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OCTOBER 1999

VOL. 24, NO. 10 (pages 149-164)

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OIG Report Update

JCAHO's one concession: Will start doing truly unannounced surveys

Despite OIG's criticism, Joint Commission unlikely to change its ways

Sensing blood in the water following the release of a four-part government report decrying the sorry state of hospital accreditation, critics of the Joint Commission on Accreditation of Healthcare Organizations are pushing harder than ever for fundamental change in how the commission does its work. But if Joint Commission officials are worried, they aren't showing it: Weeks after the release of the Health and Human Services' Office of Inspector General's (OIG) damning report, the commission has changed virtually nothing, with one exception. The organization says it intends to implement totally unannounced surveys as part of the small percentage of random surveys it conducts.

Paul Schyve, MD, senior vice president at the Joint Commission, says, "It's fair to say" that the Joint Commission isn't likely to launch many new initiatives in direct response to the OIG report, which was released July 20. "What we've done is look at what we were already working on and compare those things to the OIG recommendations," Schyve says. "For each of the recommendations, we were able to identify something that we're working on. We had already identified all of the issues the OIG has identified and are working in our way to address those issues." **(One OIG recommendation, random pulling of records, started several months ago. See related story, p. 151.)**

The Joint Commission's critics say its tepid response to the OIG report is consistent with its historical unwillingness to bend to outside forces. "For lo these many decades, the Joint Commission has ridden through one [presidential] administration after another, but those changes didn't have much of an impact on what JCAHO is doing. Nothing seems to have an impact on what JCAHO is doing," says **Sidney Wolfe**, MD, director of the Health Research Group at Public Citizen in Washington, DC, a consumer advocacy group. "They have

Stark legislation targets JCAHO's governing board

Sources close to Rep. Pete Stark (D-CA) say the congressman believes that the recently released government report on the state of hospital accreditation all but ensures that Congress will take some sort of legislative action to address deficiencies identified by the Health and Human Services' Office of Inspector General (OIG).

Stark's own bill, the Improvement of Medicare Accrediting Entity Act of 1999, introduced in June, well in advance of the OIG report, is designed to reduce conflicts of interest in accrediting agencies that review quality standards for Medicare-participating hospitals. Stark argues that, specifically with regard to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a "serious conflict of interest" exists between JCAHO's accreditation mission and its internal governance, given that most of the members of its board are representatives of the industry.

Stark's bill would require that a simple majority of an accrediting agency's governing board consist of individuals approved by the secretary of Health and Human Services. Those individuals would be required to have no financial interest in the accrediting agency or any of the facilities the agency accredits. The bill also stipulates that meetings of the governing board be open to the public.

"There needs to be some pretty strong reworking of JCAHO in order to make it truly an effective agency at ensuring the quality of hospitals," says an aide to Stark. "[The OIG report] is just one more instance where the facts show that there's too cozy a relationship between the Joint Commission and the industry."

Janet McIntyre, a JCAHO spokeswoman, notes that the composition of the Joint Commission's board already has changed dramatically over the last 10 years. For example, since 1996, the Joint Commission dropped the controversial practice of charging industry experts a $20,000 fee for the privilege of sitting on the agency's board. Additionally, McIntyre says, fully one-fourth of the board now consists of public appointees. "We think that there needs to be a balance between public representatives and experts from the health care field to help guide [JCAHO] in a very complicated process," she says.

Stark's aide says the publication of the OIG report dramatically improves the bill's chance of passage this year. ■

plans and have said they have all these new things in the offing. They're always saying that, but what is it that they're really doing?"

In the wake of the OIG report, the Joint Commission has moved decisively to change only one policy — to make its "random, unannounced surveys," which account for 5% of all the surveys it conducts, truly unannounced. Although the change happened after the release of the report, it was in the works long before that and not a direct response to OIG criticism, Schyve says.

In the past, Joint Commission surveyors gave hospitals at least 24 hours warning before showing up to conduct an "unannounced" survey, so that the hospitals could make sure appropriate personnel were in place to answer questions during the survey process. Schyve admits, however, that there were problems with the old policy. "Quite frankly, while you didn't know for sure if you were going to get [a random survey], you did know a couple of things," he says. "First, if you were going to get one, you'd get it at about the 18-month mark because they occurred in the middle of the cycle. So you knew when to worry about it. Second, we focused those surveys on areas that, as a whole, organizations had had difficulty with the previous year. So you knew what the surveyors were likely to focus on."

Because the random, unannounced surveys were, in fact, announced on short notice and predictable in certain ways, they limited the ability of surveyors to uncover certain things "going on in the organization that maybe even the hospital was not aware of," he says.

With the policy change, no notice will be given whatsoever before a random survey commences, Schyve says. Surveyors will simply walk in, show their credentials, and get to work. Also, instead of always taking place at the 18-month mark, random surveys can occur anywhere from nine months to 30 months into the triennial survey cycle. They won't occur sooner than nine months because

(Continued on page 152)

What JCAHO says it's doing to address OIG's concerns

'Accreditation with commendation' gone?

When deciding how to respond to the Health and Human Service's Office of Inspector General (OIG) report on hospital accreditation, officials at the Joint Commission "literally went down the list of recommendations" and attempted to match each point to an existing JCAHO initiative, says **Paul Schyve**, MD, senior vice president at the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

In other words, the first response was not to develop new programs in reaction to the report but to advance the notion that — even before the report was released — the Joint Commission was already taking steps to correct the problems the OIG identified.

In some cases, such as the random selection of records during the survey process, the Joint Commission did, in fact, take action before the OIG said they should, notes **Mary Jane Shevlin**, MA, CPHQ, director of quality improvement, utilization, and risk management at Pascack Valley Hospital in Westwood, NJ.

"It's already being done," she says. "The hospital now usually does not know what records the surveyor is going to look at. Medical records as well as medical staff files are being randomly selected."

Not like the old days

That's a change from the old days, says Schyve, when surveyors "would say something like, 'I want to see 10 records of patients with X condition who were admitted in the last three months.' Obviously, that leaves the organization with the ability to do quite a bit of choosing of the records. Under our new policy, surveyors give very specific indications of what records they want to see. So, it's now in the hands of the surveyor rather than in the hands of the organization what to pick and choose."

Judy Homa-Lowry, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI, adds that, in the past with medical record review, staff were able to do the audits themselves, then "hand the sheets in to the surveyor. Now, [JCAHO] is asking the surveyor to take a sample of the medical records and re-audit them to validate the reviews that were performed by staff."

The one Joint Commission initiative that seems to have been greatly influenced by the OIG report is currently the center of a debate: Should JCAHO scrap the overused "accreditation with commendation" category or revise it somehow to make it more meaningful, as the OIG recommends. Currently, an oversight task force and a separate board of directors committee are studying what action to take regarding the category. Schyve says JCAHO should reach a final verdict by the end of the year.

One of the OIG report's most stinging criticisms of the Joint Commission was that its standard survey process simply wasn't capable of adequately detecting patterns of substandard care or uncovering individual practitioners with questionable skills. Shevlin says she isn't so sure the criticism is valid. "Unless they have a surveyor who will look through every single personnel file of the hospital's caregivers and every single medical staff file, I don't really know how you know what methodologies you can put in place to detect substandard patterns of care."

Janet McIntyre, a spokeswoman for the Joint Commission, says that the introduction of outcomes measurement into JCAHO's ORYX initiative should help surveyors keep better tabs on patterns of substandard care. Once ORYX is fully implemented, surveyors would have access to hospital "profiles" based on those ORYX performance measures.

Getting more background on hospitals

The Joint Commission says it's trying to get more background information to surveyors in other ways as well. "We are currently developing a process in which surveyors will clearly have a lot more organization-specific information in terms of where the strengths are, and particularly where there may be issues that need to be looked at more intensely during the survey process," Schyve says.

JCAHO surveyors already make a point of reviewing the findings of registered state agencies who have recently surveyed the hospital, Shevlin points out. "If the Department of Health has been here to see the hospital, they look at that."

Along with having much greater access to "contextual information" about the hospital, JCAHO surveyors will also have greater latitude in addressing issues specific to individual hospitals, rather than merely taking a cookie-cutter approach, Schyve says. "Surveyors need to know that they have the freedom in the survey process to follow through on things that they see. It's like finding a loose thread, pulling on it, and asking, 'Where does it go?' — rather than simply noting that there was a loose thread and quickly moving to the next issue on this list."

Schyve says surveyors have already been instructed to vigorously follow up on concerns raised during surveys. "Obviously, as we move forward with our project to provide more contextual information up front to the surveyor, we will also give them more guidance in this," Schyve says. ■

many organizations remain in contact with the Joint Commission anyway for the first several months after a scheduled survey in an effort to address specific recommendations. "During that time period, we already know something about what's going on in the organization," he adds.

The content of the unannounced surveys will also change to become less predictable, Schyve notes. While the surveys will continue to focus in part on certain predetermined areas, such as credentialing, the surveys will devote more time to issues specific to the organization being surveyed. "For example, what were the areas where they had Type 1 recommendations [in their previous survey]?" he asks. Surveyors will also pay more attention to complaints received about the organization as well as sentinel events.

"They make it sound as though a major victory has been won for people who think hospitals should be regulated, but all that's happened is they've stopped lying."

Wolfe, for one, says he is not impressed by the Joint Commission's decision to amend its policies for random surveys. "They make it sound as though a major victory has been won for people who think hospitals should be regulated, but all that's happened is they've stopped lying," Wolfe says. "Now the so-called unannounced inspections are really going to be unannounced. Fine, but that doesn't do anything about the other 95% of surveys, which will continue to be announced weeks or months in advance."

Joint Commission spokeswoman **Janet McIntyre** says her organization has no plans right now to increase the percentage of random, unannounced surveys beyond 5%.

Although the Joint Commission hasn't made wholesale changes as a result of the OIG report, some industry observers remain concerned that it is creeping toward becoming more of a regultory body and abandoning its traditional collegial approach toward hospitals. **Richard Wade**, senior adviser for communications at the Chicago-based American Hospital Association (AHA), says he is particularly disturbed that industry groups were largely shut out of the decision-making process that led to the policy shift on unannounced surveys.

"We had been talking to the Joint Commission all along about how you implement this — if you reduce notice to four hours or 16 hours or whatever," he says. "We even put together a special advisory committee at the request of the Joint Commission to be a sounding board for the different proposals." The Joint Commission had also agreed to consult liaisons from state hospital associations in coming up with a new unannounced survey policy, Wade adds. "But the Joint Commission didn't avail themselves of those two mechanisms. We had also been led to believe there might be a pilot test of this before it was implemented," but that didn't happen, either. "We were very disappointed with the process," he says.

Schyve stresses that the Joint Commission will attempt to preserve its traditional collegial and education-oriented approach, while at the same time serving effectively in a regulatory capacity. "We want to have a collegial approach to help the organization get better," he says. "And we also want to have a regulatory approach that says, 'Look, if somebody really isn't doing the right thing or refuses to do the right thing and harms patients, we have the ability to act.' We need a balance between those approaches."

Schyve compares the Joint Commission to a general practitioner, with hospitals as its patients. "We would want our doctor to take a collegial approach to help us do better," he says. "But we would also expect our doctor do whatever was necessary to get a true, accurate picture of our physical functioning. If I thought my physician was superficial in his or her evaluation of me or was making a superficial diagnosis, I'd soon go to another physician."

Wolfe notes, however, that most patients aren't attempting to hide their condition from their doctors. He suggests a different example. "What if the police announced to the burglar community, or any community of people considering breaking laws, that they're going to show up a month from now, but until then you can do whatever you want? And when they do show up, they're only going to want to look at certain things, and you can pick out what those things are? That's very collegial."

Most experts argue, however, that the collegial vs. regulatory issue, which is at the heart of the OIG report, isn't so simple. **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Canton, MI, and an occasional consultant with the Joint Commission's consulting arm, says there are ways to achieve an effective balance between the two approaches when conducting surveys. "The Joint Commission

has the job of making sure patient care standards are in place," she says. "That doesn't mean surveyors can't be helpful, educational, and consultative, but their primary role needs to be ensuring that the standards are adhered to."

Wade adds that how the Joint Commission ends up handling the collegial vs. regulatory debate could affect the very future of voluntary accreditation. "If the Joint Commission continues to appear to the public and the government as being weak and ineffectual, then somebody will get the idea that it ought to be replaced with something completely regulatory in nature," he warns. "But if they go too far the other way, then hospitals will lose the desire to be supportive and cooperative with the Joint Commission as a quality improver. It's going to be a delicate balancing act." ■

New ruling in NC affirms peer review privacy

AHA concerned about EMTALA loophole

Supporters of keeping peer review committee records confidential got an unexpected shot in the arm recently, when the North Carolina State Supreme Court ruled that information from a medical or peer review committee cannot be used as evidence in any civil action against a hospital or health care provider.

The ruling represents the first good news in a while for confidentiality supporters still reeling from a case in California's 9th Circuit in which peer review records were allowed into evidence in a federal case involving the Emergency Medical Treatment and Active Labor Act (EMTALA).

The North Carolina ruling came in the case of Virmani v. Presbyterian Health Service Corp, In re Knight Publishing Company. In the lawsuit, Ron Virmani, MD, had sued Presbyterian Hospital challenging its decision to terminate his medical staff privileges. The decision had been based on a medical peer review committee's conclusion that Virmani wasn't providing competent care to his patients. When Virmani filed his original complaint with the clerk of court, he attached excerpts of confidential peer review reports. The following day, Presbyterian requested that the trial court seal the peer review materials filed with the complaint and close the hearing when the peer review materials were discussed. The court agreed to do so.

After the court of appeals ordered the trial court to reverse its decision and unseal the peer review documents and open the court proceedings, Presbyterian appealed to the North Carolina Supreme Court. The court concluded:

1. A trial court may close court hearings in which medical peer review documents or materials are discussed.

2. The trial court may seal peer review documents to protect their confidentiality as long as they are presented to the trial court judge and not filed with the clerk of court.

The ruling is significant because it explicitly states that protecting the confidentiality of peer review records is a "compelling public interest," says **Sam Southern**, JD, an attorney with Smith, Helms, Mulliss, and Moore in Raleigh, NC.

But Southern notes that protecting peer review confidentiality can be a double-edged sword. "If peer review is inadmissible as evidence in court and is not subject to discovery, then it's not admissible in evidence for anybody," he says. "Even in the Virmani case, Presbyterian Hospital was trying to defend the action it had taken based on the peer review documents. So, while people suing hospitals can't use peer review against the hospital, the hospital may also be unable to use them to defend itself."

Court unsealed records

The most troubling part of the Virmani decision for hospitals was the court's decision to unseal the peer review records Virmani had attached to the original complaint. While the records weren't admissible in court, they did lose their confidentiality and became publicly available to the local media. Even though such records couldn't hurt you in civil court, they could hurt you in the court of public opinion.

"The good news is that the court is not going to permit that into evidence," Southern says. "And if [the records] had received any publicity in the media, I think the defendant would be entitled to a jury who hadn't been exposed to it. Ultimately, it's not going to help the plaintiff or the defendant — whoever seeks to use it."

To reduce the likelihood that a disgruntled physician will waive the peer review privilege and file confidential records with a court, **Bo Bobbitt**, JD, an attorney with Smith, Anderson in Raleigh, NC, offered the following advice in a memorandum filed with the Raleigh-based North Carolina Hospital Association:

"1. Consider having physicians acknowledge in writing that peer review records are confidential and inadmissible as evidence.

"2. Evaluate what records are legally required to be given to a physician, and limit disclosure to only those records that must be provided."

The American Hospital Association (AHA) in Chicago says that since the controversial EMTALA case in California, in which the 9th Circuit Court ruled that state peer review protections didn't apply in a federal suit, there's been no trend toward any further erosion of peer review confidentiality nationwide.

"We're not tracking cases in a formal way, but I do not sense there is a trend toward significantly limiting the protection, although there will be instances on a regular basis where the extent of the protection gets challenged," says **Maureen Mudron**, JD, Washington, DC, council for the AHA.

Nevertheless, the EMTALA case itself, which was brought against Clear Lake, CA-based emergency room physician Wolfgang Schug, MD, remains a cause for concern, even though the court's ruling wasn't for precedent, even in the 9th Circuit. "The fact is, it happened," Mudron says. "And the concern there is that, in bringing a federal action, one might very well also have a state claim. Would the use of the federal action be a way around what otherwise would not be available under state law? We still don't know exactly how the terms of that decision will play out." ■

HCFA mandates new limits for restraint, seclusion use

Patient protections go beyond JCAHO's edicts

On July 2, the Health Care Financing Administration (HCFA) published strict new rules on patient restraints — stricter, in fact, than the standards already mandated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

John K. Stanwood, PhD, chief of psychology at the Hospital for Special Care in New Britain, CT, says this is the first time HCFA has been so specific in its guidelines on restraint and seclusion. "In the past, HCFA has basically gone along with JCAHO and our Connecticut State Health Department in ensuring that restraint standards were met by hospitals," Stanwood says. In these latest regulations, too, the federal agency states that it will consider JCAHO accreditation a sign of compliance for a hospital.

"HCFA picked the stricter standards that JCAHO first came out with, then backed off from after receiving feedback from providers," he says. But HCFA didn't back off on everything. "For example, JCAHO takes out any mention of chemical restraint in its current guidelines, and HCFA mentions chemical restraints right along with physical restraints," Stanwood notes.

He says that until HCFA published its latest regulations, both the feds and Connecticut focused more on inpatient mental health units than on acute care hospitals. But he notes that HCFA appears to have adopted the stricter guidelines for all hospitals. JCAHO had reserved those specific guidelines just for behavioral health or psychiatric facilities, including varying time lines for use of physical restraints by age of patient and how soon an independent practitioner must evaluate a patient placed in restraints.

Stanwood says that he and his colleagues aren't sure how HCFA will be able to monitor the stricter guidelines without doing their own inspections separate from JCAHO and the state.

Here's a summary of how the HCFA and JCAHO restraint standards compare:

❒ HCFA adopted JCAHO's concept of time-limited orders. In the 1999 Hospital Accreditation Standards, the intent statement for standard TX.7.1.3.1.8 provides that written orders for restraint or seclusion for behavioral health patients be limited to four hours for adults, two hours for children and adolescents 9-17, and one hour for patients younger than 9. HCFA emphasizes that the time frames represent maximum intervals for which each order can be written. And, while patients are being restrained or secluded, their status must be continually monitored, assessed, and reevaluated with an eye toward releasing them at the earliest possible time.

❒ JCAHO states in its explanation of intent for standard TX.7.1.3.1.7 that providers every day should review restraint and seclusion use related to their patients. HCFA adopted a parallel philosophy by specifying in its regulation that an order for restraint or seclusion may only be renewed in the previously mentioned increments for up to a total of 24 hours. After that, practitioners must

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New tool places resources where they're most needed

Puts patients in risk category to match services

Not every patient needs 100% of the available services in a hospital.

In a nutshell, that's the premise behind a new risk stratification tool developed by the Center for Case Management (CCM) in South Natick, MA.

Dedicating valuable and expensive services to patients with low risk is not an efficient use of a hospital's resources, contends **Shawna Kates**, ACSW, LSW, CMAC, who designed the risk stratification tool in collaboration with Karen Zander, principal and co-owner of CCM.

The tool is an outgrowth of the contemporary case management theory espoused by CCM, in which "we're not diluting the profession by cross-training, but rather re-emphasizing the contribution made by diverse team members, explains Kates, an associate with CCM based in Cherry Hill, NJ. "Utilization is distinctly different from clinical nurse management, which is distinctly different from clinical social work, and all three are beneficial to patients."

Health care has moved from the old-fashioned, lengthy hospital stays in which every patient got every service despite the cost, "to the contemporary posture in which we differentiate among our professionals," she points out. "The goal is to use them to best advantage." At the same time, there is the growing emphasis on continuity of care — "not just care for those admitted to the hospital, but primary care and ambulatory care."

With that in mind, risk stratification, says Kates, "is a combination of assessment and planning, in terms of identifying what the patient's strengths and weaknesses are and matching those with the services the hospital can provide." Placing patients in categories of risk, she adds, determines the level and content of the service to be provided.

The risk stratification tool, Kates explains, is an operations piece for health care, as well as an outcomes piece for patients — "a look at redeploying our experts." Placed in the lower category of risk, for example, would be a patient who needs less clinical intervention, has more social resources available, and is able to cope intellectually and emotionally, she says. "If a person is low on the risk stratification scale, the plan would include following up with the physician, confirming the patient's self-education, and then discharging the patient."

A patient at the high level of risk, on the other hand, would be a person with multiple hospital admissions, who is already receiving home services, with few resources for coping emotionally or financially, Kates adds. "[Those factors are] a red flag that this person will utilize, and should have dedicated to him or her, maximum services, and may require nursing and social work case management."

For that patient who is high on the risk scale, there might be a consult with a pain physician, a psychiatric evaluation, and a referral to rehab or long-term care, she says. "With every assessment, there is a plan that includes which caregivers are needed. It is all data-driven, so we can track back and say, 'Did we identify this issue; did we follow through?'"

This contrasts with traditional case management, Kates points out, "where every patient is evaluated for everything. Even though [the

patient] is alert, oriented, with good family support, lots of time is spent discussing, writing, and re-evaluating. That time could be spent on a patient with higher risk."

The key to effective use of the risk stratification tool, she points out, is not only what the patient needs when he or she leaves, but rounding up the most effective team to make those care decisions. Ask the question, Kates suggests, "Who is the best expert to identify the services the patient needs?"

"It's that whole concept of collaboration," she says. "A clinical nurse resource person is captain of the team. But depending on what the risk is — clinical or social or medical noncompliance or pharmaceutical — there may be an 'expert subcaptain.' Sometimes it might be a physical therapist, because that is what's most needed. If there is a lack of social resources, then social work needs to rise to the fore."

Given the shorter lengths of stay in today's hospital environment, Kates points out, time is of the essence. "The team needs to begin teaching [the patient] early on, identify the resources needed, and do this with mindfulness of the cost of it all. "When I started out in the business 30 years ago, there was a three-week relationship with the patient in which to hone skills and build trust between the family, the patient, and the team," she notes. "Now you have to take all those skills and wrap them up in a ball and offer them to the patient in a very brief period of time. This requires greater sensitivity than ever before, and the health care system has to have unique access to services."

With the effectiveness of critical pathways, this directing of the patient to the appropriate team member sometimes happens almost inherently, Kates says. "When a patient comes in with a certain medical diagnosis, the case manager may say to the social worker, 'This patient will really fall into your bailiwick.' But, if the system is structured so that it's 100% case management, it's still not as efficient."

CCM's term for what needs to be done is "funneling," she explains. "They all are your patients, but down the funnel you look at weeding some out, and are left with those with the greatest need who will consume the greatest services. That's where your effort needs to be." **(See related story, at right.)**

Part of the philosophy behind the risk stratification tool, Kates notes, is an outgrowth of the "new case management," which in fact has its roots in the first part of the 20th century. "The social work side traces back to the early 1900s at Massachusetts General, where Dr. Richard Cabot founded the first social work department."

Social workers' jobs then were to work closely with the original public health nurses, following people who had been treated in the infirmary into the community, she adds. It's this kind of collaboration that makes for successful case management, Kates says. "The idea of 10 years ago — the diluting of the two professions by cross-training everybody — is not efficient. Patients should have the diverse services," she adds. "A pharmaceutical case manager is different from a nurse case manager, so allow patients to receive the services they need most. It's also cost-efficient and quality-wise."

A nurse case manager and a social worker approach the same situation in two different ways, Kates explains. "When doing an assessment, a nurse case manager is looking at physicality, medication management, skin, wounds, pain. The social worker looks at, 'Was the patient taking medication at home? Is the patient already using durable medical equipment at home? Does the patient have financial resources?'"

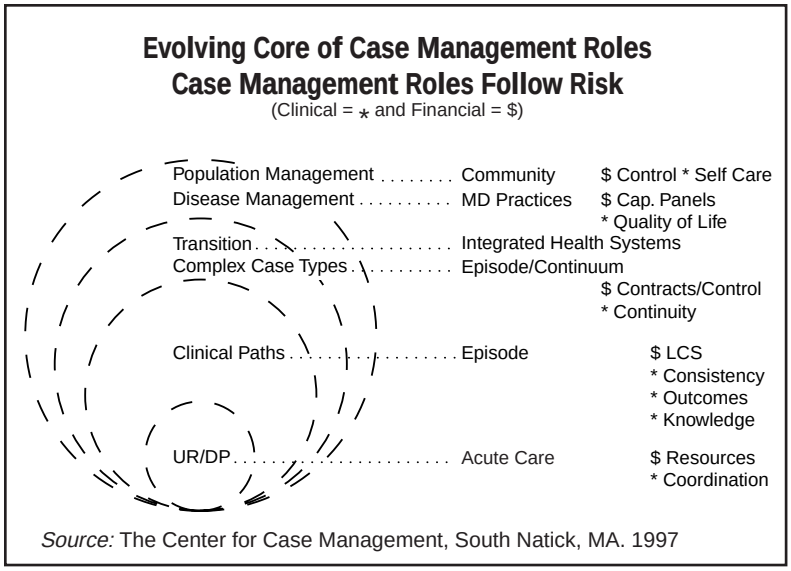
The risk stratification tool, she says, deploys the best experts to patients in a kind of triage process. "It allows us to identify what the patient needs most, and have that service delivered by the most capable person in the most efficient process to achieve the very best outcome." ■

Case management core not about different models

When the Center for Case Management in South Natick, MA, began hospital-based case management in 1986, the health care system was more stable, as was the definition of case management, says **Karen Zander**, RN, MS, CS, FAAN, principal and co-owner.

Back then, she adds, case management could be defined simply as "a clinical system in which an individual or group is accountable for coordinating patient care across a continuum or episode."

In today's health care environment, Zander says, it seems that everyone is pushing a different case management model, and everyone is sure that theirs is best. After fielding more and more requests for descriptions of the various models and for her opinion on the pros and cons of each,



Source: The Center for Case Management, South Natick, MA. 1997

Zander says she became convinced that something different was called for.

"Rather than comparing and contrasting the models, what was needed was a framework for decision-making based on where an organization was at risk financially and clinically," Zander contends. In an attempt to make sense of the diversity of the various models, she has developed a decision making tool based on what she terms "The Evolving Core of Case Management Roles." **(See illustration, above.)**

The resulting framework shows a four-step evolution, which Zander explains as follows:

1. Acute care. At this level, utilization review and discharge planning are no longer separate. Both roles are merged into case management in an attempt to control resource use related to such factors as physicians' orders and discharge planning. The concern is with levels of care (regular patient floor vs. intensive care unit). It is matching resources to reimbursement. However, the question is, Zander points out, "Should you design a whole infrastructure around this singular need to get them in and get them out?"

2. Episode. Medicare drove case management to this level, Zander notes. That is, a discrete episode of care was the new level of risk. The financial risk is that there is no reimbursement for extended length of stay while the clinical risk is a lack of coordinated, consistent care, which may compromise outcomes. This is the level where clinical pathways become useful and case managers are often assigned to manage them.

3. Continuum/integrated health systems. This level of risk involves more managed care contracting and, in anticipation of eventual capitation, the need for control over the environment beyond the acute care hospital. At this point, hospitals and other levels of care are merging or affiliating into integrated health systems. Typically, there is little continuity from one facility to another and it is not the pathway patients who are the issue. Rather, it is the complex patients who need management of their transitions to the various levels of care.

This creates a need for a combined episode-continuum infrastructure and calls for more clinical case management than clerical case management. However, Zander points out, this management represents an investment rather than a true cost savings.

4. Physician practice/community. Capitation begins to be implemented at this level and panels of patients must be case-managed, primarily through physician practices. The financial risk is to manage the per member / per month dollars so that patient care is provided at the lowest level of cost, but with the patient's quality of life and functionality remaining at the highest possible level. Ultimately, she explains, population management in the community is the goal, with case management being replaced by self-management.

With this framework in mind, Zander says, she advises health care organizations to anticipate their level of risk and to "build a case management model at least one level above where you are now." But keep in mind, she adds, that "the farther out from the acute care level you go, the more advanced practice people are needed, with higher degrees, a wider skill set, and good interpersonal skills." ■

Problems with SNFs? Seek out compromises

Discharge delays spark creative solutions

Hospitals facing discharge delays as a result of financial restrictions on skilled nursing facilities (SNFs) are well advised to seek out their own innovative solutions, suggests **Edward Emnett**, RN, CPHQ, manager of clinical resource management at South Florida Hospital in Plant City.

The SNFs are increasingly leery of accepting patients with complicated care needs because of the limited reimbursement they can expect under Medicare's new prospective payment system

(PPS), Emnett notes. With that in mind, he says he is taking a proactive approach to enhancing the relationship between his hospital and the local nursing homes.

"I've done presentations on hospital discharge planning with the [skilled nursing] facility's staff, saying, 'We're in this together, we can be a team,'" Emnett adds. "This has gotten us over some of the humps."

One issue Emnett has addressed involves a form that the state Department of Children and Families requires hospitals to complete for patients who need admission to a SNF. "The state has done audits on this in some nursing homes, and [auditors] are not amused by SNFs accepting incomplete forms," he says.

His approach to the form problem, Emnett says, has been, "Tell me what you want, and I'll try to get it." The form requires documentation from several different disciplines, which is difficult to get in a timely fashion, he points out. "We still have physicians who come in that morning and decide they want to send the patient home at noon."

As a compromise, Emnett says, he suggested that instead of filling in every line of the complex form — as the nursing home previously required — the hospital staff attach a copy of the patient's history and physical and current medication sheet. Answers to problems often lie, he notes, in such "simple, practical stuff."

Emnett sets up regular meetings with SNF administrators, he says, and arranges in-services for their staffs. "This is nothing magic, just trying to go out and talk to people," he adds. "Most of us in resource management have not had to do that [before] in the community. To me, it seemed to be the only thing to do."

St. Joseph's Medical Center in Tampa, another hospital in the Baycare Health System, recently began hosting quarterly luncheon meetings with area nursing home administrators, Emnett says. "They set it up as a networking session, to deal with common problems. So far, the overall feeling has been positive."

Another idea Emnett is pursuing is sharing hospital educational programs with nursing homes. "When we look at diagnoses, we see patterns in the readmission of patients with congestive heart failure," he notes. "We're wondering if we go back and find out how many of these patients go to nursing homes, could we take the same educational program there? It might work [for both hospital and SNF] and tighten the relationship between the two."

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Gender differences found in early heart attack deaths

When both are at younger ages, women have a higher short-term mortality after heart attack than men, according to a study published in *The New England Journal of Medicine.*

The study, published in the magazine's July 21 issue, analyzed data from the National Registry of Myocardial Infarction 2 (NRMI 2). It found that women under age 50 are twice as likely to die after a heart attack than men in the same age group. NRMI is a multicenter, multi-phase observational heart attack program sponsored by Genentech Inc.

The evaluation team, headed by Viola Vaccarino, MD, PhD, assistant professor at the Department of Epidemiology and Public Health at Yale University School of Medicine in New Haven, CT, examined data collected from 384,878 patients — 155,565 women and 229,313 men — enrolled in NRMI 2 at 1,658 hospitals across the United States.

Overall, female patients enrolled in the study were older than men, and thus hospital mortality was higher in this group (16.7% vs. 11.5%). However, when examined in specific age groups, investigators found that gender differences in mortality significantly differed according to age.

Additionally, investigators observed that women at younger ages consistently are less likely to be admitted with a diagnosis of suspected heart attack and administered life-saving reperfusion (artery-opening) therapies. These findings are consistent with previous studies which demonstrate that women are treated less aggressively for heart attack than men.

"These data suggest that the female gender may play a role in short-term mortality after heart attack, particularly among younger patients, making it difficult to diagnose and treat this patient population," said Vaccarino. "However, as early manifestations of coronary heart disease may be difficult to diagnose in women, more emphasis should be placed on the identification of diagnostic techniques and prognostic indicators for the early stages of this disease in the female population." ■

'Deadly Restraint' transmits heads-up for HCFA

'Zero tolerance for deaths from restraints'

According to a 50-state survey conducted by the *Hartford* (CT) *Courant* newspaper late last year, 142 deaths were linked to the inappropriate use of restraints between 1988 and 1998. Among the investigative team's findings:

• 23 patients died after being restrained in a face-down position.

• 20 died after being placed in wrist and ankle cuffs or vests and ignored for hours.

• Children made up 26% of 114 cases for which patient age was confirmed.

(The entire state-by-state database "Deadly Restraint" is posted at www.courant.com/news/special/restraint/death_data.stm.)

The Joint Commission on the Accreditation of Healthcare Organizations added information to that revelation recently when the agency issued an analysis of sentinel events related to restraint use. Since it began tracking sentinel events three years ago, the agency's accreditation committee has reviewed 20 cases of restraint death.

Root cause analyses of those sentinel events indicated that most of the deaths (12) occurred in psychiatric hospitals, followed by six in general hospitals and two in long-term care facilities. Nearly half of the deaths were caused by asphyxiation, and that condition was typically related to putting excessive weight on the backs of prone patients, placing a covering over patients' heads to protect from spitting or biting, or obstructing patients' airways when pulling their arms across their necks.

Identified root causes of each restraint death were inadequate patient assessment, inadequate care planning, lack of patient observation procedures, and staff-related factors, such as insufficient orientation, training, competency review, or credentialing, or insufficient staffing levels. Equipment-related factors were causes as well — use of unprotected split side rails, use of two-point rather than four-point restraints, use of high-neck vests, incorrect application of a restraining device, or a nonworking monitor or alarm.

The Joint Commission makes these recommendations for reduced restraint-related incidents:

• Intensify efforts to reduce the use of restraints and develop procedures for their consistent application.

• Revise procedures for assessing psychiatric patients.

• Enhance staff orientation and training regarding alternatives to restraints and their proper application.

• Consider age and gender of patients when setting policies.

• Continuously observe restrained patients.

• If a patient must be restrained in the supine position, ensure the head is free to rotate to the side, and elevate the head of the bed to minimize the risk of aspiration.

• If a patient must be restrained in the prone position, ensure the airway is unobstructed at all times. Do not cover the patient's face. Ensure that expansion of the patient's lungs is not restricted by excessive pressure on the patient's back. Special caution is required for children, elderly patients, and very obese patients.

• Never place a towel, bag, or other cover over a patient's face as part of the therapeutic holding process.

• Do not restrain a patient in a bed with unprotected split side rails.

• Discontinue use of high vests and waist restraints.

• Remove all smoking materials from a patient's access.

[Editor's note: If you want to contact the Joint Commission with questions or concerns regarding the use of physical restraints, call (800) 994-6610 between 8:30 a.m. and 5:00 p.m. CST, weekdays; or e-mail complaint@jcaho.org.] ■

(Continued from page 154)

reevaluate their patients face to face before writing new orders.

❒ HCFA differentiates between situations where restraints are used to provide medical-surgical care and those where restraints or seclusion are used to manage behavior, an approach similar to that adopted in existing JCAHO standards. But the new HCFA regs are not specific to the treatment setting, but to the situation the restraint is being used to address. "When a restraint is applied in the course of acute medical-surgical care, the intervention is generally not undertaken because of an unanticipated outburst of severely aggressive or destructive behavior that poses an imminent danger to the patient and others," states the HCFA document. Rather, they may be necessary to ensure that an IV or feeding tube will not be removed, or that a patient will not re-injure himself by moving after surgery has been completed. "The use of restraints or seclusion to manage behavior is an emergency measure that should be reserved for those occasions when an unanticipated, severely aggressive, or destructive behavior places the patient or others in imminent

danger," states the document.

• HCFA adopted JCAHO's definition of seclusion: "the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving."

Michelle Camicia, RN, MS, CRRN, clinical manager at California Pacific Medical Center, a community teaching hospital in San Francisco, says that, in general, HCFA's new regulations require practitioners and institutions to treat restraint use as it is — a high-risk intervention that requires competent staff who have to be able to manage patient behavior and properly apply restraints. But she sees problems as well.

"I disagree with having two separate standards for observation," she says. "HCFA terms it 'continual assessment.' I agree that we should always be assessing the appropriateness of discontinuing the restraint. However, this does not require constant observation. The frequency of observation requirements should be the same regardless of the indication for the restraint. And I disagree with constant observation. Observation should be based on assessment of the patient's behavior."

The word "discipline" appears for the first time in the new HCFA regs: "The patient has the right to be free from the use of seclusion or restraint, of any form, as a means of coercion, discipline, convenience, or retaliation by staff." The authors explain that discipline is not an acceptable reason for secluding or restraining a patient, and "in the treatment environment, it is impossible to distinguish between 'discipline' and 'punishment.'"

The regulations also include new requirements for staff training ensuring that providers will learn the appropriate and safe use of seclusion and restraints. The HCFA authors state that these training programs should review alternatives to restraint and seclusion, to teach skills so that staff who have direct patient contact are well-equipped to handle behaviors and symptoms as much as possible without the use of restraints or seclusion.

The document containing HCFA's new restraint regulations in the July 2 issue of the *Federal Register* introduces new conditions of participation (COP) relating to patients' rights.[1] (COPs must be met by hospitals to be approved for, or to continue participation in, the Medicare and Medicaid programs.) In addition to those previously mentioned regulations ensuring "freedom from restraints . . . unless clinically necessary," six protective standards are presented by HCFA in the document including assurances of a patient's privacy and safety, confidentiality of patient records, and the right to make decisions about care. According to the new regulations, upon admission, hospitals are required to notify patients of their rights.

The regulations became effective on Aug. 2. HCFA has already issued regulations restricting the use of restraints in other settings, including intermediate care facilities for the mentally retarded and nursing homes. The agency is working with the Office of Inspector General to obtain information about existing patient abuse reporting systems and oversight of psychiatric hospitals.

(Editor's note: To see the entire document, visit the Federal Register *Web site at: http://www.access.gpo.gov/su_docs/fedreg/frcont99.html. Click "Friday, July 2, 1999" and scroll down the table of contents to "Health Care Financing Administration: Hospital participation conditions; patients' rights." You can view the document either in html or PDF format.)*

Reference

1. 64 *Federal Register* 36,069 (July 2, 1999). ■

Written plans strengthen patient care quality

They provide framework for QI strategies

Many written plans are required by the Joint Commission's standards. But these plans are also important to a hospital from a business standpoint. A written plan helps to clarify and focus the organization's attention on important patient care and administrative processes. It also provides a logical framework within which physicians and staff can develop and pursue improvement strategies. Lastly, a written plan serves as a basis for discussion with various stakeholders.

Preparation of comprehensive plans that meet Joint Commission requirements will not guarantee improved patient care, but lack of a sound plan will, almost certainly, invite failure.

In the two previous columns, 10 of the plans required by the Joint Commission's standards were described. This month, the remaining three are detailed.

Utilization review plan

The Medicare Hospital Conditions of Participation still require hospitals to have a written utilization review plan, although the need for such a plan is not specifically spelled out in the Joint Commission's standards. The utilization review plan should contain:

- a confidentiality policy which applies to all utilization management activities;
- a conflict of interest policy, in relation to all utilization management activities;
- description of the process or mechanisms by which one evaluates and communicates, at a minimum:

— appropriateness and medical necessity of admission;

— appropriateness and medical necessity of continued stay;

— appropriateness and timeliness of clinical services;

— problems or areas of concern revealed through utilization review activities;

— hospital-specific length of stay norms;

— criteria used in the review process;

— effectiveness of the discharge planning process;

— flow of information and reporting process.

Information management plan (IM.1)

The information management plan of the organization must be leadership-driven and describe how all types of information (manual and automated) are maintained. The mechanisms for security, confidentiality, and integrity of information must be described. One component of the plan should be a needs assessment that covers what data and systems are necessary and relevant to:

- type, structure, size, and complexity;
- needs of information users;
- planning;
- research and education;
- data set parity and data connectivity;
- internal and external transmission;
- reporting needs over time;
- continuous performance improvement;
- comparisons with past performance and external comparisons;
- support of customer and supplier relationships;
- enhancement of cost effectiveness;
- enhancement of work flow;
- support of clinical and administrative decision making.

Other considerations in the needs assessment include: What technology is appropriate and affordable? Does the organization plan to expand or redesign services? What long-range plans may affect the information needs of the organization?

Include in the information management plan a data inventory which summarizes what data are collected, where the data are maintained, the form of the data (manual or automated), how long the data have been collected and stored, availability of data dictionaries, methods of accessing information, reporting capabilities, and key contact people.

Environment of care plan (EC.1.3 - EC.1.9)

The activities related to managing the environment of care can all be put into separate sections in one "Environment of Care" plan, or they can be maintained as separate plans. An individual must be named to direct all environment of care activities. Since 1995, the Joint Commission has also required facilities to complete a statement of conditions (SOC) in preparation for the survey. The SOC has four parts: (1) introduction and instructions; (2) basic building information; (3) life safety assessment; and (4) plan for improvement. The SOC should cover every building in the organization, including ambulatory services. The heart of the SOC are parts 3 and 4 ,which detail the results of the organizationwide safety assessment, what deficiencies were identified, and plans for corrective actions.

Listed below are the activities that must be addressed under the broad environment of care function and a brief description of what should be included in the plan. Each of these plans, whether integrated into an overall environment of care plan or documented separately, should contain a performance standard which relates to an improvement target and how this target will be achieved. Surveyors will expect to see work in progress toward achieving the targets in each of the environment of care activities (e.g., goals, measurement, data collection, and headway toward improvement):

- **Emergency preparedness** (internal and external).

The organization should detail the recovery plans that are in place for internal and external events that might compromise services. For

example, if a flood were to occur in the pharmacy, how would patient medication services be continued? The process for drills, testing, and inspection procedures must also be spelled out in this plan. The organization should strive to design an efficient prevention system and hospitalwide attitude of readiness for a wide range of disasters that (it is hoped) will never occur.

• **Hazardous materials.**

The exposure of health care workers to harmful chemicals such as formaldehyde; hazardous materials such as mercury; infectious substances such as blood; or biohazardous waste such as radionuclides — is a necessary part of the job.

However, it is the hospital's responsibility to see that no worker or patient is harmed by such exposures and to see that the natural environment is not harmed either. The hazardous materials plan should describe the types and whereabouts of hazardous materials in the organization, how hazardous waste is managed, and how exposures are to be handled. An inventory of hazardous materials should be maintained by individual departments, and there should be a defined process for periodically updating these inventories.

• **Medical equipment.**

This plan must address how medical equipment is kept in proper working order. Be sure to include an inventory of all equipment in the organization and how often maintenance and safety checks are conducted. User competencies should also be addressed. Define how competencies are maintained for all medical equipment. An area of special focus is maintenance of competencies for high-risk equipment or equipment that is infrequently used, e.g., pediatric defibrillators. The plan should also address the process used by the organization to report medical equipment and product problems to the Food and Drug Administration.

• **Life safety.**

This plan should include a description of how the organization minimizes the risk of a fire and maximizes its ability to control one should it occur through a variety of engineering specifications and administrative duties. The plan should include the mechanisms by which managers and staff are made familiar with fire prevention techniques as well as the location of fire alarms, extinguishers, exits, and smoke barriers and how to respond.

In the area of fire prevention, the organization should also have an established nonsmoking policy. It is acceptable to allow exceptions to the policy if authorized by the patient's licensed independent practitioner, however, the criteria for such exceptions should be approved by the medical staff.

• **Security.**

In 1995, the Joint Commission increased its emphasis on security plans. The organization's security plan should describe the mechanisms used to prevent child abductions, theft, drugs, and violent behavior, and methods for training physicians and staff. The goal is to provide a low-risk, secure environment across all health care settings.

• **Safety management.**

This plan must address all the items in the intent statement of the standard, including management of grounds and equipment, risk assessment for other hazards, compliance with OHSA standards, and annual evaluation for effectiveness. Be sure to document how risks are identified (e.g., safety rounds, findings from accident and injury investigations, product recalls, etc.) and how such risks are investigated and resolved.

• **Utilities management.**

The plan should describe the process for maintaining utility systems and procedures for handling a system failure. The organization must have a systematic process for ensuring that utilities — water, electrical, telecommunications, air handling, medical gases, computers, etc. — are properly constructed and maintained so as not to pose a risk to patients should a utility system fail.

COMING IN FUTURE MONTHS

- An insider's view of the Joint Commission: This may surprise you
- Medicare conditions of participation: They're being revised
- A report on *HPR's* reader survey: Your three greatest challenges
- The latest news on effective discharge planning
- How accurate are the data your hospital submits?

The preparation of patient care and administrative plans is not the end result. The successful implementation of that plan is the ultimate goal.

However, a well-written plan will demonstrate to the Joint Commission that careful consideration has been given to activities. Most importantly, each plan provides a framework for ensuring quality patient care in the organization. ■

AHA advises against stockpiling medicine

The latest fear among health care industry experts is that providers who depend on pharmaceuticals and other medical supplies plan on stockpiling their supplies in anticipation of the new millennium.

Concern over suppliers' and distributors' ability to provide uninterrupted flow of medicine and medical supplies has led some providers to make larger than normal purchases.

The Chicago-based American Hospital Association (AHA) is urging providers to resist the temptation to hoard supplies, and is assuring that supply requirements will be met as long as all purchasers stay with their normal buying patterns.

"The prudent, responsible approach to year 2000 materials management is not to hoard or stockpile," says **Jonathan T. Lord**, MD, chief operating officer at the AHA.

In preparation for the year 2000, however, the AHA recommends that health care providers take the following steps:

• Identify pharmaceuticals and medical/surgical supplies that are mission-critical for patient care delivery, and the normal purchasing requirements for those supplies.

• Develop contingency plans with your suppliers and distributors to support your normal inventory needs for these mission-critical supplies; identify any substitute items that can be used; and plan for managing potential supply interruptions.

• Expand existing emergency agreements between hospitals to include problems that might result from year 2000 computer glitches. ▼

Report: HIV patient care still 'inferior' for some

Quality of care among HIV patients in the United States is improving but remains "inferior" for large segments of the population, says an analysis in the June 23-30 issue of the *Journal of the American Medical Association*.

Three interviews with more than 2,000

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

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HIV-infected individuals between January 1996 and January 1998 suggested that "inferior patterns of care" were seen for blacks and Latinos compared with whites, the uninsured, and Medicaid-insured compared with the privately insured, women compared with men, and other risk and/or exposure groups compared with men who had sex with men. The disparity persisted even after adjustments for variations in CD4 cell count.

Outcome measures were patterns of ambulatory and emergency room visits and receipt of antiretroviral therapy and prophylaxis against Pneumocystis carinii pneumonia.

(See: JAMA *1999; 281:2,305-2,315.)* ■

SourceKit

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