figure up the bonuses and [registrars] get them with their paychecks."

Depending on the assertiveness of the registrar, and to a large extent, the shift and area in which he or she works, those bonuses can be as little as $2 or $3 or as much as $40 or $50, Dailey notes. "Those on third shift don't collect much, because they don't have as many patients to see."

Registrars make note of insurance cards to see the kind of plan to which patients belong, she says. They have suggested scripts to use during collection efforts, which include statements such as "How would you like to pay your copay today?" and "We accept checks, credit cards, or cash," Dailey adds.

Hospital administrators are looking toward an eventual bonus payout on $100,000 in collections, she says, which probably would be close to 100% of the money due, according to Dailey. "Our biggest trial is to get patients used to paying up front. We've posted signs saying that if you're a self-pay [patient] or have a copay on an MRI [magnetic resonance imaging], payment is expected up front. That is starting to help."

In some cases, patients actually want to pay but can't because the appropriate amount has not been determined, Dailey notes. "We're hoping that we can set a figure of $50 or so [to be paid] toward whatever the deductible is. We're coordinating with information systems and patient financial services on the charges [for various procedures]."

Upfront collections in the emergency department (ED) alone have increased by about 80%, Dailey says, in part because of a change in the triage process that occurred during the quarter that ended June 2002. The new procedure, she adds, was implemented after careful examination of the provisions of the Emergency Medical Treatment and Labor Act.

After the nurse triages the patient and determines that his or her condition is not an emergency, Dailey explains, registrars are free to register the person and collect the copay. In the past, she says, registrars waited until the end of the ED visit to attempt to collect the payment. "That didn't work because the patients never got back to us. Now we get them before they go back to be treated."

Most patients have a set copay for ED treatment, Dailey notes. "If it's a 20% deductible, we don't try to collect those." Eventually, however, the hospital plans to work out the deductibles and collect accordingly, she says. ■

(Continued from page 70)

answer during this assessment:

- What needs changing to improve performance?
- What actions can be taken with what predictable consequences?
- How will the success of actions be measured?

If you have done a good job understanding the system, you should be able to improve performance by cutting out unnecessary steps, re-designing the process, or whatever. The consequences will be an improvement in discharge planning activities — and without any investment in IT.

Now (and only now) should you consider if IT could further enhance the process. By first understanding and improving the case manager's activities, you can better predict what benefits IT solutions will bring to the way the process works. The result may be less investment in IT or a realization that IT truly will improve performance. Automation should be "pulled" into the work of case managers. Technology should not "push" the way the work gets done.

The features and functionality of IT should not lead the design and management of case managers' work. All too often, people are persuaded that IT system features will benefit the work of case managers because, generally speaking, the features fit with current views about the work requirements and processes. For example, IT links to insurance companies that allow for confirmation of patient insurance benefits will lead to more timely discharge planning decisions — but that can only be true when case managers know how to effectively use this information to make post-hospital service arrangements.

The value of IT should be questioned from a thorough understanding of the "what and why" of case management performance. This investigation is something that only can be done by involving people who do the work. Then improve the efficiency of the process in achieving its desired purpose. Don't make decisions about the use of IT before this first step is completed. The traditional approach to implementing new automation is "push" — here is the new computer system, now use it. When IT is "pulled" into case management processes, people understand the value and know exactly what to expect. Often implementation problems, resistance and so on, simply do not exist when a bottom-up approach is used.

Success at integrating IT into case management activities doesn't come in equipment or software but rather in the empowerment of the people who do the work. One misconception regarding IT is that installing new software will reduce staffing needs when, often, additional personnel must be hired. If case managers are not provided adequate levels of support, they are unlikely to use new technologies effectively.

The promised benefits of computerization also will fall short unless a significant investment is made in showing case managers how to integrate the technology with their daily activities.

Ultimately, the human aspects of IT are far more important than the technological side. It is futile to support just one part. In other words, purchasing new technology is useless without funding staff support and training. New software products cannot simply be added on to the already full plate of activities expected of case managers. It has to become an integral part of the case manager's experience in order to gain performance improvements. To achieve this goal, case managers are likely to need ongoing one-on-one and just-in-time instruction in using new technologies. This is not a job that can be performed by a technical troubleshooter or IT specialist. Someone with an understanding of case management activities as well as the associated computer systems should be available for ongoing staff training and support.

The IT industry is continually reinventing itself with the introduction of new and improved automated solutions. Will these products actually benefit case managers or merely add financial and productivity burdens? After more than a decade of having IT available to assist in case management functions, the benefits are becoming clear.

However, before committing to the purchase of new technology, make sure the people who do the work understand the value it will bring to case management activities. As hospitals acquire more and more computerization capabilities, the necessity for case managers to understand the role of IT becomes increasingly critical. The enthusiasm over

COMING IN FUTURE MONTHS

- Denial management: The role of the case manager
- How to measure your case management effectiveness
- Dealing with frequent-flyer patients
- Clinical pathways for COPD and CHF

new technology can quickly change from being an exciting possibility to an intimidating nuisance if IT is "pushed" into the case management process and the human side is not adequately supported. ■

HIPAA security rule now in its final form

Signature standard not included

Final security standards under the Health Insurance Portability and Accountability Act (HIPAA) for protecting patient health information when it is maintained or transmitted electronically have been adopted by the Department of Health and Human Services (HHS).

All "covered entities," which include health care providers, health plans, and health care clearinghouses, must comply with the rule, which was published in the *Federal Register*. It includes the following provisions:

- All work force members, including management, must receive security awareness training.
- Organizations must conduct risk analyses to determine information security risks and vulnerabilities.
- Organizations must establish policies and procedures that allow access to electronic protected health information (PHI) on need-to-know basis.
- Organizations must implement audit controls that record and examine who has logged into information systems that contain PHI.
- Organizations must limit physical access to facilities that contain electronic PHI.
- Organizations must establish and enforce sanctions against members of the work force who don't follow information security policies and procedures.

The electronic signature standard, a component of the proposed rule, was removed from the final version, which was published in the Feb. 20, 2003, *Federal Register*. HHS has said it will publish that standard in a separate final rule, but did not say when. Some security experts have said the rule, while well integrated with the HIPAA privacy rule, lacks specific guidance in some critical areas, such as the requirement that encryption be used "only when deemed appropriate."

John Christiansen, JD, an attorney with Preston Gates in Seattle, has said the HHS accomplished one of its goals, which was to integrate the security rule with the privacy rule. He said many redundancies had been eliminated, in addition to some unclear concepts and rules.

HHS writes in the rule's preamble that the regulations are consistent with "generally accepted security principles."

The regulations will become enforceable for most covered entities, including hospitals, on April 21, 2005. Small health plans will have an additional year to comply. To view the final rule, go to www.access.gpo.gov. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■