

Can compliance programs help physicians improve quality of care?

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Outline

- Systems and culture
 - The new coding rules
 - Terms of engagement
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Systems and culture

The new quality revolution

- To err is human (IOM report)
 - Crossing the quality chasm (IOM report)
 - 98,000 die in hospitals because of preventable medical errors
 - Like a 747 going down, killing everyone on board, every day
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Crossing the quality chasm

- Safety flaws are unacceptably common, but the effective remedy is not to browbeat the health care workforce by asking them to try harder to give safe care. Members of the health care workforce are already trying hard to do their jobs well. In fact, the courage, hard work, and commitment of doctors, nurses, and others in health care are today the only real means we have of stemming the flood of errors that are latent in our health care systems.
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Crossing the quality chasm

- As medical science and technology have advanced at a rapid pace, however, the health care delivery system has floundered in its ability to provide consistently high-quality care to all Americans. Research on the quality of care reveals a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately.
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Translation

- Medicine is now too complicated to expect humans, unassisted, to provide safe and proper care
 - The system should be designed with the primary goal of protecting patients
 - Culture, procedures, pathways, computer assistance
 - Encourage reporting of issues
 - Place rules on potentially dangerous activities
 - Require compliance with best practices unless documentation shows reason to deviate
 - Provide decision support
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Goals of a compliance program (USSC)

- To have an effective compliance and ethics program ... an organization shall—
 - (1) exercise due diligence to prevent and detect criminal conduct; and
 - (2) otherwise promote an organizational culture that encourages ethical conduct and a commitment to quality.
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Goals of quality program

- To have an effective quality improvement program ... an organization shall—
 - (1) exercise due diligence to prevent and detect medical errors and deviations from best practice; and
 - (2) otherwise promote an organizational culture that encourages safe conduct and a commitment to quality.
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'7 elements' and quality

1. Implementing written policies and procedures;
 2. Designating a quality officer and quality committee;
 3. Conducting effective training and education;
 4. Developing effective lines of communication;
 5. Conducting internal monitoring and auditing;
 6. Enforcing standards through well-publicized disciplinary guidelines (rarely); and
 7. Responding promptly to detected problems and undertaking corrective action.
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There's more to safety culture than just that

- Looking for system causes, rather than focusing on human error
 - Analysis of near misses
 - Just culture: discipline only when the human, not the system, was the major problem
 - Evil: police
 - Drunk: medical intervention (e.g. drug counseling)
 - Stupid: move to a position where she can function safely
 - Reckless: depends upon the degree—police, discipline, termination
 - Etc.
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Transferable skills

- Developing data streams to track quality (i.e., introduce coding for quality measures)
 - Chart reviews
 - Training delivery
 - Communication lines
 - Monitoring programs
 - Response plans and follow up
 - Etc.
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Just be careful!

- See rules of engagement, later in this talk



The new coding rules

Value based purchasing — CMS' vision

- The Centers for Medicare & Medicaid Services (CMS) has articulated a vision for health care quality—*the right care for every person every time*. To achieve this vision, CMS is committed to care that is safe, effective, timely, patient-centered, efficient, and equitable. Medicare's current payment systems reward quantity, rather than quality of care, and provide neither incentive nor support to improve quality of care. Value-based purchasing (VBP), which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care.
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PQRI as an example of VBP

- In general, the quality measures consist of a numerator and a denominator that permit the calculation of the percentage...
 - The denominator population is defined by certain ICD-9 and CPT Category I codes specified in the measure that are submitted by eligible professionals as part of a claim ...
 - If the patient does fall into the denominator population, the applicable ... code ... that defines the numerator should be submitted.
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PQRI

- Where a patient falls in the denominator population but specifications define circumstances in which a patient may be excluded from the measure's denominator population, ... modifiers ... are available to describe medical, patient, system, or other reasons for such exclusion. Where the performance exclusion does not apply, a [code] may be used to indicate that the process of care was not provided for a reason not otherwise specified.
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A very brief example

- Simplified for presentation. See CMS PQRI site for details:
http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage
 - Similar challenge as was E/M coding—just over 130 different variations instead of a few dozens
 - Applicable measures vary by specialty
 - Most docs will do three different measures if they participate, as can achieve maximum bonus with three
 - Bonus up to 1.5% of Medicare payment during the period
 - Currently, pay for reporting
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Oral Antiplatelet Therapy ... for Patients with Coronary Artery Disease

- Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy
 - An ICD-9 diagnosis code for coronary artery disease and a CPT E/M service code are required to identify patients for denominator inclusion (list of codes omitted from this presentation)
 - Append a modifier ... to report **documented** circumstances that appropriately exclude patients from the denominator.
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Numerator of oral antiplatelet therapy

- Patients who were prescribed oral antiplatelet therapy
 - "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
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Terms of engagement

Don't do other people's jobs

Don't do other people's jobs

- Many organizations already have a quality of care review process
 - Intervention by compliance officer may be seen as ill-informed interference
 - If you do it, others won't
 - Refer findings with potential quality issues
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Refer findings with potential quality issues

- Incorrect documentation
 - Insufficient
 - Invented
 - Incorrect utilization/medical necessity
 - Underutilization
 - Overutilization
 - EMTALA
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**If a serious gap exists, make
sure it gets filled**

Fill the gaps!

- First step is to find them
 - Learn what quality control activities occur
 - Find out what *should* occur
 - Evaluate adequacy of the activities
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Adequacy of quality control activities

- Group think
 - Conflicts of interest
 - Domination by problem person
 - No frank discussions
 - No statistics
 - Nothing happens
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Keep a finger on the pulse

- Sit on quality oversight committee
 - Meet periodically with person(s) responsible for quality of care monitoring
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Find a champion

Find a champion

- Physicians don't think a bean counter knows beans about health care and won't obey
- Why can't you be effective by yourself?

Power and influence

- “Power is ... the potential ability to influence behavior, to change the course of events, to overcome resistance, and to get people to do things that they would not otherwise do. Politics and influence are the processes, the actions, the behaviors through which this potential power is utilized and realized.”

Pfeffer, Jeffrey. **Understanding Power in Organizations**

Power sources

- Hierarchical: organizational position
 - Reward: ability to give out rewards
 - Coercive: ability to mete out punishment
 - Expert: superior skills and knowledge
 - Referent: others' respect and admiration
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Hierarchical

- Ban on corporate practice of medicine in some states
 - Clinicians typically in separate hierarchy
 - Medical staff
 - Compliance officer typically has no hierarchical power
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Reward

- Typically not in the purview of compliance officers
 - Might get “compliance bonuses” built into compensation structure
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Coercive

- Can you directly punish a physician?
 - Can you affect her income?
 - Can you fire a physician?
 - State laws may have special protections for physicians, e.g., hearing rights
 - Faculty have special protections
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Expert

- Physicians view themselves, not you, as having superior skills and knowledge
 - What you know doesn't count: it's how much they value your knowledge that does
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Referent

- Do physicians view you as a role model?
 - Do you have charisma?
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Champion traits

- Seek a physician who has the power
 - Most physicians are passionately committed to good health care
 - Cultivate allies
 - Understand the power structure
 - Respected, knowledgeable
 - Active in medical staff organization
 - Has the “hammer”
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Questions?


