AMERICAN HEALTH CONSULTANTS

COMPLIANCE HOTLINE™

THE NATION'S ESSENTIAL ALERT FOR HEALTH CARE COMPLIANCE OFFICERS

MONDAY
APRIL 29, 2002

HHS Inspector General focuses spotlight on quality of care

The use of administrative sanction likely to increase, according to Office of Inspector General

Health and Human Services Inspector General (IG) Janet Rehnquist has been on the job nine months now, and **Lew Morris**, IG for legal affairs in the Office of Inspector General (OIG), says she has made improving quality of care one of her top priorities. "To that end, we are going to be putting more and more resources into investigations, audits, and inspections," he told attendees at the Philadelphia-based Health Care Compliance Association's annual meeting in Chicago April 23.

About six weeks ago, Morris says the OIG spent two days meeting with counterparts in the Department of Justice as well as state and local enforcement authorities in an effort to develop tools to help identify poor quality of care and poor long-term care, along with effective responses to those problems.

"Closing down a facility does not always advance the best interests of residents," says Morris. "Oftentimes, it has disastrous effects." He says a better method often is to remove the "bad actors" at the top of the organization.

To date, most quality-of-care issues have been limited to long-term care facilities. But that may be changing. "I think we are expanding into other kinds of custodial institutions and have done that in the past," says **James Sheehan**, U.S. attorney and chief of the civil division in Philadelphia. He

*See **Quality of care**, page 2*

How to effectively utilize on-line compliance training

"Training is a challenge," says **Susie Draper**, corporate compliance administrator and privacy officer for Intermountain Healthcare, based in Salt Lake City. "In health care, it poses some extra challenges," she argues. Those include scheduling, making sure the content is interesting and applicable to a variety of employees, and ensuring widespread participation.

Unfortunately, what often happens with health care education is "spray and pray," says Draper. "You spray a ton of information at your audience, and then you pray that something sticks," she explains. "You hope at least it makes it through the

*See **On-line training**, page 3*

PROs playing expanded role in quality of care

Quality of care has taken on a higher profile in a variety of ways, says **Alice Gosfield**, president of Gosfield and Associates in Philadelphia. Not only is this clearly detailed in the Department of Health and Human Services' Office of Inspector General's (OIG) Work Plan, but the involvement of peer review organizations (PRO) is increasing dramatically.

PROs always have had a powerful sanction authority, says Gosfield. PROs, which now are frequently referred to as quality improvement organizations, have retained the authority to recommend sanctions to exclude providers from Medicare. Moreover, their determinations are binding on claims payment agencies.

However, Gosfield says PROs now are moving across all sites of care with specific performance measures. In addition, they review all cases that come under the Emergency Medical Treatment and

*See **PROs and quality**, page 2*

Quality of care

Continued from page 1

says the issue of quality in hospitals is going to be "more difficult" for the government to get to directly but "not impossible."

Morris reaffirmed a recent warning by OIG Senior Counsel Mac Thornton that the OIG plans to expand its use of administrative authorities. **(See *Compliance Hotline,* April 15, 2002.)** While most providers are familiar with the OIG's exclusion authorities, the office also wields a range of civil monetary penalties (CMP) that Morris says "go right to the heart" of the type of program abuses the OIG is witnessing.

In the exclusion context, that means going after those at the top of organizations who are responsible for poor care, he says. "We have the authority to exclude anyone who causes or provides services which do not meet professionally recognized standards of care," he asserts.

"We also have a CMP that addresses the payment of kickbacks," Morris says. That CMP allows the OIG to collect a $50,000 per-violation penalty as well as three times the amount of the kickback for every violation of that criminal statute. While there are many cases that probably should be pursued criminally, there are others where that may be "over the top," he adds. "We are going to start taking back money from those people who are engaged in kickbacks."

According to **Linda Waszynski**, the assistant U.S. attorney in Chicago, CMPs are an important option for government prosecutors because U.S. Attorneys cannot prosecute every case. Some cases instead are referred back to the IG to determine if they warrant a CMP or some other administrative action. "It becomes harder and harder as there are more and more health care fraud cases that come to the forefront," she says.

The majority of providers will never deal with a U.S. attorney, she adds. More likely, they will deal with someone from HHS, a contractor, or a peer-review organization when questions about coding and overpayment arise.

According to Morris, HHS Secretary Tommy Thompson also has asked the IG to devote additional resources to investigate several areas surrounding grant administration. He says there are concerns about weaknesses in the selection process and lax monitoring of grant programs and progress as well as poor performance in general.

"We do a fair amount of work in the grant area as it is," says Morris. "But I think you are going to see that our auditors and our evaluators, in particular, are going to be looking at how the grant process works and see if we can't find ways to improve the integrity of the system."

According to Waszynski, the fact so many providers now have compliance plans now brings a whole different perspective to the cases that U.S. attorneys look at. "I am seeing far more voluntary disclosures," she reports.

"Actually, I see too many voluntary disclosures as an assistant U.S. attorney," says Waszynski. She contends that most of the voluntary disclosures she receives actually should go to the contractors because, in all but the most limited situations, they turn out to be nothing more than overpayments. ■

PROs and quality

Continued from page 1

Active Labor Act statutes and are obligated to review beneficiary complaints that are referred by the regional office. "They are profoundly significant," she asserts.

Changing the name from a peer review organization to a quality improvement organization is more than just semantics, says **Phil Dunne**, chief executive officer of the Texas Medical Foundation in Austin.

(Continued on page 3)

Compliance Hotline™ is published every two weeks by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. *Compliance Hotline*™ is a trademark of American Health Consultants®.

SUBSCRIBER INFORMATION
Please call **(800) 688-2421** to subscribe or if you have fax transmission problems. Outside U.S. and Canada, call **(404) 262-5536**. Our customer service hours are 8:30 a.m. to 6 p.m. EST.

Dunne says that PROs actually have been increasing the emphasis on quality since 1994. "Each series of contracts that we [execute] with CMS has increased the interest in quality," he reports. What often has not been noticed is that PROs are increasing their work in the area of compliance, he adds.

An important area that sometimes is overlooked is documentation, says Dunne. "It has to be documented as to what you did so that we can identify the necessity, the quality, and the correctness of the billing procedure," he explains.

Gosfield says providers should use clinical practice guidelines as the foundation for everything including price, hiring, human resource allocation, and capital budgets. Most importantly, she says if providers document based on clinical practice guidelines, they will eliminate much of the compliance exposure not only with respect to quality but also overutilization, underutilization, false-claims liability, and malpractice liability.

PROs' interest in quality of care and quality improvement may be growing, but they remain interested in medical necessity as well, Dunne says. "We are still going to be interested in your monitoring and audit functions, looking at one-day stays and same-day readmissions," he says. PROs also will continue to have an interest in assigning patients the correct status and how that is billed to a government program as well as admission necessity and diagnosis-related group projects.

According to Gosfield, regardless of the type of health care enterprise, the role of physicians in this area is imperative. Providers can work on patient safety in terms of hospital or nursing home systems, but the role of physicians remains central. "Doing something that makes the right thing the easy thing to do is critical," she says.

Gosfield says compliance departments all too often function "off to one side" and are not well integrated into the business case for the company. By moving into a more collaborative frame of reference that seeks to use all science available in a standardized and clinically relevant fashion designed to help physicians build effective patient relationships, she says an entirely new culture can be established. "That will help make compliance part of the fundamental mission of any health care organization," Gosfield says. ■

On-line training

Continued from page 1

course evaluation and in compliance through the competency testing."

According to Draper, the objective of compliance officers should be to tailor that information to your audience, often using a new on-line approach.

She points out that different generations, and even many among the same generation, have very different problem-solving and learning styles. For example, some employees are more audio-oriented while others are more visual. Some employees prefer to manage their own learning more than others. Everyone wants their education to be meaningful, but the definition of "meaningful" will vary, she adds.

According to Draper, there are some distinct advantages for new on-line training strategies. For example, the interactive style often makes it very appealing to a variety of different generations. "Learners can choose the sequence; it is not linear," she says.

Many employees may want to be able to choose the sequence of their learning and access the web as an additional resource to augment their learning, she adds.

Ease of use is another advantage, Draper says. She says Intermountain has employed a number of different pilot programs in its on-line training. Some were rudimentary while others proved ineffective. Now that the interfaces are easier to use, effectiveness also has improved, she reports.

With 22 hospitals and 100 clinics throughout Utah and Idaho, consistency sometimes is a challenge, Draper says. "You sometimes are unable to structure the information and maintain its quality," she says. "We have looked to on-line or electronic training as a means to standardize the quality of information."

Nothing frustrates an employee audience more than believing it is getting only half the story, adds Draper. In a classroom environment, lessons are often cut short and instructions can be unclear. "We found that web-based or electronic training has made it much easier to structure information,

(Continued on page 4)

and employees have had greater satisfaction," she says.

Draper says the most important feature of web-based training is that it is "learner-controlled." Employees do not have control over many areas, she explains. "If you can develop an educational seminar so that they navigate the pathways and control the sequence of information, they will be able to determine the level of detail they confront."

Within Intermountain's system, she says employees can opt for only bulleted information or follow it all the way to the *Federal Register,* if they desire. They also can select the presentation mode, Draper adds.

Another advantages of on-line training is that it always is available. That is very important, since one of the initial challenges often is scheduling. On-line training also is self-paced, and Draper says Intermountain has experienced greater comprehension as a result.

However, there are other challenges in addition to generational preferences, warns Draper. Some employees, such as nurses, already spend considerable time on-line and are not anxious to spend time on-line learning. In addition, not all organizations are well suited to meet the demands of on-line training, and some organizations have greater computer penetration than others. Some employees may have Internet access but not intranet access, she adds.

Dan Roach, vice president and corporate compliance officer at San Francisco-based Catholic Healthcare West (CHW), which operates nearly 50 acute-care facilities throughout California and the West Coast, says CHW explored a variety of options for training and found that some worked far better than others. "We ran into some real hurdles and some unanticipated hurdles," he reports.

Roach says the first question to address when developing an on-line capability or on-line training resource is the substantive content and the target audience. "Don't assume that content is accurate," he warns. Some content may have been developed for a certain region of the country or developed using certain fiscal intermediary or carrier data, or local medical review policies.

"Those can vary significantly in different parts of the country," he warns. Some variation may be unavoidable if a broad-based program is going to be developed. But employees must at least be alerted to that possibility, he says.

Compliance officers also should pay close attention to how the material was developed, how it is maintained, and how it is updated, Roach says. "Health care is a rapidly changing environment," he points out. "You don't want to buy something that is going to remain stale and become rapidly outdated."

Roach also advises prospective purchasers to check references to find out what other organizations are doing and what their experience has been as well as what hurdles they have encountered in implementing a specific program. ■

HCCA moves ahead with effectiveness standards

The Philadelphia-based Health Care Compliance Association (HCCA) announced April 23 that it is initiating a public- and private-sector effort to develop "Generally Accepted Performance Measurement Standards" for health care compliance programs. The objective is to establish standards for the health care industry to measure compliance program performance and quantify the return organizations achieve on their investment in compliance programs.

HCCA has appointed **L. Stephan Vincze**, a member of the HCCA board of directors and ethics and compliance officer for TAP Pharmaceutical Products in Lake Forest, IL, to chair the Compliance Program Measurement Task Force and lead the project.

According to Vincze, the keys to success are shifting the focus from criminal sentencing to "good business practice," from abstract data concepts to practical concrete tools, and from an "us-against-them" mentality to a genuine public-private sector partnership.

The first segment of the health care industry to be explored is hospital compliance programs. HCCA plans to draft and review hospital program measurement products and provide drafts to the HCCA Task Force, OIG, and Centers for Medicare & Medicaid for review by August 2002 and release draft hospital measurement checklists for public review and comment by October 2002. ■