Compliance, Risk Management, and Quality Assurance
How to Play in the Same Sandbox

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Objectives

♦ Define Compliance, Risk, and Quality
♦ Descriptions of each department and roles of each position specific to acute care setting
♦ Where the job duties converge and diverge
♦ Goals for each department
♦ Provide examples and ideas on how to handle issues when they arise – and why we need to be on the same page
Let’s Have a Play Date

♦ Compliance, Risk Management and Quality Assurance overlap in daily duties and share goals
♦ Their functions deal with patient care, documentation, and medical services
♦ Data and outcomes are analyzed, audited, and amended in order to increase patient satisfaction, patient outcomes, and payment for services by Federal and State programs
♦ Main goals are to promote service excellence and meet Federal, State, and Accreditation standards, and to ensure all services are rendered appropriately for payment
♦ Although the duties and goals overlap, differences in the processes and audience are most notable

Definitions

♦ Compliance
♦ Risk Management
♦ Quality Assurance
Compliance

♦ Conforming to a rule, policy, standard, or law
♦ The OIG guidance tells us that Compliance Programs are
  – intended to help develop internal controls that promote
    adherence to applicable Federal and State law, and the program
    requirements of Federal, State, and private health plans

Risk Management

♦ Is a function that considers patient safety, quality assurance, and
  patients’ rights
♦ The potential for risk permeates all aspects of healthcare, including
  medical mistakes, electronic record keeping, provider
  organizations, and facility management
♦ The Joint Commission, defines risk management in healthcare as
  “(c) clinical and administrative activities undertaken to identify,
  evaluate, and reduce the risk of injury to patients, staff, and visitors
  and the risk of loss to the organization itself”
Quality Assurance

♦ Is a program for the systematic monitoring and evaluation of the various aspects of the hospital to ensure that standards of quality are being met

♦ CMS clearly states that quality healthcare for people with Medicare is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS)


Benefits of Playing Together

Let’s Share the Sandbox
Togetherness

♦ Working together will:
  – Create efficiency of scale
  – Lessen redundancy
  – Promote achievement of goals
  – Diminish the risk of “False Claims Act” (FCA) action
    • Accurate reporting will ensure quality-based reporting requirements are met

Togetherness

♦ If Compliance, Risk Management, and Quality Assurance worked together, there would be:
  – Increase in patient satisfaction
  – Better quality outcomes
  – Decrease in malpractice
  – Increase in compliance with billing
  – Better documentation to support medical necessity
  – Appropriate payment for services rendered
What Should Be Shared And Why?

♦ Data collected on Present on Admission and Denials
  – Is there a pattern?
  – Do the doctors need to be educated?
    • Did we miss a diagnosis?
  – Is it on the OIG Work Plan?

What Should Be Shared And Why?

♦ Never Events
  – Did we submit claims
    • Did we get paid?
  – What was the event?
  – Is it subject to malpractice?
  – Should Compliance and Internal Audit monitor claim submission?
What Should Be Shared And Why?

♦ Other Quality Measure results reported to CMS and the State compared to billed services:
  – Ensure that the provider is compliant with the government’s goals of aligning quality with payment
  – Ensure that the provider is only billing for services that meet these quality standards in order to avoid FCA questions

What Should Be Shared And Why?

♦ Department of Health and other agency visits related to Patient Care/Quality Issues
  – What quality measures could be affected?
  – Are the Medicare Conditions of Participation violated?
  – Is there a pattern?
  – Do we open ourselves up to Quality of Care OIG reviews/potential CIA?
Job Functions And Overlap

I want to take my pad and paper and go home!

The Compliance Officer

- Develops, initiates, maintains, and revises policies and procedures for the Compliance Program and its related activities (HIPAA Privacy)
- Manages day-to-day operation of the Program
- Develops and periodically reviews and updates the Code of Business Conduct and Ethics
- Collaborates with other departments (e.g., Risk Management, Internal Audit, Finance, etc.) to direct compliance issues to appropriate existing channels for investigation and resolution
- Consults with the Medical Center’s attorney, as needed
The Compliance Officer

♦ Responds to alleged violations of rules, regulations, policies, procedures, and Standards of Conduct by recommending or initiating investigative procedures
♦ Coordinates outside agency reviews related to payment and other State and Federal reviews
♦ Develops and oversees a system for uniform handling of such violations
♦ Acts as an independent review and evaluation resource to ensure that compliance issues/concerns within the organization are being appropriately evaluated, investigated, and resolved

The Compliance Officer

♦ Monitors and coordinates compliance activities of other departments, as needed
♦ Identifies potential areas of compliance vulnerability and risk
♦ Develops/implements corrective action plans for resolution of problematic issues
♦ Provides general guidance on how to avoid or deal with similar situations in the future
♦ Reports directly to the CEO and Board at least quarterly, and as needed
♦ Provides education to all staff
The Risk Manager

♦ Consults with legal counsel on matters involving hospital professional liability
  – Oversee litigation matters
  – Determine whether a claim should be paid, litigated, or denied
♦ Manages insurance programs for all hospital coverage
♦ Monitors incidents and claims reporting system
♦ Determines allocation of risk through the purchase of commercial insurance, deductibles, self-insurance fund, and evaluation of financial feasibility

The Risk Manager

♦ Responsible for hospital liability program components:
  – Professional liability
  – General liability
  – Motor vehicle liability
  – Property
  – Directors and officers
  – Fiduciary liability (ERISA, OSHA, HIPAA, Joint Commission)
  – Medicare and Medicaid regulations
  – Healthcare regulations
  – State reporting requirements
  – Patient safety
  – Root Cause Analysis (RCA)
The Risk Manager

- Understand, thoroughly, legal defense, depositions, production of documents and interrogatories
- Coordinate and oversee medical peer-review and institutional committees on issues related to standard of care (RCA)
- Oversee/manage system for tracking and trending of generic screening of potentially high-risk behavior leading to patient, staff, and visitor injuries
- Oversee/manage the appropriate operational linkages to correct actual and potential problems that have been identified

The Risk Manager

- Oversee and manage formal program for ongoing education for all hospital staff, including physicians
- Respond to crisis situations that have risk management implications and assist staff with problem solving
- Supervise all professional and support staff in risk management department
- Monitor department budget and assets of self-insurance funds
- Represent department on appropriate hospital committees
- Report to CEO
The Quality Assurance Director

♦ Oversee the duties and functions necessary to assure regulatory and accreditation compliance
♦ Advise the Hospital and Board on these issues
♦ Coordinate regulatory survey and reporting activities within the organization, including staff compliance with patient safety goals and compliance with Joint Commission and CMS standards
♦ Collaborate with cross-functional teams to deliver enterprise quality solutions
♦ Monitor, daily, the QA process to insure that the methods are being followed

The Quality Assurance Director

♦ Education of staff
♦ Develop client-driven QA metrics and targets
♦ Develop and monitor unit/department specific QA/PI plans, initiating appropriate action to improve outcomes
♦ This position has cross accountability and interactions with Risk Management, Education, Medical, and Compliance
♦ Ensure Compliance with all Medicare and Medicaid Quality Initiative Programs
Overlap

- Ensure Compliance with all Medicare and Medicaid Quality Initiative Programs
- Ensure the information provided to CMS and the State is accurate and reflects the patient care and status
- Collaboration on investigation and resolution of issues (i.e., Patient Care, Quality of Care, Documentation, CMS Reporting)
- Compliance with CMS Conditions of Participation and Joint Commission as well as State standards
- Staff Education

What Are The Goals For Each Department?

And what toys can they share?
Compliance

♦ The main goal of the Compliance Program for any Provider is “to prevent fraud and abuse, mitigate any identified issues that may crop up through reporting or auditing, to make sure that repayment is made when necessary, and that there is a corrective action plan in place to reduce the risk of continued occurrence”

Risk Management

♦ Risk Management proactively identifies risks and minimizes risks, when possible, by eliminating hazardous activities or practices
♦ When it is not possible to eliminate the potentially unsafe activities, then the goal is to proactively minimize and mitigate those risks by altering the processes/systems to make them safer
Risk Management

♦ If an adverse event does occur, Risk Management implements a system so it will not result in significant harm or loss
♦ Healthcare Risk Management seeks to improve safety for all (patients, visitors, staff, volunteers, etc.)
♦ Ultimately, the goal is to improve patient quality of care, providing better protection of the organization’s financial and reputational assets

Quality Assurance

♦ The goals of a quality assurance program are to:
  – Prevent problems from occurring
  – Detect and correct issues when they occur
  – Encourage higher standards of care
  – Eliminate or educate poor practitioners and providers
  – Improve the average level of practice
  – Reward excellence
## Examples

<table>
<thead>
<tr>
<th>Program</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ The Hospital Inpatient Quality Reporting</td>
<td>♦ Data is reported on the Hospital Compare Website</td>
</tr>
<tr>
<td>♦ Value Based Purchasing</td>
<td>- Is the information correct?</td>
</tr>
<tr>
<td></td>
<td>- Can it impact quality of care?</td>
</tr>
<tr>
<td></td>
<td>♦ Payments are made based on specific quality measures</td>
</tr>
<tr>
<td></td>
<td>- If quality measures are not met, how much risk is there for quality issues with JC and CoP?</td>
</tr>
</tbody>
</table>
### Examples

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<tr>
<td>♦ Readmission Reduction</td>
<td>♦ Reduced payments for higher than expected readmission rates for specific conditions</td>
</tr>
<tr>
<td></td>
<td>− If patients are readmitted, does this impact quality?</td>
</tr>
<tr>
<td></td>
<td>− What are we not doing right?</td>
</tr>
<tr>
<td>♦ Present on Admission</td>
<td>♦ Reduced DRG payment for complications or hospital acquired conditions</td>
</tr>
<tr>
<td></td>
<td>− Are the bills going out correctly?</td>
</tr>
<tr>
<td></td>
<td>− DRG Validation</td>
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### Examples

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<td>♦ Observation Status</td>
<td>♦ Reduced payment based on OP standards (big settlements)</td>
</tr>
<tr>
<td></td>
<td>− Large settlements and CIA’s related to incorrect use of IP status and Observation</td>
</tr>
<tr>
<td>♦ Program for Evaluating Payment Patterns Electronic Report (PEPPER)</td>
<td>♦ Contains hospital-specific data key areas associated with Medicare improper payments, DRG coding and/or admission necessity issues</td>
</tr>
<tr>
<td></td>
<td>− Can be used to identify outliers</td>
</tr>
</tbody>
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Potential False Claims
Another Reason To Play Nice!

♦ By submitting a claim to CMS for payment, the hospital is certifying that all conditions for payment are met
♦ CMS can mine quality data submitted by the hospital
♦ Who submits the quality data to CMS? Is it always accurate?

Potential False Claims
Another Reason To Play Nice!

♦ If claim is submitted for payment and the government’s definition of quality is not met, the claim may be deemed fraudulent based on the theory of worthless service
♦ The alignment of payment with quality