Sentinel Event Alert

A complimentary publication of The Joint Commission

Issue 65, June 22, 2022

Diagnostic overshadowing among groups experiencing health disparities

A 42-year-old woman with a diagnosis of mental illness visited a gastroenterologist after experiencing frequent nausea and stomach pain. The doctor diagnosed functional abdominal pain syndrome (FAPS) and told the patient she would have to "learn to live with it." Later, the patient discovered FAPS was a "somatization disorder," meaning that her pain was attributed to her mental and emotional state. The patient lived with the pain and nausea for months and began unintentionally losing weight, which triggered anorexia. Eventually the patient sought out a new gastroenterologist at a women's medical center. This time, the physician took her symptoms seriously, put her through a series of tests, and after administering a breath test, determined that the patient suffered from small intestinal bacterial overgrowth.[1]

The initial misdiagnosis had a significant impact on the quality of life of this patient, who spent over a year recovering her lost weight and getting her eating disorder under control. This patient still takes medication for her mental illness diagnosis but is tempted to leave these off the medication list she provides to future healthcare practitioners. This was the second misdiagnosis she received in two years, so she worries about disclosing her medication regimen since it may influence how the doctor sees her.[1]

This situation – given from the patient's point of view – is an example of the risk of diagnostic overshadowing, defined as the attribution of symptoms to an existing diagnosis rather than a potential co-morbid condition.[2,3] The medical literature includes extensive evidence that diagnostic overshadowing exists within the interactions of clinicians with patients of all ages who have physical disabilities or previous diagnoses such as, but not limited to, autism, mobility disabilities and neurological deficits, as well as patients with conditions or characteristics such as, but not limited to, LGBTQ identifications, history of substance abuse, low health literacy and obesity.[2,4-23]

Why it is important to address diagnostic overshadowing

- *Diagnostic overshadowing is a harm that stems from cognitive bias* – Correlated to clinician bias (i.e., cognitive bias),[24] diagnostic overshadowing can be detrimental to quality of care and can contribute to delays in diagnosis and treatment, unnecessary or unsafe care and inequities of care.[25] Once an initial diagnosis has been made, momentum sometimes takes hold and reduces a clinician's ability to consider other alternatives.[24] This bias can affect future patient workups and how handoffs to other providers are framed. See the sidebar, "Case example of clinical bias/diagnostic overshadowing."
- *Diagnostic overshadowing contributes to health disparities and is of particular concern in groups experiencing health disparities, such as individuals with disabilities.*
- *Many people have a pre-existing diagnosis or condition* – Diagnostic overshadowing can occur with virtually any patient with a pre-existing diagnosis or condition. Over 1 billion people are estimated to experience disability. This corresponds to about 15% of the world's population, with up to 190 million (3.8%) people aged 15 years and older having significant difficulties in functioning, often requiring healthcare services. The number of people experiencing disability is increasing due to a rise in chronic health conditions and population aging. People with disability face barriers,

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization.

stigmatization and discrimination when accessing health and health-related services and strategies.[26]

- ***Individuals with disabilities are at greater risk of diagnostic overshadowing*** – The potential of diagnostic overshadowing presents added risk to individuals with disabilities. See the sidebar box, "Diagnostic overshadowing – Potential for added risk to individuals with disabilities" for statistics.
- ***Speed, stress and lack of training contribute to diagnostic overshadowing*** – Time pressures faced by clinicians can cause them to hurry or to be impatient. Singh, et al, 2019,[33] found that, after prompting a conversation with a patient about their concerns, clinicians interrupted patients after a median of only 11 seconds and came away with an understanding of the patient's concerns in only 36% of the encounters. As a result of time pressures and other factors, patients are often unable to present a complete or accurate narrative of their symptoms, medical histories and current medications.
- ***Diagnostic overshadowing is a failure to deliver a proper diagnosis*** – "Diagnostic overshadowing signifies a departure from clinically accepted principles of developing a differential diagnosis," said Ana Pujols McKee, executive vice president, chief medical officer, and chief diversity, equity and inclusion officer at The Joint Commission. "By adhering closely to diagnostic principles, processes and procedures, a clinician is more likely to arrive at a safe and accurate conclusion." Excellent resources relating to diagnostic principles can be found at the Society to Improve Diagnosis in Medicine and Agency for Healthcare Research and Quality's Diagnostic Safety and Quality websites. Schiff, et al., 2018[34] provides 10 principles for conservative, "care-full" diagnosis. Singh, et al, 2019,[35] reviews measures to improve diagnostic safety, and Bradford, et al., 2020,[36] reviews common principles of diagnostic safety.
- ***Most clinicians do not have training, experience and skills grounded in treating individuals with disabilities – again putting these individuals at increased risk for diagnostic overshadowing*** – Virtually every major report addressing the poor health of persons with disabilities has called for improvements in the training of healthcare

Case example of clinical bias/diagnostic overshadowing

A 26-year-old Black female comes to the emergency department complaining of pelvic pain and diarrhea. During a review of her medical history, the physician finds that she has been prescribed anti-anxiety and birth control medications and has previously been diagnosed with a sexually transmitted disease. The young woman is covered by Medicaid. The physician – feeling rushed due to the time and cost pressures of the ED – neglects to discuss the young woman's social history and assumes a diagnosis of pelvic inflammation caused by a sexually transmitted disease. The young woman is sent home with an antibiotic prescription. The physician fails to explore the possibility of endometriosis, cancer or another cause.

Diagnostic overshadowing – Potential for added risk to individuals with disabilities

- Pregnant women with a disability have a higher risk for severe pregnancy- or birth-related complications and 11 times the risk of maternal death.[27]
- Persons with physical, intellectual or developmental disabilities have shorter life expectancies than those without disabilities.[28]
- Having an intellectual disability was the strongest independent predictor for COVID-19 infection and the second strongest predictor for COVID-19 death.[29]

Also, Americans with disabilities are:

- More than three times as likely to have arthritis, diabetes or a heart attack.[30]
- Five times more likely to experience a stroke, COPD or depression.[30]
- More likely to be obese.[31]
- More likely to have unmet medical, dental and prescription needs.[32]

providers when it comes to providing care to adults with disabilities.[31] A recent study found that about one-third of U.S. physicians do not know their legal requirements under the Americans with Disabilities Act (ADA).[37] Some U.S. medical schools provide disability competency training, but most do not.[25] The National Council on Disability (NCD) calls for comprehensive disability clinical care education and disability competency training to be incorporated into all medical, nursing, healthcare professional and allied health professional schools, as well as post-graduate residency, fellowship and continuing medical education programs.[25]

A lack of accessible data and a biased approach to care

In many clinical scenarios, providers do not have access to aggregated data that would identify a particular patient as someone who is at greater risk for diagnostic overshadowing. These data can help a clinician to identify an individual who is more likely to experience health disparities not only due to their pre-existing conditions or disabilities, but also due to race, ethnicity and language; sexual orientation/gender identity; geography; health insurance coverage; access to providers and pharmacies; and other social determinants of health.[38]

These all are characteristics that tend to result in bias of the clinician or healthcare provider (i.e., aspects that are more likely to result in a biased approach to care). Clinicians need to take into consideration how a patient's race, social class and gender identification, along with disabilities and previous diagnoses, may affect their evaluation. To accomplish this, clinicians can use an “intersectional approach” to care. An intersectional approach acknowledges systemic discrimination due to sexual orientation and identity, gender and gender identity, race, economic status, immigration status, national origin and ability, among other aspects of one’s identity, and that this systemic discrimination impacts access to opportunity.[39] In healthcare, an intersectional approach emphasizes how physicians and other healthcare providers should recognize the ways in which their patients’ identities or characteristics may impact their medical care; it focuses on the patients’ attitudes towards their providers and the efficacy of their treatment plans.[2]

"When a physician sees a patient with a multitude of characteristics that are associated with sub-optimal health outcomes, they need to appreciate those crossroads and then initiate an intersectional approach to their medical needs," said Rick Rader, M.D., president of the American Association on Health and Disability and member of the National Council on Disability.

Alerting fellow providers to a patient’s disability status in the electronic health record (EHR) also can help address diagnostic overshadowing. For example, UCHealth in Colorado began collecting patients' disability status during new patient registration implemented by a centralized call center serving 53 primary care clinics.[40] The call center agents inquired about mobility, hearing, cognition, communication, manual dexterity, vision and general disabilities. The collected information was integrated into the demographics section of the EHR. In six weeks, the agents registered 3,673 new patients and increased disability documentation in the EHR from less than 10% to 54%. There were no reports of concerns from patients when asked about their disability for inclusion in their record. To improve efficiency of documentation, the study's authors recommend using patient portals and other ways of collecting this information in addition to using a call center.

Actions suggested by The Joint Commission

The Joint Commission recommends the following suggested actions to help recognize and address diagnostic overshadowing among groups experiencing health disparities.

1. Create an awareness of diagnostic overshadowing during clinical peer and quality assurance reviews and by addressing it in training and education programs.

- Create training and educational programs to review diagnostic principles designed to identify the increased risk of comorbidity and diagnostic overshadowing in all patients and especially in populations experiencing disabilities or health disparities.[4,6,21] Include diagnostic overshadowing case studies and examples, such as those found in Cho, 2019.[2]
- Develop curricula focused on the care of individuals with disabilities and within other populations experiencing health disparities in residency, fellowship and continued medical education programs for physicians, physician assistants and nurse practitioners.[25]

- Regularly review diagnostic principles, particularly those relating to diagnostic accuracy, safety and quality.
- Evaluate whether diagnostic overshadowing or any form of bias could have contributed to an adverse outcome when reviewing adverse events.

2. Use listening and interviewing techniques designed to gain better patient engagement and shared decision making.[6]

- Allow the patient to find and express their voice.
- Pay close attention to non-verbal communication.
- Be aware of the physical setting and how it can be adjusted to make the patient more comfortable.
- As long as state and federal privacy laws permit, engage with those individuals the patient knows and trusts best to help communicate effectively with the patient.

3. Collect and aggregate data about pre-existing conditions and disabilities and create EHR prompts for clinicians.

- Collect and aggregate data about pre-existing conditions, disabilities and health disparities for all patients across their lifespans at patient registration or intake. Integrate these data into the EHR.[40,41]
- Create prompts, alerts or other ways for clinicians to be made aware of patients with complex intersectional profiles and to remind them of necessary tests and accommodations for these patients.[41,42]

4. Use an intersectional framework when assessing patients in groups prone to diagnostic overshadowing to overcome cognitive biases and look beyond previous diagnoses.[2]

5. Review your organization's ADA compliance using the added perspective of diagnostic overshadowing to ensure that it meets the needs of patients with physical disabilities.

- Modify policies, practices and procedures to allow for all patients to obtain convenient access to appointments and ensure that the patient receives adequate time with the clinician.
- When diagnosing individuals requiring special access, use facilities and medical and diagnostic equipment required by ADA law, including testing laboratories, exam tables, imaging machines and scales.
- Train staff about their responsibilities under the ADA, including what accommodations they must provide to patients with disabilities.[4]

Related Joint Commission requirements

References

1. Rosenhaft A. My experience with diagnostic overshadowing. NAMI Blog. National Alliance on Mental Health. October 2021.
2. Cho HL. Can intersectionality help lead to more accurate diagnosis? *American Journal of Bioethics*, Feb. 2019;19(2):37-39.
3. Jones S, Howard L and Thornicroft G. 'Diagnostic overshadowing': Worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica*, 2008:118:169-171.
4. Agaronnik ND, et al. Perspectives of patients with pre-existing mobility disability on the process of diagnosing their cancer. *Journal of General Internal Medicine*, Nov. 17, 2020;36(5):1250-7.
5. Antel A, et al. Diagnosing lymphoma in the shadow of an epidemic: lessons learned from the diagnostic challenges posed by the dual tuberculosis and HIV epidemics. *Leukemia & Lymphoma*, 2020;61(14):3417-3421.
6. Blair J, et al. Diagnostic overshadowing: see beyond the diagnosis. *British Journal of Family Medicine,* January/February 2017.
7. Centers for Disease Control and Prevention. Newsroom Releases. CDC: 1 in 4 adults live with a disability, Aug. 16, 2018.
8. Das S & Kulkarni K. 'Brain on Fire': An extraordinary cinematic depiction of the phenomenon of diagnostic overshadowing. *General Psychiatry*, July 19, 2021;34(4):e100504.
9. Dillane I & Doody O. Nursing people with intellectual disability and dementia experiencing pain: An integrative review. *Journal of Clinical Nursing*, Feb. 20, 2019. doi.org/10.1111/jocn.14834
10. Focella ES. Prejudice and stereotyping in healthcare. Wiley Online Library. Sept. 2, 2020. https://doi.org/10.1002/9781119057840.ch101
11. Iezzoni LI. Dangers of diagnostic overshadowing. *New England Journal of Medicine*, May 30, 2019;380;22.
12. Ingraham P. A rational guide to fibromyalgia. The science of the mysterious disease of pain, exhaustion, and mental fog. Dec. 28, 2021.
13. Javaid A, et al. Diagnostic overshadowing in learning disability: Think beyond the disability. *Progress in Neurology and Psychiatry*, 2019;(23)2.
14. Jürisson M, et al. Physical-mental health comorbidity: A population-based cross-sectional study. *PLOS One*, Dec. 2, 2021.
15. Kasinathan J. Dig deep psychiatry, it takes a village. *Australasian Psychiatry*, 2021;29(4):381-382.
16. Molloy R, et al. Understanding the experience of diagnostic overshadowing associated with severe mental illness from the consumer and health professional perspective: a qualitative systematic review

protocol. *JBI Evidence Synthesis*, 2021;19(6):1362-1368.
17. Munro J, et al. An inductive qualitative content analysis of stigma experienced by people with rare diseases. *Psychological Health*, Apr. 22, 2021;1-16.
18. National Institute for Health and Care Excellence (U.K.) Guidance. Individual research recommendation details. Care and support for people with dementia. Aug. 31, 2016.
19. Consortium from Swinburne University of Technology, University of New South Wales and University of Newcastle. "Health Literacy Development: Facilitator guide – Service journey toolkit." 2021.
20. Raven MC. Diagnostic overshadowing dangers. Agency for Healthcare Research and Quality Patient Safety Network. June 1, 2017.
21. Shefer G, et al. Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms – a qualitative study. *Plos One*, 2014;9(11): e111682.
22. Stavropoulos KK-M, et al. Differential diagnosis of autism spectrum disorder and post traumatic stress disorder: two clinical cases. *Journal of Clinical Medicine*, 2018;7(4):71. doi.org/10.3390/jcm7040071
23. Trnka S. Diagnostic refusals, temporality, and subjectivity among "non-compliant" sufferers of asthma. *Subjectivity,* 2018;11,1-20.
24. The Joint Commission. *Quick Safety*. Cognitive biases in health care. Oct. 2016, Issue 28.
25. National Council on Disability. Policy Framework. Health Equity Framework for People with Disabilities. Feb. 2022.
26. World Health Organization. Disability and health fact sheet. Last updated Nov. 24, 2021.
27. Gleason JL, et al. Risk of adverse maternal outcomes in pregnant women with disabilities. *JAMA Network Open*. 2021.
28. Forman-Hoffman VL, et al. Disability status, mortality, and leading causes of death in the United States Community Population. *Medical Care*, 2015;53(4),346-354.
29. Gleason JL, et al. The devastating impact of Covid-19 on individuals with intellectual disabilities in the United States. *JAMA Catalyst* (2021).
30. Williams M, et al. Exploring Health Disparities Among Individuals with Disabilities Within the United States. American Public Health Association [Paper presentation]. American Association of Public Health, Virtual. Oct. 2020.
31. Krahn GL, et al. Persons with disability as an unrecognized health disparity population. *American Journal of Public Health*, 2015;105:S198-S204.
32. Mahmoudi E & Meade MA. Disparities in access to health care among adults with physical disabilities: Analysis of a representative national sample for a ten-year period. *Disability and Health Journal,* 2015; 8(2):182-190.
33. Singh Ospina N, et al. Eliciting the patient's agenda-secondary analysis of recorded clinical encounters. *Journal of General Internal Medicine*, 2019;34:36-40. doi.org/10.1007/s11606-018-4540-5
34. Schiff GD, et al. Ten principles for more conservative, care-full diagnosis. *Annals of Internal Medicine*, 2018;169(9):643-645.
35. Singh H, et al. Measures to improve diagnostic safety in clinical practice, *Journal of Patient Safety*: Dec. 2019;15(4):311-316.
36. Bradford A, et al. Towards diagnostic safety in high reliability organizations: Translating priorities into action. Veterans Administration's *Forum* - translating research into quality healthcare for veterans, Summer 2020.
37. Iezzoni LI, et al. U.S. physicians' knowledge about the Americans with Disability Act and accommodation of patients with disability. *Health Affairs*, Jan. 2022;41(1). doi.org/10.1377/hlthaff.2021.01136
38. Michigan Health & Hospital Association (MHA) Keystone Center. Eliminating disparities to advance health equity and improve quality. July 2020.
39. The Opportunity Agenda. Ten tips for putting intersectionality into practice. The Opportunity Agenda website. Last updated 2017.
40. Morris MA, et al. Implementation of collection of patients' disability status by centralized scheduling. *Joint Commission Journal of Quality and Patient Safety*, Oct. 2021;47(10):627-636.
41. Mudrick NR, et al. Can disability accommodation needs stored in electronic health records help providers prepare for patient visits? A qualitative study. *BMC Health Services Research,* 2020;20:958 doi.org/10.1186/s12913-020-05808-z
42. Konerman MA, et al. Impact of an electronic health record alert in primary care on increasing hepatitis C screening and curative treatment for baby boomers. *Hepatology*, Dec. 2017; 66(6):1805-1813.

Joint Commission Requirements Addressing Disparities and Disability Issues

The following table presents the disparities and disability issues (e.g., discrimination, disability, communication, language, culture) addressed in Joint Commission accreditation requirements across programs. EPs = Elements of Performance

Requirement	Program
Prohibit Discrimination	Critical Access Hospital (RI.01.01.01, EP 29) Hospital (RI.01.01.01, EP 29)
Access to Support Individual	Critical Access Hospital (RI.01.01.01, EPs 2, 28) Hospital (RI.01.01.01, EPs 2, 28)
Collect Race and Ethnicity Data	Ambulatory – Primary Care Medical Home (PCMH) (RC.02.01.01, EP 25) Behavioral Health – Behavioral Health Home (BHH) (RC.02.01.01, EP 26) Critical Access Hospital – PCMH (RC.02.01.01, EP 25) Hospital (RC.02.01.01, EP 25)
Collect Language Data, including: • Language and Communication Needs • Preferred Language Data	Ambulatory (RC.02.01.01, EP 1) Assisted Living Communities (RC.02.01.01, EP 1) Behavioral Health (CTS.02.02.01, EP 1; RC.02.01.01, EP 1) Critical Access Hospital (RC.02.01.01, EP 1) Home Care (RC.02.01.01, EP 1) Hospital (RC.02.01.01, EP 1) Nursing Care Center (RC.02.01.01, EP 1) Office-Based Surgery (RC.02.01.01, EP 1)
Address Language Needs: • Respect the Need for Effective Communication • Identify and Address Communication Needs • Meet Communication Needs • Provide Interpreter and Translation Services • Address Vision, Speech, Hearing Needs	Ambulatory (PC.02.01.21, EPs 1-2; RI.01.01.01, EP 5, RI.01.01.03, EPs 1-4) Assisted Living Communities (RI.01.01.03, EPs 1, 3) Behavioral Health – BHH (CTS.03.01.03, EPs 21, 22], RI.01.01.03, EP 1-3) Critical Access Hospital (PC.02.01.21, EPs 1-2; PC.02.03.01, EP 1; RI.01.01.01, EP 5; RI.01.01.03, EPs 1-3) Home Care (PC.02.03.01, EPs 1 and 3; RI.01.01.01, EP 5; RI.01.01.03, EPs 1-3, 7, 8) Hospital (PC.02.01.21, EPs 1-2; PC.02.03.01, EP 1; RI.01.01.01, EP 5; RI.01.01.03, EPs 1-3) Nursing Care Center (PC.02.03.01, EP 1; RI.01.01.03, EPs 1-3) Office-Based Surgery (RI.01.01.03, EP 3)
Address Health Literacy Needs	Ambulatory – PCMH (PC.02.03.01, EPs 30-31) Behavioral Health – BHH (CTS.04.01.03, EPs 25, 26) Critical Access Hospital – PCMH (PC.02.03.01, EPs 30-31) Hospital – PCMH (PC.02.03.01, EPs 30-31)
Address Cultural Needs	Ambulatory (RI.01.01.01, EP 6) Assisted Living Communities (RI.01.01.01, EP 6) Behavioral Health (RI.01.01.01, EP 6) Critical Access Hospital (PC.02.03.01, EP 1; RI.01.01.01, EP 6) Home Care (RI.01.01.01, EP 6) Hospital (PC.02.03.01, EP 1; RI.01.01.01, EPs 6) Nursing Care Center (RI.01.01.01, EP 6)
Qualifications for Language Interpreters and Translators	Hospital (HR.01.01.01, EP 1, Note 4)
Address Patient Rights and Treat with Dignity and Respect	Ambulatory (RI.01.01.01, EPs 1, 4) Assisted Living Communities (RI.01.01.01, EP 4) Behavioral Health (RI.01.01.01, EPs 1, 4) Critical Access Hospital (RI.01.01.01, EPs 1, 4) Home Care (RI.01.01.01, EPs 1, 4) Hospital (RI.01.01.01, EPs 1, 4) Nursing Care Center (RI.01.01.01, EP 4)

Address Complaints	Ambulatory (RI.01.07.01, EPs 1-7) Assisted Living (RI.01.07.01, EPs 1-7) Behavioral Health (RI.01.07.01, EPs 1-7) Critical Access Hospital (RI.01.07.01, EPs 1-7) Home Care (RI.01.07.01, EPs 1-7) Hospital (RI.01.07.01, EPs 1-7) Nursing Care Center (RI.01.07.01, EPs 1-7) Office-Based Surgery (RI.01.07.01, EPs 1-7)
Plan for Fire Response	Ambulatory (EC.02.03.01, EP 9) Assisted Living (EC.02.03.01, EP 9) Behavioral Health (EC.02.03.01, EP 9) Critical Access Hospital (EC.02.03.01, EP 9) Home Care (EC.02.03.01, EP 9) Hospital (EC.02.03.01, EP 9) Laboratory (EC.02.03.01, EP 9) Nursing Care Center (EC.02.03.01, EP 9) Office-Based Surgery (EC.02.03.01, EP 9)
Provide Safe, Functional Environment	Ambulatory (EC.02.06.01, EP 1) Assisted Living (EC.02.06.01, EP 1) Behavioral Health (EC.02.06.01, EP 1) Critical Access Hospital (EC.02.06.01, EP 1) Home Care (EC.02.06.01, EP 1) Hospital (EC.02.06.01, EP 1) Laboratory (EC.02.06.01, EP 28,30) Nursing Care Center (EC.02.06.01, EP 1) Office-Based Surgery (EC.02.06.01, EP 1)
Manage Environment During Construction	Ambulatory (EC.02.06.05, EP 1,2) Assisted Living (EC.02.06.05, EP 1,2) Behavioral Health (EC.02.06.05, EP 1,2) Critical Access Hospital (EC.02.06.05, EP 1,2) Hospital (EC.02.06.05, EP 1,2) Laboratory (EC.02.06.05, EP 1) Nursing Care Center (EC.02.06.05, EP 2)
Address Integrity of Egress	Ambulatory (LS.03.01.20, EPs 3, 5, 6) Assisted Living (LS.02.01.20, EPs 10, 12, 14) Behavioral Health (LS.02.01.20, EPs 9, 10, 12-14, 16, 24, 40-42) Critical Access Hospital (LS.02.01.20, EPs 9, 10, 12-14, 16, 24, 40-42) (LS.03.01.20, EPs 3, 5, 6) Home Care (LS.02.01.20, EPs 9, 10, 12-14, 16, 24, 40-42) Hospital (LS.02.01.20, EPs 9, 10, 12-14, 16, 24, 40-42) (LS.03.01.20, EPs 3, 5, 6) Nursing Care Center (LS.02.01.20, EPs 10, 12, 14)
Provide Fire Alarm Systems	Ambulatory (LS.03.01.34, EPs 1, 4, 5) Assisted Living (LS.02.01.34, EPs 1, 5) Behavioral Health (LS.02.01.34, EPs 1, 4, 5) Critical Access Hospital (LS.02.01.34, EPs 1, 4, 5) (LS.03.01.34, EPs 1, 4, 5) Home Care (LS.02.01.34, EPs 1, 4, 5) Hospital (LS.02.01.34, EPs 1, 4, 5) (LS.03.01.34, EPs 1, 4, 5) Nursing Care Center (LS.02.01.34, EPs 1, 4, 5)
Plan for Emergency Operations	Ambulatory (EM.02.01.01, EP 15) Critical Access Hospital (EM.12.01.01, EPs 2, 3) Home Care (EM.02.01.01, EP 15) Hospital (EM.12.01.01, EPs 2, 3 – Effective 7/1/2022)
Plan for Communicating During Emergencies	Assisted Living (EM.02.02.01, EP 5) Critical Access Hospital (EM.12.02.01, EP 2) Home Care (EM.02.02.01, EP 5) Hospital (EM.12.02.01, EP 2 – Effective 7/1/2022)

