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Important news about insurance and risk management for hospices and home health care agencies.

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Outcomes and Pay for Performance

Barbara Stover Gingerich RN MS FACHE CHCE

Pay for performance for home health continues to be developed through ongoing demonstration projects. It is the responsibility of the Medicare Payment Commission (MedPAC) to review the results of these projects and make recommendations regarding [1] how to structure value-based adjustments aimed at improving quality care and [2] how to pay for performance/ outcome results. This focus was mandated by the Deficit Control Act of 2005, which also stipulated that home health providers participate in quality reporting by the beginning of 2007. Failure to participate in quality reporting would result in a 2% point reduction in the inflation update for that year for the nonparticipating providers [Niewenhous, 2007].

Care Continuum Concepts

While community-based program; i.e. home health was an initial focus of the P4P initiative, the concept has expanded to include hospitals, physicians, and hospice providers. Within the hospital and physician practice setting, the key application foci are on [1] chronic disease management and [2] preventative care. In addition, the demonstration projects not only involve just Medicare reimbursement, but also Medicaid and Private Pay reimbursement streams.

Home Health Demonstration Project Status

At the present time the Home Health P4P demonstration project has over 550 participating agencies. There are seven states included in this project. These states were selected because they are representative of the total national home health agency geographics and demographics [urban and rural], as well as agency size and structure [government, nonprofit, proprietary]. The states selected for this demonstration project are Alabama, California Connecticut, Georgia, Illinois Massachusetts, and Tennessee.

Quality and Outcome Determinations

While the healthcare industry has developed several approaches to demonstrating care quality [clinical pathways, evidence-based practice], Medicare has approached the home health outcome determinations via the Outcomes Assessment and Information Set [OASIS] data collection and reporting.

• *Clinical Pathways Care Model*

The clinical pathway care delivery model had its start within the acute setting as early as 1992; however, the integration of this care model into the home care and hospice settings occurred in the mid 1990's. Although several models were developed and took hold in the home care setting, the key components in all systems were similar. These components, which focused on a specific diagnosis, were a Standard for Care, Outcome Measurements, Patient Teaching Tools and Structured Visit Notes

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Outcomes and Pay for Performance [P4P]

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[Gingerich, 1995]. As technology advanced within the home care setting, the pathways were then adapted to an electronic format and integrated into numerous points of care documentation computer software offerings. Providers were cautioned to individualize these clinical care paths to the individual patient's needs.

As the home care industry transitioned into Prospective Payment and then to Episodes of Care, these pathways were adapted to meet not only changes in practice standards, but also reimbursement models [Gingerich, 2001].

- ***Evidence-based Practice Models***

Over the years, since evidence-based practice [EBP] standards have become available, there are many published examples of evidence-based care guidelines. As early as 1998, Blue Cross and Blue Shield of North Carolina released evidence -based guidelines for hospice care. [http://www.bcbsnc.com/services/medical-policy/pdf/hospice_care.pdf] Establishing evidence-based care within an agency includes several critical steps. The foundation for these practice guidelines is built upon education, but the guidelines must contain quantitative and qualitative measurements, evaluation time frames, methods and frequency, followup steps, communication and benchmarking. [Depalma, 2003] It has been stated that evidence-based practice (EBP) expands the clinical pathway model to use the best evidence available in its model development.

- ***Outcomes Assessment Information Set [OASIS]***

Since its inception as a data set designed to be collected at key points in care and service delivery, OASIS has gone through a number of revisions. At the present time 11 agencies from three states (Colorado, Ohio, Massachusetts) are testing the revised data set in both paper as well as electronic medical record format. The testing that is underway seeks to identify revisions and final elements to be included in OASIS C. Once testing is complete, comments and input from CMS groups, the National Quality Forum and providers will be sought. Anticipated current revisions are the inclusion of process items, revisions to existing items, medication management items, and the addition of diagnosis-specific data collection items. These revisions are intended to be more inclusive of evidence-based practice and to assist in development of the payment incentives aligned with P4P.

> Proactive steps taken now can help stabilize an agency through the transition to pay for performance.

P4

National Quality Forum [NQF]

NQF is seeking to improve measures and outcomes and to work towards the development of a set of measures that can be evaluated across all care settings. Currently there are several demonstration projects underway that are directly related to expanding P4P beyond the community care setting. These include the Electronic Health Records, Physician-Hospital Sharing [Compare Measures], Hospital Quality Initiatives, the Medicare Care Management Performance and Nursing Home Value-Based Purchasing demonstration projects. Two key priority measures being examined across the care continuum are Flu and Pneumonia Immunizations and Pressure Ulcers. At the present time NQF has endorsed 15 home health performance measures and they are the ones that are posted on the Home Health Compare website.

Home Health P4P - 2008-2009

During this two-year period, the outcomes that are being measured that directly impact reimbursement include home care patient acute care hospitalization rates, emergent care needs, degree of improvement in patient functioning in the areas of ambulation/locomotion, bathing, transferring, oral medication management and surgical wound improvement status. Providers participating in the demonstration project are randomly assigned to either a control or treatment group, and an incentive payment system is in place that is focused on maintaining budget neutrality and calculates the incentive based upon performance and measurement results for each measure individually.

It is acknowledged that the results of these demonstration projects will have a direct impact on all home health providers. It has also been stated that with the implementation of the revised Hospice Conditions of Participation [CoPs] and the focus on quality initiatives within the hospice setting, hospice providers can anticipate a similar P4P initiative to be instituted within the hospice provider setting.

Taking Action

Preparation and proactive action can assist providers to enhance their agency's readiness for P4P. Providers are examining and evaluating existing care delivery models [clinical care paths] to determine how their implementation would affect efficiency, quality care and care outcomes. Regardless of the care delivery model utilized, the focus is on outcome improvement and evaluating the change in patients from admission, through care and at discharge. In addition providers have established quality indicators to monitor, track and trend acute care hospitalizations, with a followup focus on addressing trends and individual variances in the desired outcome.

Another key action to undertake is the provision of ongoing staff education regarding the meaning and interpretation of OASIS data elements and on achieving clinical and operational excellence. Consistency in the completion of the OASIS data sets is essential to the collection of reliable and valid patient information. Agencies should also access their online Home Health Compare data, generated from their OASIS assessments, to assure that the information is accurate and up to date. Given the anticipated future emphasis on chronic disease management, there is an increase in the use of nurse specialists as home health case managers for specific patient populations. These nurse specialists also serve as in-house consultants to other staff. This approach is valuable not only to the home care setting, but also across the care continuum. The current P4P demonstration projects in other care settings focus outcome achievements across the care continuum. With that focus in mind, agency leaders need to proactively work to increase collaboration with providers across the care continuum, including acute care hospitals, rehabilitation centers, skilled nursing facilities and physicians.

Another strategy is to incorporate the use of diagnosis-specific clinical pathway care delivery models that have outcome and variance tracking tools. These should be integrated into the clinical documentation and data collection system. The use of visuals, such as bar graphs, histograms or scatter diagrams, will help staff to readily

observe trends and identify potential areas for improvement. Actions can then be developed that emphasize targeting specific unmet outcomes and the ongoing measurement of incremental improvements in these outcomes.

Supporting staff through the change process and educating staff on theories of change management, will better prepare them for change and help them understand that change is ongoing in the fast-paced health care industry.

Summary

Although CMS has been traveling the path to P4P for almost 20 years, the reality is that P4P will soon be implemented for home care, with other care settings not far behind. Proactive steps taken now can help stabilize the agency through the transition from payment for episodes of care based upon the existing Home Health Reimbursement Groups [HHRG's] to the new pay for performance model.

In addition, by developing and implementing a quality improvement program that includes quality indicators focused on care outcomes and accuracy of OASIS data, agencies will find themselves better prepared for the future reimbursement model. It is important to provide ongoing education regarding the Quality Improvement Program and OASIS Data collection, so that all staff will have a clearer understanding of the importance and impact that these factors have on the total viability and stability of the agency.

Finally by keeping alert for updates and revisions in both the OASIS and the proposed P4P model, agency leaders will be provided with the most lead-time possible to prepare for the reality of P4P.

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Patient Satisfaction, Patient Expectations, Patient Safety

Patient satisfaction is closely tied to communication.

Betty Norman, BSN, MBA, CPHRM

Patient/Family Satisfaction

A comprehensive Risk Management (RM) Program should always include a review of information obtained from patient/family satisfaction surveys, as well as patient/family complaints. Most accrediting and licensing agencies require hospice and home care organizations to have some process in place to measure patient/family satisfaction.

Satisfaction surveys allow an organization to collect data on an individual patient's perception of care, treatment, and services. They can also be used for other risk management and safety functions, including assessing overall services and soliciting feedback and suggestions for improvement.

Patient/Family Expectations

But, other than actively soliciting feedback via surveys or responding to patient/family complaints, is it possible to take a more proactive approach to Risk Management when it comes to patient satisfaction? One way might be to have ongoing dialogue with the patient and their family regarding expectations.

Studies have shown that unsatisfied or unhappy patients are more likely to contact an attorney and/or consider litigation against healthcare organizations. Patients and their family members tend to be more satisfied with the quality of care provided by an agency if they are frequently informed of their condition, health status, daily activities, and other details of their care.

Effective communication begins with setting expectations for care and services for potential or newly admitted patients and their families. Each team member should play a role in informing and educating patients and their caregivers about what they can expect from the home/hospice healthcare system, from admission on.

Setting expectations first involves informing patients and their families of the organization's mission, philosophy and available services. This can be done as part of a preadmission evaluation or conference, or during the first home visit. The discussion of expectations should be part of each team member's first interaction with the patient, and is an important step in the development of the plan of care. It is often discovered during this process that patients and family caregivers have unrealistic expectations about the level and duration of services that will be provided.

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Patient Satisfaction, Patient Expectations, Patient Safety

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There should also be some discussion of the fact that the home environment is uncontrolled and not a risk free setting. In most cases, staff will not be present twenty-four hours a day. Consideration should be given to individualized safety initiatives, such as fall prevention strategies and alert devices.

Communication, Caregiver(s) and Safety

Ongoing communication with the patient and/or family should involve periodic "check-ins" to determine whether the organization is meeting expectations and whether the patient is satisfied with the care and services that are being provided. This can be documented as part of the interdisciplinary review of the care plan.

Communication is an important part of patient safety and risk management. The Joint Commission (www.jointcommission.org) has found that communication problems are often at the root of sentinel events (unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof). As a result, they have developed a National Patient Safety Goal aimed at improving the effectiveness of communication between caregivers.

It is important to keep in mind that in the home environment, the main patient caregiver may be a family member or close friend, and they will ultimately play an important role in the success of the care plan. The Joint Commission Home Care National Patient Safety Goal 13 is to "Encourage patients' active involvement in their own care as a [patient] safety strategy." The rationale for this standard is that communication with the patient and their family about all aspects of care, treatment, or services is an important characteristic of a culture of safety. When the patient knows what to expect, he or she can be an important source of information about potential adverse events and hazardous conditions. Open communication benefits everyone.

In summary, patient satisfaction appears to be closely tied to understanding and meeting patient and family expectations. In order for that to happen, all members of the home care or hospice team need to assure that there is ongoing discussion with the patient and their caregiver(s) about those expectations. ♥

Tips for Effective Communication

- Introduce Yourself
- Make Eye Contact
- Provide Information
- Have Patient/Caregiver Repeat Back
- Explicitly Ask for Input
- Summarize Important Information
- Write Down Important Information or Instructions
- Allow Time for Questions or Concerns
- Talk About Next Steps
- Monitor on Ongoing Basis

A New Focus for QAPI: One Organization's Perspective

Delaware Hospice has always been dedicated to providing the highest quality care to our patients and families. As a non-profit hospice whose service area includes the entire state of Delaware, we have had the opportunity to reach over 30,000 patients in our 25 years of service. Our family satisfaction has remained high amidst our continued growth. A contributing factor to this success has been the establishment of a solid Quality Assessment and Performance Improvement (QAPI) Program.

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In the mid-nineties, in response to the original Medicare Conditions of Participation and the Joint Commission requirements, Delaware Hospice implemented a formal organization-wide Quality Assurance program. Policies were written and implemented, a Quality Improvement model was established, staff and board of trustees were educated, and the Operations Team was given jurisdiction over the Quality Assurance program. Program activities included collecting and analyzing data (such as patient demographics, care delivery, incidents and complaints, and family satisfaction), and using that data to determine areas for improvement. On a monthly basis, the Operations Team would review pertinent data and be updated on the latest performance improvement projects.

Response to New COPs

The newly revised Medicare Conditions of Participation include clear expectations of a QAPI program and have shifted the focus from data surveillance to a more data-driven improvement process. Because of the increased emphasis on QAPI, we stepped back and took a look at our current program and how it might be restructured to better implement and support the new conditions of participation. The **QAPI Steering Committee** was established. This committee is responsible for ensuring compliance with the conditions of participation related to QAPI through the following agenda:

- Approve recommended goals for quality improvement
- Approve new performance improvement projects
- Review the documentation of all performance improvement project progress and outcomes on a regular basis
- Review the findings for all standard self-assessments (NHPCO and Joint Commission)
- Disseminate information to all staff; provide quarterly reports to the Administrative Team and the Board of Trustees
- Oversee the implementation of NHPCO's Quality Partners Initiative in 2008
- Establish the annual goals for QAPI for the organization
- Educate the Board of Trustees and staff related to Delaware Hospice QAPI goals and activities
- Support staff and leadership participation in QAPI activities

Multi-Disciplinary Approach

In an effort to make this a multi-disciplinary program, membership represents all aspects of Delaware Hospice. Members not only include clinical leaders, but also staff from human resources, the business office, the information technology department, compliance and education, and community education. A member of the board of trustees was also invited to participate, and serves as a liaison to the board.

In response to the volume and scope of information that was being handled, as well as the growing emphasis on a 360 degree review of the organization, the steering committee was restructured to include **two sub-committees** — *one with a clinical focus and one with an administrative focus*. The main purpose of these committees is to review and analyze data and reports applicable to their focus, and make recommendations for policy or practice changes or performance improvement projects to the QAPI Steering Committee. The standard agenda for the sub-committees focuses on:

- Data analysis and monitoring
- The establishment of specific goals for quality improvement
- The recommendation, initiation and oversight of performance improvement projects
- The management of the Joint Commission annual Periodic Performance Review and the annual NHPCO Self-Assessment
- Communication of QAPI activities to all staff
- Support of participation by staff in QAPI activities

Sub-committee members include more field and front line staff to encourage and support ownership and participation in the QAPI program among staff of all levels. The Clinical Sub-committee is comprised of nurses, social workers, counseling staff, hospice aides, clinical team leaders, volunteer coordinator, medical records staff, a community education representative and the patient record database administrator. The Administrative Sub-committee is comprised of staff from the business office and human resources department, a community education representative, the manager of information technology, office managers, and a member of the development department.

Culture Change

Since the creation of these committees, Delaware Hospice has seen among staff, a resurgence of interest in all things quality-related. This two-tiered approach allows for involvement of staff at all levels of the organization thereby promoting a feeling of inclusivity and ownership in the QAPI program. In addition, the Board of Trustees, now having a direct link to the QAPI program, is better informed and integrated into the quality activities of the organization. ♥

New Hospice Conditions of Participation: QAPI

KEY ISSUES

- Measure, analyze and track quality indicators
- Monitor effectiveness and safety of services and quality of care
- Identify opportunities and priorities for improvement
- Focus on high risk, high volume, or problem-prone areas
- Track adverse patient events, analyze their causes, and implement preventive actions
- Develop performance improvement projects
- Governing Body responsibility

COMPLIANCE CONCERNS: Survey and Audit Preparation

Barbara Stover Gingerich RN MS FACHE CHCE

Providers are experiencing an increase in regulatory, reimbursement and compliance audits. As the Recovery Audit Contractor [RAC] program transitions to a national focus, there is the expectation that there will be a concurrent increase in RAC offsite reviews, as well as onsite audits. The Centers for Medicare and Medicaid Services [CMS] recently designated four national RAC's that will focus their efforts in 19 states [Arizona, Colorado, Florida, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, North Dakota, Rhode Island, South Carolina, South Dakota, Utah, Vermont and Wyoming]. This is only the next step of the national expansion of this program, which also is expanded to include hospice providers.

CMS also recently announced a focus on Medicare Contractor Reform with the transitioning date for home health providers to begin by the end of 2008. The total program implementation time line is from 2005-2011 and in March 2007, CMS announced the consolidation of the home health and hospice workload into 4 A/B MAC. In addition, as the new Conditions of Participation are implemented, state and accreditation surveys will take on both a revised and an enhanced focus.

As a result of these many initiatives and the regulations that mandate these undertakings, providers can expect increased record review requests and onsite surveys.

Regulatory Foundation

Section 302 of the Tax Relief and Health Care Act of 2006 mandates that the RAC program be in place within all states by January 1, 2010. This Act also mandates that CMS take the appropriate steps \to assure permanency of the program. As this program spreads to all 50 states, the focus remains unchanged, i.e. [1] Return dollars to the Medicare Trust Funds and [2] Identify monies to be returned to providers. [www.cms.hhs.gov/RAC]

The Medicare Administrative Contractors [MAC's] revisions were mandated in Section 911 of Medicare Modernization Act (MMA) of 2003. This requires new Medicare Administrative Contractors (MACs) to be designated to replace the existing contracting authority. This focus of the revised MAC program is to be on comprehensive quality care and beneficiary and provider service. The target reduction of MAC contractors is a 50% reduction.

The new Hospice Conditions of Participation [CoPs] were released in the summer of 2008, with the implementation date established by year-end. As a result, accreditators focused on revising and updating survey standards and onsite survey process to comply with these new CoPs.

Hospice Key Risk Areas

The key medical review denials during the first six months of 2008 were:

- Documentation failed to support a six-month terminal prognosis [918]
- Missing/incomplete/untimely certification [215]
- No clinical documentation received [131]
- Missing/incomplete/untimely election statements [121]
- Reduced level of care [89][Cahaba Hospice Medical Review Statistics, 2008]

These denials totaled over 62.5% of the total claims selected for review. Other high risk areas for hospice providers include the terminality of the patients who have been on service for extended time periods, often with diagnoses such as Alzheimer's disease, heart disease, COPD or adult failure to thrive.

Hospice billing errors reported during a nine-month time period ending in October 2008 revealed the following top five hospice billing errors:

- 37402: Hospice sequential billing error (9,928)
- U5181: OC 27 required when cert date falls w/in DOS billed (7,462)
- U5150: NOE not on file for hospice election (4,685)
- 38200: Duplicate claim (4 184)
- 32030: Value code "61" or "G8" required on hospice claim (4,136)[Cahaba, 2008]

Home Health Key Risk Areas

The key medical review denials during the first six months of 2008 for home care providers were:

- Medical necessity not supported in clinical record [2725]
- Missing/incomplete/untimely plan of care [720]
- Homebound status not supported in clinical record [645]
- Clinical documentation not received [440]
- Missing/incomplete/untimely orders [345][Cahaba Home Health Medical Review Statistics, 2008]

These denials totaled over 63.5% of the total claims selected for review. Other high-risk areas for home health providers include the recertification process, wound care patients, as well as admission, discharge and transfer processes.

Home health billing errors reported during a nine-month time period ending in October 2008 revealed the following top five home health billing errors:

- 38107: Matching RAP not found (77,022)
- 38157/38200: Duplicate RAP/claim (26,746)
- U538G/U538I: RAP/claim overlaps existing HH PPS episode (18,707]
- 32226: Revenue code requires units (15,405)
- 31755: DOS inconsistent with HIPPS service date (8,318)[Cahaba, 2008]

Common Non-Provider Specific Risk Areas

There are a number of risk areas common to all provider types, and these include the provider's Compliance Program Structure and elements, structuring of processes and protocols, such as billing, admission, discharges, documentation accuracy and completeness, and failure to take action when corrective action is indicated.

Preparation

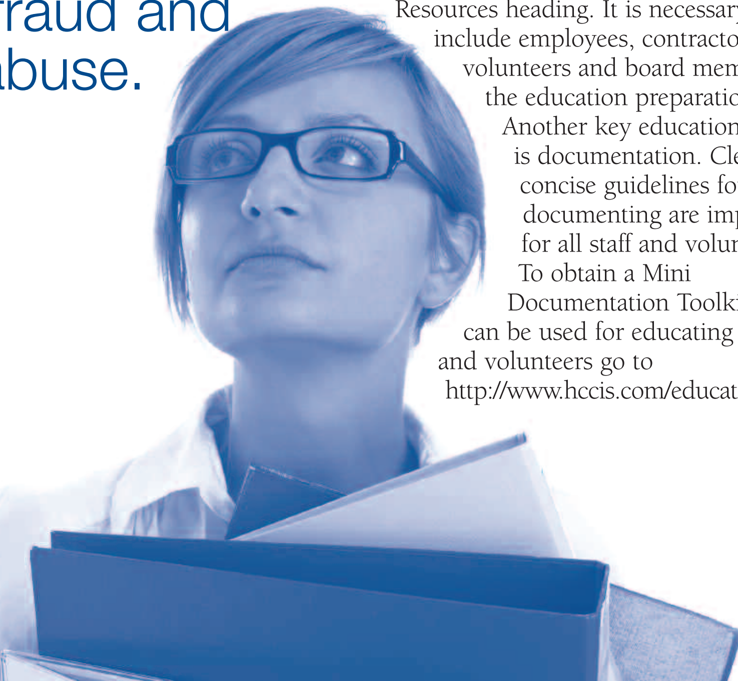
Similar steps and actions are needed by all providers in preparing for audits, surveys or focused reviews. One of the key elements of preparation is to conduct internal self-audits that scrutinize high-risk clinical and operational processes. These reviews should encompass both general risk areas, as well as provider-specific key risk areas.

• Compliance Program
The required elements in structuring a compliance program include hiring a qualified compliance officer, developing written standards and policies, such as codes of conduct, conflict of interest and confidentiality and providing education and training to staff, volunteers and board members. The provider is expected to conduct compliance audits and address any findings not meeting standards. This includes record reviews of clinical, billing and personnel files, as well as reviews of marketing materials and the provider's web site.

• Clinical Record Audits
By incorporating the identified medical review areas specific to the provider setting, as well as quality improvement and outcome indicators into the clinical record audit tool, providers can focus the mandated quarterly clinical record reviews into areas where the most significant impact can be achieved. Objective measurement and audit tools remove the subjectivity of the review and produce more accurate and comprehensive record audit findings.

• Personnel Process Audits
Adhering to personnel policies, prehire screening and background checks, as well as ongoing compliance with Labor, OSHA and employment protocols, can be determined by conducting an initial audit of new hires within 60 days of employment in addition to quarterly, randomly-selected audits of personnel files. Key items to include in these audits are to confirm the presence of current clearances, licenses, certifications and organization-specific requirements, such as education, CPR, insurances, as well as health screening, immunizations and performance evaluations.

Maintaining an active compliance program protects the provider against allegations of fraud and abuse.



• Billing Audits
Established steps in the billing process should include validation of existing visit documentation, signed certifications and orders and determining that the admission and intake included the required information and patient signature elements. Billing audits that focus on the top billing/claims errors are also important in order that providers can assure that their records meet focused Medicare billing review edits and do not result in Medicare requesting return of monies previously paid for services.

• Competency and Education
When preparing for audits and surveys, it is important to assure that staff possess the competencies needed for the provision of patient care. In addition, education relative to the audit and survey process, along with hints on how to respond to surveyor questions, preparing patients for surveyor visits and revised policy and procedure education, as well as training on the use of new or revised forms is essential. To download a copy of the Health Care Aide Educator: Educational Inservice Competency and Evaluation, please go to http://www.hccis.com/resources.htm and access the inservice under the Other Resources heading. It is necessary to include employees, contractors, volunteers and board members in the education preparation. Another key education topic is documentation. Clear and concise guidelines for documenting are important for all staff and volunteers. To obtain a Mini Documentation Toolkit that can be used for educating staff and volunteers go to http://www.hccis.com/education.htm.

• Quality Improvement Activities
Quality improvement initiatives are integral to preparation for audits and surveys. Tracking and trending data relative to care outcomes, patient satisfaction and complaints reflects the organization's approach to quality improvement and assists in supporting positive audit and survey results. Adverse events and incident investigation are also key parts of the organization's total quality program. By documenting and addressing findings, organizations are able to address a proactive approach to problem solving and resolution.

• Communication and Corporate Culture
Organizations must work to promote a positive and supportive corporate environment. An organization with a willingness to listen and learn about problems, concerns, errors or other operational and clinical-related issues is an organization that encourages staff and volunteers to come forward with their concerns. Leaders that are interested in finding improvement opportunities, not in placing blame or finding fault, lead an organization that is prepared for audits and surveys. By maintaining this approach and two-way communications with staff and volunteers, the culture of finding the right way and doing right becomes the unspoken norm and is critical to preparing for audits and surveys.

• Response to Medical Review Inquiries
As noted in both home health and hospice denial data, many Medicare claims are denied because the organization has failed to submit the documentation to support reimbursement. The response to inquiries is a time-critical process and organizations must put in place an ironclad process that assures prompt attention to these requests and submissions in keeping with required time frames.

Taking Action

As these preparation strategies are implemented, the next step is to develop correction action plans and follow these plans to address and reevaluate audit findings. Providers need to implement corrective action plans that include specific actions, revisions, and monitoring and ongoing evaluation of results achieved and maintained. In order that the entire organization is informed and knowledgeable about these activities, reports regarding findings, trends, action plans and results should be shared with staff, compliance and quality

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Survey and Audit Preparation

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improvement committees and board and professional advisory groups.

Summary

The examples provided here are only a few of the many steps and actions that can assist organizations before and during audits and surveys. What is most important is that organizations prepare for these events and that they understand the importance of this preparation. For example, national programs, such as RACs, are paid a contingency fee based upon their recoupment payments and in the permanent RAC program, recoupments can be reversed at any step in the appeals process, during which denials are overturned and findings reversed. This means that compensation to the RAC is contingent on the original finding being upheld throughout all steps of the appeals process. It also means that providers must be aware of not only the important steps in preparation, but also their role and responsibility in the appeals process and be prepared to follow all steps in the process.

In addition to understanding the RAC review, medical record review and certification and licensing survey process, providers must be aware of all regulatory trends and government activities focused on their provider setting. Maintaining an active compliance program protects the provider against allegations of fraud and abuse and keeps an active vigilance of organization operations.

In order to decrease the overall consequences from external audits and surveys, when problems are identified, it is also important to obtain outside legal and consultative assistance early in the process. Legal and consultative assistance can conduct independent objective investigations and audits and develop appropriate action planning strategies for implementation. ♥

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