HOSPITAL PEER REVIEW®

YOUR BEST SOURCE FOR JCAHO, CREDENTIALING, AND QUALITY INFORMATION

CELEBRATING 28 YEARS OF SERVING THE HEALTH CARE QUALITY PROFESSIONAL

28

THOMSON AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

OCTOBER 2003

VOL. 28, NO. 10 • (pages 133-148)

Requirements on core performance measures are set to increase

Quality managers bracing for jump in workload

Are you ready to add another set of core measures to your to-do list? There is no doubt that the Joint Commission on Accreditation of Healthcare Organizations' new requirement for gathering data on an additional set of performance measures, effective January 2004, will increase your workload significantly. In addition, new measure sets to address surgical infection prevention, the intensive care unit (ICU), pain management, and inpatient pediatric asthma are being developed and are expected to become available during the next six to 24 months.

"Core measures are one more responsibility added to our peer review, continuous quality improvement, and regulatory hats," says **Linda Golabiewski**, RHIA, CPHQ, quality outcomes manager at Maricopa Integrated Health System in Phoenix.

As a quality manager, you'll need to fine-tune your ability to view departments in a more "data-driven" mode, she says. "It is evident that the Joint Commission wants to put its finger on the organization's pulse, via data. You could almost say it wants to have a data mart of each organization's information." You could be facing an uphill battle if your facility hasn't already begun to collect data for some of the new core measures, Golabiewski warns.

"You may be caught off-guard if you don't have a good feeling for how you compare to other facilities. It could be a very revealing experience, and one that will require explanation to top leadership," she says.

Even the best-prepared quality managers will be challenged. Although **Pam Spach**, RN, BSN, CPHQ, director of performance improvement and disease management at NorthEast Medical Center in Concord, NC, already has established data collection for all patients, as opposed to only Medicare patients, and has been referencing all four sets of core measures in the facility's internal data tracking, she is concerned about another potential problem area. "The new measures for surgical site infection, ICU, pain management, and inpatient pediatric asthma will create additional work," she says. "These pieces of data are not necessarily collected as designated by the Joint Commission."

Numerous additional indicators likely will be added in the coming

months, Golabiewski notes. "The quality manager of the future will need a solid understanding and use of statistical methods, severity adjusting, stratification of the data, and the proper way to present it," she stresses.

Here are effective ways to ensure compliance with the Joint Commission's new core measure requirements:

- **Use work groups to identify and facilitate specific improvements**.

Several systemwide teams and work groups help drive process improvements for the core measure patient populations of acute myocardial infarction and community-acquired pneumonia at Banner Desert Medical Center, a 600-bed hospital in Mesa, AZ, says **Maureen Mulligan**, RN, BAM, CPHQ, a quality specialist at the facility.

These teams typically meet via telephone conference lines, with documents posted on the corporate intranet site and/or e-mailed to participants. The teams have annual charters, which include several well-defined action items for the coming year, she says. For example, a goal was set to improve documentation of smoking cessation counseling, adds Mulligan. "We found a common theme in our hospital system that smoking cessation documentation, as well as tools utilized, are inconsistent between facilities and between departments within a facility."

Nursing units at the facility's heart center and the respiratory-telemetry unit both monitor unit-specific smoking cessation counseling rates for acute myocardial infarction patients on a monthly basis, she explains.

These steps were taken to improve that area:

— A smoking cessation toolkit was developed by the population health management team, including a policy, educational materials for patients in English and Spanish, and a standardized documentation form with discharge instructions.

— A start date for the policy was established.

— Each facility was asked to educate staff prior to the start date.

— Materials were posted on the company intranet site and distributed to the facilities.

"We hope to see improved documentation of smoking cessation counseling for *all* patient populations, based on this change," says Mulligan.

Similarly, an adult immunization toolkit has been developed to improve consistency of immunizing community-acquired pneumonia patients, and is going through the rollout phase now, she reports.

- **Choose the third measure carefully**.

Consider the following when selecting a core measure population, Mulligan advises:

— Identify your typical patient populations, as not all facilities care for all core measure patient populations.

— Use your facility's mission/vision/values statements for guidance.

— Assess your ability to implement process improvement activities within the various core measure populations and your ability to collect data within the various core measure populations, considering both staffing resources and whether data are accessible electronically or manually.

— Make sure you have input from key customers, such as medical staff, administration, managers, and information technology.

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 additional copies, $269 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Staci Kusterbeck**, (631) 425-9760.
Editor, *Discharge Planning Advisor*, **Lila Margaret Moore**.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

— Consider differences in cost between the various available core measure population projects, both vendor costs and internal costs. Then do a selection matrix with the information, and prioritize your choice accordingly.

- **Obtain buy-in from staff and administrators**.

Each facility's monthly results for each core measure are posted on secure pages on the corporate intranet site, says Mulligan. "Data also are rolled up by region within our system, so data can be compared at both a facility level and at a regional level," she says.

Facility size, facility-specific goals, corporate goals, and national core measure benchmark results also are posted for comparison, she says.

In 2002, Banner Health began linking a portion of hospital executives' annual salary to reaching established goals for their facility, including one or more of the core measures, Mulligan reports.

"This helps strengthen the buy-in of executives to make core measure improvements a high priority in their work. It also creates a trickledown effect to make core measure improvements a high priority within the organization," she says.

- **Keep others informed about progress**.

You must keep medical and hospital staff informed of your progress on core measures, Mulligan advises. The facility's core measure data are reported to the appropriate medical staff committees on a quarterly basis, she adds.

"Our medical center departments also maintain scorecards to measure their department's progress on their goals," she notes.

For example, several departments monitor their smoking cessation counseling rates on a monthly basis, in addition to other core measures.

Current core measure data are posted for staff to see and are discussed in staff meetings, she notes. Nursing clinical managers and case managers also discuss core measures during their daily rounds with staff and in coordination with patient care discussions, she says.

"Prompters" also are placed on patient charts, such as a sticker stating, "This AMI patient appears to meet ACC/AHA indications for the following drugs:

☐ aspirin;
☐ beta-blocker;
☐ ACE inhibitor;
☐ lipid-lowering agent.

Please consider ordering the Rx or document in the medical record the reason(s) why Rx is not appropriate for this patient."

"Now that we have 12 months of data for two of our core measure sets, we feel we are ready to start reporting physician-specific rates of selected core measures to the medical staff committees, as well as to their reappointment files," Mulligan says.

Some of the system's hospitals send a letter to the physician of record on every outlier case. For example, the letter might state: "Dr. ____, it appears that patient _____ was eligible for a beta-blocker within 24 hours of arrival for an AMI. There may have been contraindications to the use of a specific medication, but none were explicitly documented."

- **Use customized data fields.**

"For us, our vendor's cooperation to customize our data collection tool has been very helpful," Mulligan reports. The customized fields have made it easier to zero in on the core measure-related issues that are important to each hospital or to units within a hospital, such as smoking cessation counseling, she explains.

"They have also made it easier for us to provide physician-specific data for their reappointment files, helping us to fulfill a Joint Commission requirement," Mulligan adds.

- **Determine if the upcoming measures will require additional resources.**

Several of the hospitals within the system have begun to discuss the ICU core measures, Mulligan says. "We have determined that we will need additional electronic support and additional manpower to meet our ICU data collection needs, including ICU core measure sets," she adds.

Currently, quality management staff do retrospective reviews to obtain core measure data, she explains. "With the surgical site infection and ICU core measure sets, we'll need to expand that to include infection control nurses and ICU staff, as well as possibly moving toward concurrent data collection for some data sets," she says. "This will require additional planning, monies, and time to make the changes."

The new Joint Commission requirements may convince administrators to invest in resources to allow for increased clinical data collection and use, Golabiewski predicts. A personal digital assistant, wireless, voice recognition, bar-coded, or web-based system could be used to capture clinical data at the point of care, she says.

"We have been working fervently to hardwire as many processes as possible within our documentation systems to capture the information needed for data collection," Spach reports. "That seems to be the key."

Golabiewski gives the example of an emergency

department patient whose vital signs are recorded manually on the patient's chart.

"All of this information could be entered or captured from the devices used to analyze the patient's condition, such as the thermometer and the blood pressure cuff," she says.

- **Determine whether your vendor can handle the hospital's data needs for the additional measures.**

A vendor has to address the issues of system scalability, training, and quick turnaround for updates, Golabiewski points out. "Our vendor is going web-based, which will allow them to update the system quickly and give them the capability to increase capacity on their end without us having to allow for network growth."

Data quality control is another key issue, she says, noting that coders are held to coding guidelines and compliance requirements. "The information requested for the core measures is first queried out by coded data." Therefore, it may require a quick lesson for providers in what has to be documented in the chart, such as pneumonias and cardiac results, in order for the coders to assign the appropriate code, Golabiewski explains.

- **Use one vendor for the entire system**.

Try to use one vendor for all core measure sets if possible, Mulligan recommends. "It's much easier to use your current vendor for an additional population than it is to contract with an additional vendor." While each facility in the Banner Health System independently chooses the core measure sets for which it collects and reports data, a single vendor is used for core measure sets across the 20-hospital system, she reports. Here are several benefits of using a single vendor:

— Results can be compared more easily. "Having one vendor enables us to more easily compare results between facilities within our hospital system," Mulligan says.

— Computerized chart information is uploaded in the same way on the same dates for all facilities. This improves consistency and accountability, she adds. "Data uploading dates, chart abstraction due dates, and reporting dates are all scheduled in advance."

— The corporate office has access to core measure data for all facilities.

Data can be accessed directly by the corporate office, rather than asking hospitals to provide the data to them, Mulligan explains. This means that turnaround time for producing systemwide reports is shorter; customized data collection fields such as physician identifier fields are standardized across facilities; the corporate office can audit for data collection issues such as facilities not using new data collection fields; and the corporate office can query, download, and analyze data from multiple facilities, such as predicted and observed mortality rates.

"There is better coordination and resolution of issues, since the corporate office acts as a go-between to resolve issues between hospitals, information technology, and/or the vendor," she says.

When new core measure patient populations are added, there is no need to go shopping for another vendor, Mulligan says. "This would certainly be a benefit for hospitals that are not part of a system as well. This saves time, stress, and probably money, too." ■

Recent power outage puts spotlight on problem areas

Fix potential problems before a disaster occurs

When a patient in a wheelchair needs to get from an upper floor to street level after dialysis, the elevators are inoperable.

A "bucket brigade" is the only way to get water to the upper floors of your hospital, since water pumping is no longer functional.

There is no air-conditioning almost everywhere in your city on a hot summer day, which leads to a huge influx of patients with respiratory illnesses.

If one of these scenarios occurred at your facility, it would be a major headache and potentially dangerous. But quality managers faced an unprecedented situation when all of these problems occurred on a single day as a result of the power outage on Aug. 14, 2003, which posed a major threat to the ability to deliver quality patient care. The blackout plunged dozens of cities in the eastern United States and Canada into darkness.

An array of complex problems had to be dealt with immediately, including providing electrical power to life-support equipment for inpatients in surgery or intensive care, providing power to outpatients dependent on battery-powered devices, and loss of vital data due to computer systems being down. To make matters worse, the power outage affected phone service and caused traffic jams, which hindered the ability of staff to communicate and report to work, says **Dale Woodin**, CHFM, deputy executive director of advocacy for

the Chicago-based American Society for Healthcare Engineering. "The massive scale of the blackout caused problems with basic communication and traffic issues."

Normal operations were disrupted and many nonessential procedures delayed, he says. "An extended outage makes for more delays and greater disruption to normal business operations."

To ensure your facility is prepared for a power outage, consider the following situations that occurred during the blackout:

- **Fuel supplies for generators were limited.**

Very few facilities reported problems with backup generator systems, Woodin notes. "For the most part, the systems performed as designed. The most common problem was delays in getting fuel shipments to replenish tanks."

Not knowing the duration of the blackout was a major concern, with different hospitals having different amounts of fuel supplies for their generators, says **Richard Botney**, MD, assistant professor in the department of anesthesiology and perioperative medicine at Oregon Health and Science University in Portland. "If the outage were sustained, some facilities were positioned to continue their work, while others were not, due in large part to loss of fuel supplies," he explains.

- **The duration of generators was a concern**.

Ensuring that generators continued to work also was an issue, as shown by a number of failures when the generators continued to be used over a prolonged period, he says.

The generators are supposed to be tested regularly and maintained as per Joint Commission on Accreditation of Healthcare Organizations requirements, he notes. Maintenance and testing of this vital equipment is essential, he emphasizes.

"Things happen during prolonged use that don't appear to be a problem during short-term use," Botney points out. Should your facility face a sustained loss of power with loss of backup generator power, that would be an extremely dire situation because patients dependent on life-sustaining equipment would be threatened, he explains, although certain vital pieces of equipment are designed to operate by hand, such as cardiac bypass machines and mechanical ventilation.

For the most part, emergency power is meant for just that situation — an emergency, Woodin says. "It is not meant to run indefinitely or sustain normal operations." The Joint Commission has stringent requirements for the ongoing testing and maintenance of emergency power systems, he underscores. "These are referenced from the NFPA codes 101, 99, and 110."

In addition, the Joint Commission defines what systems must be supplied by emergency power and requires that organizations develop contingency plans in the event of a utility failure, Woodin adds. When surveyors come to your facility, they will inquire as to the inspection and maintenance of the generators and related devices of the emergency power system, he says.

"JCAHO prescribes that generators should test run monthly with actual hospital loads," he says, adding that the automatic transfer switches connecting the generator to the building loads also must be tested monthly. "This drill is very effective in testing the entire system, from generators to end outlets and lights." ■

ACCREDITATION
Field Report

Tips from a recent JCAHO survey

[Editor's note: If your facility recently was surveyed, please contact Staci Kusterbeck, Editor, Hospital Peer Review*, 280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: stacikusterbeck@aol.com.]*

During a July 2003 Joint Commission survey at Childrens Hospital Los Angeles, two areas took center stage: patient safety and performance improvement. "Everywhere surveyors went, they would ask staff what they have done to improve patient safety in the area, and what the area has done for performance improvement," reports **Sharon A. Chinn**, RN, the facility's patient care services manager of regulations and outcomes. Here are key points of the survey:

- **Surveyors were impressed with the opening conference on performance improvement**. The facility had done its homework to prepare, says Chinn. "We took a very proactive approach to that particular conference — it wasn't just convening the key people in a room and waiting for them to ask us the questions. Our presentation was extremely organized." This paid off because it sent a clear message that performance improvement

was a priority throughout the facility, she says.

The facility's medical director of patient safety and medical director of performance improvement gave detailed presentations on patient safety, which included discussing methodology and philosophy, explaining several programs that were implemented, and giving beginning and ending data to demonstrate specific improvements that were made. Poster boards were made up to display progress with the following areas:

— patient safety technology enabled process improvement;

— discharge planning;

— culture of safety;

— financial results of the operational functional project team;

— operational enhancement from a performance improvement perspective;

— pediatric dosage standardizations;

— prevention of ventriculoperitoneal shunt infections;

— trigger chart review identification of adverse drug events in pediatric inpatients.

"The room was full of PI boards," says Chinn. "The surveyors told us, 'You have presented this so thoroughly, we have hardly any questions.'"

• **Surveyors asked open-ended questions**. "The surveyors didn't ask leading questions at all; they were looking for very spontaneous answers," says **Kathy G. Anderson**, manager of medical staff services. "They were fishing to make sure everyone was really involved, to see whether or not the goals had trickled down through the organization."

All patient care areas have dedicated performance improvement information boards, and staff could refer to the data on the boards, she adds. For example, staff in all areas talked about the use of two patient identifiers and could explain how this is tied to safety with regard to processes such as medication administration and procedures. Likewise, surgical staff explained the policy for surgical site markings, and intensive care unit nurses described efforts to reduce noise in the unit so that alarms can be heard over competing noise.

• **Educational efforts paid off**. "We have done a lot to orient the staff to goals, and that really came out in the survey," Chinn says. "People were very familiar with them." The goals have been stressed facilitywide with the following initiatives:

— Articles in the weekly hospital newsletter cover patient safety on an ongoing basis. In the months before the survey, the six National Patient Safety Goals were featured in six separate issues. The newsletter also included a "JCAHO Q&A Corner," which asked a specific question each week related to overall survey preparation, such as, "If there were a fire in your department, what would be your specific responsibilities?"

— The *JCAHO Preparedness Staff Handbook* was developed and distributed to all staff. The 19-page book contains 10 sections: management of the environment of care, infection control, management of information, performance improvement, medical staff, patient's rights and organizational ethics, patient safety, continuum of care, assessment of patient, and human resources.

— A *Patient Safety Newsletter* was handed out to staff, with a one-page summary of all the National Patient Safety Goals.

— Laminated cards were given to every employee, concisely listing the safety goals and the facility's rules to comply with each goal. "They are the same dimensions as our ID badges, and were hole-punched to fit on the same clip," Chinn says. The cards read as follows:

1. Patient identifiers: Two required. Inpatient: Name and MR#. Outpatient: Name and DOB.
2. Invasive procedures: Mark the site for right/left, multiple sites, or level. Have everything needed before start of case, *e.g.,* records, X-rays. Team pauses to verify patient, procedure, and site.
3. Verbal orders: Only in emergencies or when delay would harm patient. Read-back required. In emergencies, repeat back abbreviations.
4. Abbreviations: Use only approved abbreviations. Do not use ara-a, da, nitro, hctz, mr, p-asp, 5fu, 5fc, and cpz.
5. High-alert medications: No concentrated potassium or sodium storage on wards. Double-check with 2 persons. Limit drug concentrations on formulary. Free-flow protection: All intravenous pumps have free-flow protection.
6. Alarms: Routine preventive maintenance. Assure alarm audibility. Never disable an alarm. Respond to all alarms.

• Two Joint Commission fairs were held prior to the survey, from 5 a.m. to 3 p.m. to allow both 12-hour shifts to attend. Nursing staff were required to attend, and attendance was optional for other patient care services staff, including social work, child life, language and cultural services, spiritual care services, pharmacy, nutrition, and rehabilitative services.

At the fairs, staff received intensive education on the standards and how to comply, with booths

(Continued on page 143)

Discharge Planning Advisor®

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Independent CMs face greater HIPAA challenge

Don't debate; get authorization

Whether as employees of a covered health care entity or independent business associates, case managers must ensure that they are in compliance with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA).

The burden of compliance may be greater, however, for the independent case manager, notes **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, CMCN, CLNC, owner of Integrist Health Care Consulting, LLC, a Duncansville, PA-based firm that provides case management and legal nurse consulting services. "[Independent case managers] must assume responsibility not only to comply, but also to conduct their own risk assessments and develop their own policies and documents."

Despite a provision of HIPAA that includes case management in the list of health care "providers" who do not need a signed authorization to use and disclose the protected health information (PHI) of their clients in the course of coordinating patient care, Kauffman-Nearhoof says, the most sensible course for independent case managers probably is not to fight the battles that claiming that right would entail.

45 CFR 164.502 (a) (1) *"A permitted entity is permitted to use or disclose protected health information as follows: (i) to the individual; (ii) for treatment, payment, or health care operations, as permitted by law and in compliance with 164.506.*

A parenthetical statement in HIPAA "throws case managers in" with the list of health care providers who do not need the authorization, she adds.

CFR45 164.502 (Health Care Operations) permits use and disclosure of PHI for certain activities, including *"population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination . . . and related functions that do not include treatment."*

HIPAA defines a health care provider **(45 CFR 164.501 (5) (1) & (2)** *as one who "delivers health care to the individual based on the orders of another health care provider; [and] typically provides services or products or reports the diagnosis or results associated with the health care directly to another health care provider who provides the services or products or reports to the individual."*

45 CFR 164.506 (c) *"A covered entity may use or disclose protected health information for its own treatment, payment, or health care operations (2) for treatment activities of a health care provider; (4) for health care operations activities of the entity that receives the information, if each entity either has or had relationship with the individual who is the subject of the protected health information being requested (5).*

But Kauffman-Nearhoof says, "The health care world simply does not always see independent case managers in that bucket. My recommendation is just to get the authorization, get it signed, and move on."

In this situation, it is critical to understand the difference between an independent case manager and one who is working for a covered entity such as a hospital, says **Jackie Birmingham**, RN, MS, CMAC, vice president for professional services for *e*Discharge with Curaspan Inc. in Newton, MA, and a veteran case management consultant.

CM, DP communications covered in HIPAA FAQs

Here are a two frequently asked questions from the Department of Health and Human Services' HIPAA web site that specifically address the types of communication that case managers and discharge planners engage in:

Question: "Are health care providers restricted from consulting with other providers about a patient's condition without the patient's written authorization?"
Answer: "No. Consulting with another health care provider about a patient is within the HIPAA privacy rule's definition of 'treatment' and, therefore, is permissible. In addition, a health care provider (or other covered entity) is expressly permitted to disclose protected health information about an individual to a health care provider for that provider's treatment of the individual."

Question: "May covered entities use information regarding specific clinical conditions of individuals in order to communicate about products or services for such conditions without a prior authorization?"
Answer: "Yes, if the communication is for the individual's treatment or for case management, care coordination, or the recommendation of alternative therapies. The HIPAA privacy rule permits the use of clinical information to the extent it is reasonably necessary for these communications." ■

"An independent case manager may be hired by a family to work with an at-risk patient, and this case manager may be working with hospital-based case managers on the discharge plan," she notes. "Since the independent case manager is not acting on behalf of the hospital, it is wise to have a signed authorization."

In the case of hospital or other facility case managers, Birmingham says, there is no need for this additional authorization before contacting post-acute providers to determine if they can provide the services needed by a patient. "Case managers who are carrying out the function of discharge planning do not need authorization from the patient before contacting the post-acute provider. However, the discharge planner should always verify that the patient has signed the consent form that the hospital uses to provide care."

In the case of independent case managers, says Kauffman-Nearhoof, "there is a lack of agreement within the HIPAA consultation community. Under treatment, care coordination by providers is determined not to require an authorization. However, the issue is further muddled when we attempt to clarify the role of the case manager."

"Among the attorneys I've worked with," she continues, "there is indecision as to whether a case manager can be called a health care provider. For example, under 'treatment,' which is defined as 'coordination of health care,' the interpretation is left up in the air. [Case managers] are not really hands-on, but they do provide care coordination. It's a gray area but appears to be clarified under the statement from HIPAA in its definition of "health care operations," as noted above.

Rather than argue, she suggests, in the case of case managers not acting on behalf of a hospital or other health care facility, "just proceed with the appropriate authorization. It is the most conservative and safest approach, rather than attempting to garner consensus as to the 'case manager as care coordinator' role."

Further complicating the issue, she notes, there is another exception to the rule. "Workers compensation management and [management] of similar programs do not require an authorization when efforts are focused on coordination of care and payment of services."

Kauffman-Nearhoof adds that although the stipulation that patients sign a consent form before receiving treatment was removed in the final version of HIPAA — at the same time that notice of privacy and authorization regulations were enhanced — there is a strong possibility the consent requirement could be reinstated.

"HIPAA did away with it but left the door open" for its return, she adds. "There are a lot of legislators demanding that it be looked at again."

Another related point of concern, Birmingham says, is that states also have privacy rules that must be followed. "Some states have more restrictions than HIPAA and set out specific guidelines," she notes. "The burden of knowing all the privacy rules related to releasing PHI in the course of planning post-acute care is an important issue. And it is only one of the regulations directing how discharge planning is carried out."

Even among discharge planners working for health care facilities, there has been confusion concerning whether authorization is needed for them to use PHI when seeking appropriate post-acute care for a patient, Birmingham says. "When I do seminars about HIPAA, a question that comes up is, 'Can discharge planners contact a post-acute care provider to determine if a bed or service is available without specific authorization?'"

Her answer to that question is "yes," she says, citing a reference from the Department of Health and Human Services' web site (www.hhs.gov/ocr/privacysummary.pdf). "When you are contacting a post-acute provider for a specific patient who needs a rehabilitation facility that provides 'physical therapy, occupational therapy, and is located within five miles of where the patient lives,' you don't need specific authorization."

"When implementing the *e*Discharge work flow management tool for discharge planning," Birmingham adds, "we spend a lot of time going over the regulations, including HIPAA and the Conditions of Participation for Medicare, regarding patient choice issues that drive discharge planning work."

When that discussion starts, she says, case managers who are doing discharge planning as part of their workday sometimes are shocked at how many rules they must follow. Knowing the rules when doing discharge planning is critical, she emphasizes, since the very nature of the work is to send out patient information to other health care providers. ■

Enhance care by making CM part of Medicare

Value of case managers 'yet to be recognized'

Even with their dependence on health maintenance organizations (HMOs), many of the nation's elderly suffer from a lack of coordinated care, are often confused about their treatment — including proper use of medications — and frequently end up in the hospital for lack of proper preventive measures.

At the same time, notes case management consultant **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, CMCN, CLNC, many seniors don't have extra financial resources to put toward self-pay health initiatives. With that in mind, Kauffman-Nearhoof, owner of Integrist Health Care Consulting in Duncansville, PA, says she has been focusing her efforts since spring 2003 on getting government programs such as Medicaid and Medicare to cover the cost of case management.

"My proposal is that, if the government would add case management as a component of Medicare and Medicaid — saying that if [recipients] get certain government health care benefits, they agree to case management as a mechanism to manage care and costs — everybody wins," she adds.

Case management, Kauffman-Nearhoof contends, is one answer to managing the skyrocketing costs of health care as baby boomers enter a system with insufficient nurses to care for them. "With a holistic approach to assessment, including team planning, collaboration, intervention, and provider communication, optimal outcomes become the primary focus." Unlike physicians and dietitians, she notes, case managers cannot bill Medicare and Medicaid for their professional services.

In letters to legislators, Kauffman-Nearhoof argues that case managers should be permitted to practice their profession "proactively rather than reactively.

"We propose and request your support to introduce new legislation that would permit experienced and qualified licensed nurses and certified case managers to provide our professional services, independently if we choose and on the home front, and recognize our value by permitting us to be reimbursed for our professional services by Medicare, Medicaid, and other insurers," she writes. Complicating her efforts, Kauffman-Nearhoof notes wryly, is the fact that "organizing nurses is like herding cats.

"Case managers are mostly nurses, and nurses are impossible to organize," she adds. "They have no idea of the clout they would have politically if they organized and advocated as a professional entity to be reckoned with, and often perceive their work as a job and not a profession."

Adding to the challenge, Kauffman-Nearhoof says, many nurses — most of whom are women — are busy people raising families and taking care of aging parents. "When they go home from work, they don't want to do another [work-related] thing.

"And if they are working for a hospital," she adds, "most of their needs are met. The facility takes care of their benefits and their financial, educational, and social needs. [Lobbying efforts] are generally left to those of us working independently, and we're a small group compared to the entire population of nurses."

[For more information about the lobbying effort, including a template for the letter Kauffman-Nearhoof intends to send to legislators, contact:

- ***Cathy Kauffman-Nearhoof**, Owner, Integrist Health Care Consulting, Duncansville, PA. Telephone: (814) 696-7881. E-mail: cknearhoof@integristhealthcare.com. Web site: www.integristhealthcare.com.]* ■

How to determine 'What's a business associate?'

Case managers sometimes are confused as to what constitutes a "business associate" as referred to in the Health Insurance Portability and Accountability Act (HIPAA), notes **Cathy Kauffman-Nearhoof**, RN, BSN, CCM, *NMCC*, CLNC, owner of Integrist Healthcare Consulting in Duncansville, PA. When case managers are working for health care facilities and insurance companies, she notes, the issue is of lesser concern, since the details typically are managed by corporate attorneys and privacy officers. However, smaller case management entities and independents must identify their business associates and apply appropriate business agreements and policies, Kauffman-Nearhoof says. To determine who is a business associates, consider the following:

Step 1. Check each applicable statement.

☐ Does the outside organization perform services for or on your behalf?

☐ Does your business or organization disclose protected health information (PHI) to the outside entity?

If you did not check both boxes, the organization in question is not your business associate. If you checked both boxes, go to step 2, below.

Step 2. Check each applicable statement.

☐ Does the outside organization receive PHI to provide treatment?

☐ Is the outside organization a financial institution processing consumer-related transactions for the purpose of payment for health services?

☐ Is your contract with the organization one within which you both participate in an organized health care arrangement or where you're both in an affiliated arrangement?

If you checked any of the boxes above, the organization is not your business associate. If none of the boxes are checked, the organization is your business associate, and you should prepare a business associate agreement.

What's next? You've found relationships that qualify as business associates. In those situations, case managers need to prepare a business associate contract. Because the role of case managers is not yet defined clearly by the Department of Health and Human Services (HHS), we look to the agency for further guidance regarding this and other components of HIPAA regulations. For now, use these steps to prepare business associate contracts:

Step 1.

A. Prepare your list of current contracts.

B. Review your current contracts and agreements to identify and categorize each business associate relationship.

C. Identify contract renewal dates for current business associate relationships and update and revise in accordance with the most current guidance from HHS. (Go to: www.hhs.gov.)

Step 2.

A. Identify and list each organization you have identified as a business associate.

B. Create a business associate agreement.

C. If you developed new agreements prior to April 14, 2003, HIPAA language should have been inserted into the agreement as an addendum if a new agreement was not developed.

D. Create new and ongoing agreements when you assess new business relationships are business associates. ■

(Continued from page 138)

on the National Patient Safety Goals, pain tools, food/drug interactions, needle safety, information consent/site identification, and "Surviving JCAHO," which gave tips on self-care and stress management during a survey.

The booths were staffed by managers who explained the posted information and answered questions. A test was given to all employees, comprised of questions relevant to each booth. "The successfully completed test was evidence of attendance for the employee's manager," Chinn says.

• **Surveyors wanted to see evidence of a team approach to patient care**. Another recurring theme during the survey was an emphasis on interdisciplinary contributions to planning of care, says Anderson. "They wanted to see written documentation of this in the medical record, but they also wanted to hear people talk about it."

When surveyors spoke with staff during chart reviews, they looked for evidence of a cohesive team approach, such as involvement from medicine, social workers, child life, chaplains, diet and nutrition, and rehabilitative services.

The surveyors expected the entire team to convene for the area interviews, and asked questions such as "Go around the table and explain what your role is in the care of this patient."

"Our staff know that all pediatric patients require the same team approach, whether a rehabilitation or transplant patient," Chinn says. "Surveyors were impressed with that." ■

New quality trend puts spotlight on success

Using appreciative inquiry to boost performance

When you do a root-cause analysis or educate staff about improving patient safety, do you sometimes feel your message is all "doom and gloom?" If so, take note of a growing trend, which spotlights events that went well, as opposed to what went wrong.

Appreciative inquiry (AI) has been used for some time in various industries as a novel way to give feedback, conduct performance appraisals, and hire employees. "Organizations are looking for a positive way to communicate with and to direct their human capital," explains **Joseph Roebuck**, a Succasunna, NJ-based consultant specializing in AI. Now, cutting-edge quality managers are using this approach to boost performance improvement efforts and morale at the same time.

"AI can be used in conjunction with quality improvement efforts by flipping over the initial question of the planning phase of an improvement effort," he says. In other words, instead of asking, "What is being done wrong or poorly?" ask, "What is it that we do best?"

As a quality manager, you can have a dramatic impact on staff morale by using the AI method, adds **Tina Maund**, MS, RN, CPHQ, director of performance improvement for Overlook Hospital in Summit, NJ, where AI has been used successfully for several projects. "When you focus on what went well, people feel really good about that. They are much more energized, instead of viewing it as another uphill battle." Staff are quick to offer suggestions, she adds, such as, "Here's something that always works well for me; can we try that?"

Still, it can be a difficult transition to switch your focus from the traditional critical thinking and problem analysis methods of quality improvement, Roebuck says.

He suggests using AI principles in combination with these time-tested methods. Here are some ways to use AI for performance improvement:

• **Perform a root-cause analysis**.

Usually, this is done to find out the causes of the process failure, but you also can determine the root cause of an exceptionally effective process, Maund says.

Recently, a root-cause analysis was done for a case that triggered a review because of delays that exceeded time goals. The goal is 90 minutes or less from "door to balloon," meaning the time a patient arrives in the emergency department (ED) until the balloon is inflated for angioplasty if the patient is eligible for treatment, she explains.

A detailed analysis was done to track every step in the process, beginning with the time of the patient's call to emergency medical services (EMS). "We were able to identify several factors that had slowed the process down," Maund says.

In addition to the outlying case that caused concern, the team examined the facility's best-time case, which was 48 minutes.

The two cases were compared head to head, using process flowcharts and cause-and-effect diagrams. "The differences really jump off the page at you," she says. "We were looking for glitches that needed to be addressed, but also drivers of best-time performance." For the best-time case,

the electrocardiogram (EKG) was done prior to the patient's arrival, the results had been transmitted, and the room was set up, so the team was 100% ready to go when the patient arrived, she explains.

The team learned a great deal from this comparison process, Maund says, such as reinforcing the need for obtaining the EKG results before the patient arrives. Another key area that came to light is the importance of educating patients to call EMS immediately after the onset of heart attack symptoms, to shorten the time from onset of symptoms to arrival, and to expedite patient evaluation and early treatment through EMS protocols, she explains.

"EMS will assess the patient and do a field EKG and transmit it so the ED physician can read it, be aware of the assessment findings, and when indicated, anticipate that we will be initiating the angioplasty protocol, so we are ready to go when the patient arrives," she explains. "Whereas, if the patient drives himself to the hospital, we don't even know he is coming."

To use AI principles to improve this area, Maund says she would identify a population that has learned key symptoms and generally responds with quick follow-up. "In obstetrics and pediatrics, generally people are very responsive to learning about symptoms of problems and following up quickly on them."

This is in sharp contrast to the delays in the general adult population, even though people are aware of symptoms of stroke and heart attack, she says. The goal would be to identify factors that account for the difference in behavior and see if the drivers of the quick-response behavior in pregnancy and children can be adapted to achieve quick calls to EMS when heart attack and stroke symptoms appear, Maund explains.

In the best-time case, when the patient arrived, the ED staff already knew his story and could match that with the clinical picture they were seeing, which expedited care, Maund says. "It's important for the EMS people to get enough detail to flesh out the picture and communicate that with the staff here."

In the longer case, communication of the patient's story from EMS was limited. "This involved system issues," she says. "It was 3 a.m. when EMS arrived; the ED was very busy with a code going on and also had another critically ill patient." However, during the case review, the team emphasized the importance of following up with EMS. "They emphasized that we are going to be making decisions based on the patient's story and EKG, and those are major ingredients in determining whether the patient is a candidate for angioplasty," Maund says.

This triggers some advance preparation, which saves time once the patient arrives, she says. The team is exploring ways to enhance critical communication even when resources are stretched, Maund adds.

- **Reduce mislabeled blood specimens**.

At Overlook, efforts were being made to decrease the number of mislabeled blood specimens, Maund says. "This doesn't happen frequently. In fact, it's something that happens very seldom; and thankfully, we have never had a critical impact as a result. But obviously, we want them to be labeled 100% correctly because the potential for patient harm is there."

After an extensive root-cause analysis and a major process redesign, the problem still existed, Maund says.

Instead of focusing only on the problem units and their processes, she met with staff from four areas that *always* had correctly labeled specimens, including pediatrics and the preadmission testing area. The goal was to discover what they were doing right, she explains. "We got a group together in a room and spent a couple of hours going through the process."

It was discovered that there was a major difference in the processes used between the two groups, she says. On the units that had 100% correctly labeled specimens, they focused on one patient at a time. The pediatrics staff explained that they obtain the labels for a child who needs blood drawn, take the child to a separate area to draw the blood, and then go back to the regular patient room, always taking a single patient through the process.

Labels and identification band are checked before the procedure, and the tubes of blood are immediately labeled and placed in one area to be sent to the lab before the staff member turns his or her attention to the next patient. A similar process is used in preadmission testing, with focus on only one patient at a time.

As a result of this discovery, the process was revised for all units to include these steps:

— Obtain a single set of patient labels, and get the necessary equipment.

— Do a visual check of the labels and ID band before you draw blood.

— Label the tube, and before you leave the room, check the labeled tube with the ID band.

Interruptions must be limited, especially for routine morning blood draws, when nurses and patient care technicians likely are to field requests to turn patients or accompany them to the bathroom. "The goal is to just focus on this particular task until it is completed," Maund says. ■

Will new survey process threaten confidentiality?

In addition to preparing staff for unannounced surveys and ensuring continuous preparedness, you also may have looming concerns about legal disclosure related to the Joint Commission on Accreditation of Healthcare Organizations' new accreditation process.

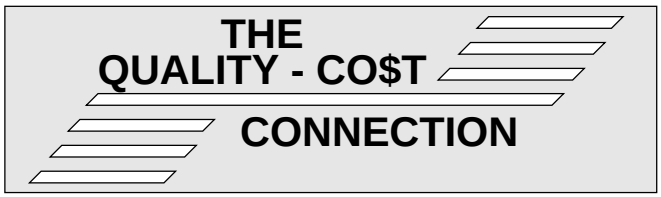
Concerns involve the periodic performance review (PPR), an integral component of the new survey process that requires you to conduct a midcycle self-assessment, develop a plan of action to address identified areas of noncompliance, and identify measures of success to demonstrate that problem areas have been resolved.

What has hospital risk managers worried is the possibility that PPR information is potentially discoverable. The likelihood of an organization's PPR becoming publicly available is minimal, according to **Patrice L. Spath**, BA, RHIT, a health care quality specialist with Brown-Spath & Associates in Forest Grove, OR. "However, some hospital attorneys have expressed concerns about loss of confidentiality protections once the information is transmitted to the Joint Commission."

Although most organizations are expected to use the standard PPR process, the Joint Commission has approved two other options in order to mitigate concerns.

Option 1. The organization performs the midcycle self-assessment, develops the plan of action and measures of success, and attests that it has completed the foregoing activities but has, for substantive reasons, been advised not to submit its self-assessment or plan of action to the Joint Commission. The measures of success are provided for assessment during the complete on-site survey.

Option 2. The organization need not conduct a midcycle self-assessment and develop a plan of action. Instead, an on-site survey will occur at the midpoint of the organization's accreditation cycle, which will be approximately one-third the length of a typical full on-site survey. The organization will be charged a fee to cover the costs of the survey, and will develop and submit a plan of action to address any areas of noncompliance found during the on-site survey, and provide measures of success for assessment at the time of the complete on-site survey. ■



Are nursing home residents safe?

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

Health care quality managers often oversee patient safety activities in a variety of health care settings. One area of considerable media attention right now is the quality of nursing home care. Because many integrated health care delivery systems include some level of long-term care, quality managers need to understand high-priority resident safety concerns so that effective monitoring and improvement initiatives can be developed.

Ensuring the safety of nursing home residents can be challenging, given that Alzheimer's disease and its related dementias account for two-thirds of all nursing home admissions. The turnover rate among caregivers in nursing homes is very high as well. Resident falls are the most frequent causes of liability claims against long-term care providers with treatment issues comprising the next highest category. Treatment issues frequently involve pressure ulcers (*e.g.*, delayed treatment) and continence-related and nutrition-related problems.

Patient monitoring issues also are a problem area. These stem from wandering, elopement, and restraint-related issues (*e.g.*, failure to supervise, failure to properly monitor restrained residents). Hazardous wandering and elopements are among the most costly patient hazards in long-term care environments. Cognitively impaired residents can wander into stairwells or other unsafe areas, leave the facility in search of home or familiar surroundings, or wander into others' rooms. Elopers are differentiated from wanderers by their purposeful,

overt, and oftentimes repeated attempts to leave the building and the premises. In addition to the potential for serious resident injury, elopement incidents may attract significant media attention and can severely damage a facility's reputation.

Another concern for nursing home residents is the risk of abuse by other residents or by staff. Nationwide, there have been several criminal convictions against nursing home staff involving the use of physical force or restraint, forcible administration of medication, abusive searches, and failure to provide adequate food for residents.

The Centers for Medicare & Medicaid Services (CMS) nursing home requirements for quality of care are stringent. The regulations require that each resident receives, and the facility provides, care and services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with his or her comprehensive assessment and plan of care.

Falling under the government's definition of quality of care are such areas as activities of daily living, pressure sores, urinary incontinence, range of motion, nasogastric tubes, medication errors, and accident prevention. Nursing home facilities must ensure that clinically avoidable pressure sores do not develop and existing pressure ulcers are appropriately treated. Facilities must be constantly vigilant to minimize accident hazards: any physical feature that can endanger a resident's safety.

Accident hazards include, but are not limited to, physical restraints, poorly maintained equipment, bathing facilities lacking nonslip surfaces, electrical hazards, accessible wet floors, insecurely fixed handrails, and water temperatures in sinks and bathtubs that can scald or harm residents.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) long-term care accreditation standards go beyond CMS regulations in many respects, including risk and safety management requirements. For example, in its "environment of care" chapter, JCAHO requires a nursing home to appoint an individual to direct the overall safety management program.

Use the results of the resident comprehensive initial assessments and periodic reassessments to identify residents at high-risk for incidents or accidental harm. The CMS-mandated Resident-Assessment Instrument (RAI), which comprises the Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs), provide resident-specific information that can be used for preliminary screening to identify potential problems.

Residents with urinary incontinence and indwelling catheters, behavioral symptoms, a history of falls, feeding tubes, and/or physical restraints are at higher risk for iatrogenic events. Appropriate preventive measures should be put in place.

Medication errors are another patient safety concern in long-term care. Errors can occur at any time in the process, from ordering to administration. The nursing facility should have a plan for preventing medication errors through detection and evaluation. It is important that all medication errors are reported to identify and correct

CE *questions*

13. Which is recommended to comply with the new core measure requirements from JCAHO?
    A. Avoid sharing core measure data between hospital departments.
    B. Use technology to capture clinical data at point of care.
    C. Select different vendors for each core measure set.
    D. Choose a new vendor for the additional core measure requirements.
14. Which was a common problem at hospitals in areas affected by recent power outages?
    A. Generator backup systems failed.
    B. Automatic transfer switches failed because they were not tested monthly.
    C. There were delays in getting fuel shipments for generators.
    D. Generators failed because they were not maintained regularly.
15. Which is an example of the use of appreciative inquiry by a quality manager?
    A During a root-cause analysis, a problem case is compared with a best-time case.
    B. Only the end result of cases are studied.
    C. Only good outcomes are studied.
    D. Adverse outcomes are the primary focus of performance improvement initiatives.
16. What impressed JCAHO surveyors during a July survey at Childrens Hospital Los Angeles?
    A. At the opening performance improvement conference, quality managers waited to be asked specific questions.
    B. A team approach was only required for pediatric inpatients.
    C. Only unit managers were expected to discuss performance improvement.
    D. Staff used performance improvement boards as tools to discuss projects with surveyors.

Answer Key: 13. B; 14. C; 15. A; 16. D

problem-prone activities. Emphasize improving processes and systems to encourage error reporting; a punitive approach reduces the likelihood errors will be reported. In many long-term care facilities, the pharmacist assumes responsibility for reviewing medication errors and categorizing them according to type, *e.g.,* prescribing, dispensing, administration, monitoring. The information gathered from error reporting should be used to educate caregivers and redesign problematic processes.

Treatment-related problems can be addressed through protocols or practice guidelines. The descriptions of how various conditions should be managed are just as useful in long-term care as they are in other health care facilities. The American Medical Directors Association (AMDA) has developed clinical practice guidelines for depression, pressure ulcers, heart failure, and urinary incontinence that are to be used by members of the interdisciplinary team (www.amda.com). Each guideline includes an algorithm to be used in conjunction with the written text. AMDA also recommends that the guidelines be used in conjunction with the MDS and appropriate RAPs.

Reducing resident abuse situations starts with a better understanding of the underlying causes. The National Eldercare Institute on Elder Abuse and the State Long-Term Care Ombudsman Services have identified three primary factors that may contribute to abuse situations:

- Those with cognitive impairment often are resistant to care and difficult to help, especially when staff are poorly trained.
- Training for nursing assistants, particularly training in how to cope with confrontational situations, often is inadequate. High staff turnover rates may result in haphazard training.
- Many residents have no regular visits from family and friends who can monitor their care.

Factors such as high turnover rates and inadequate staffing levels can make it hard for staff to handle demanding situations. The challenges of caring for large numbers of chronic care patients can result in inappropriate use of physical or chemical restraints and highly stressful working conditions that can lead to abusive behavior.

Staff must receive training on how to manage resident aggression and interpersonal conflict among residents. Initial orientation and continuing education and training in these issues are essential. Medicare and Medicaid participation requirements prohibit nursing facilities from employing anyone as a nurse aid on a full-time basis for more than four months unless he or she completes a state-approved training or competency evaluations program (or meets certain exceptions). Temporary, per diem, or other nonpermanent employees must have completed an approved program.

It is important that professional staff constantly monitor residents for signs of abuse. Federal law requires that a physician actively supervise the resident's care. The American Medical Association recommends that attending physicians and nursing facility medical directors help to identify and prevent resident mistreatment by these methods:

- Participating in the development and monitoring of the resident's care plan.
- Assessing the need for physical restraints and antipsychotic drugs to ensure these are not being used primarily for behavior modification or control.
- Monitoring reports to identify potential problems, *e.g.,* irregularities in a resident's drug regimen, resident/family complaints, and findings of substandard care by the state's inspection agency.

Quality managers must ensure that patients continue to receive safe health services after discharge from the hospital. It may be impossible to eliminate every chance for an incident, especially in those environments where patients are not monitored constantly. Nonetheless, much can be done to reduce error occurrence. Senior managers and boards in integrated health systems need to be proactive in the development of safety enhancement initiatives for all sites of care. In addition, improving communication and collaboration with patients and families can provide additional safeguards in the provision of care. Harm from health care services, as well as from the environment in which services are carried out, must be avoided and risk minimized in all care delivery settings. ■

COMING IN FUTURE MONTHS

- Steps to take immediately if your facility is facing a random CMS survey
- Avoid wrong-site, wrong-person, wrong-procedure surgery
- What you must know about disclosure concerns for new JCAHO survey process
- How to make physicians your allies in quality improvement initiatives
- Novel ways to be sure medical staff handwriting always is legible

Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) takes effect Nov. 10.

To provide you with critical information on the updated regulations from the Centers for Medicare & Medicaid Services, Thomson American Health Consultants offers **New EMTALA Regulations: Are They Too Good to be True?** — an audio conference on Tuesday, Oct. 21, from 2:30-3:30 p.m., EST.

While the new rule clarifies many points and is intended to reduce the compliance burden for hospitals and physicians, it's only good news if you implement it correctly. You still could face violations, hefty fines, confusion, and misinterpretation. Find out the answers to these questions:

- How do you provide emergency treatment during a national emergency?
- How does EMTALA apply to inpatients, including those admitted through the emergency department?
- What should be the procedure regarding on-call lists?
- What's the new rule regarding hospital-owned ambulances?
- How are off-campus clinics affected?

The program will be presented by **James R. Hubler**, MD, JD, FACEP, FAAEM, FCLM, attending physician and clinical assistant professor of surgery, department of emergency medicine, OSF Saint Francis Hospital and University of Illinois College of Medicine in Peoria; and **Robert A. Bitterman**, MD, JD, FACEP, director of risk management and managed care, department of emergency medicine, Carolinas Medical Center in Charlotte, NC.

Our expert advice will help you steer clear of potential pitfalls. "The new rule could aggravate an existing problem," Bitterman told *The New York Times*. "Specialists are not accepting on-call duties as frequently as we would like. . . . The new rule could make it more difficult for patients to get timely access to those specialists."

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $249, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package includes handouts, additional reading, a free 48-hour replay of the live conference, and a CD recording of the program. For more information or to register, call customer service at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahcpub.com. When ordering, reference effort code: **83941**. ■

CE objectives

To earn CE credit, CE participants should be able to meet the following objectives:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■