



*HCCA's 12<sup>TH</sup> ANNUAL* COMPLIANCE INSTITUTE

APRIL 13-16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

## Integrating Quality Auditing with Compliance Auditing

Terri Camp RN MHL, CQO/CNE  
Jefferson Healthcare  
Port Townsend, Washington



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373



### Objectives

Participants should be able to:

- Articulate why Quality of Care is a compliance issue, and the role of the Compliance Program in quality oversight
- Discuss how audits for quality of care can be integrated and/or accounted for in the compliance auditing process
- Demonstrate how resources can be maximized with an integrated auditing process



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

2

## Issue/Situation:

### OIG 2005 Guidance

#### Section E. Substandard Care

The OIG has authority to exclude any individual or entity from participation in Federal health care programs if the individual or entity provides unnecessary items or services (*i.e.*, items or services in excess of the needs of a patient) or substandard items or services (*i.e.*, items or services of a quality which fails to meet professionally recognized standards of health care) [...]

In reviewing the quality of care provided, hospitals must not limit their review to the quality of their nursing and other ancillary services. Hospitals must monitor the quality of medical services provided at the hospital by appropriately overseeing the credentialing and peer review of their medical staffs.

- <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

3

## Issue/Situation:

### National Quality Forum— “Hospital Governing Boards and Quality of Care: A Call to Responsibility”

#### – Principles for Hospital Boards of Trustees

1. “...hospital governing boards are responsible for ensuring the quality of healthcare provided in their institutions. To fulfill their role in ensuring quality, hospital governing boards should:
  - a. Ensure that quality is a paramount priority and a primary focus of board activities. Pragmatically, boards may wish to take a more active role in ensuring quality by beginning with a focus on patient safety, recognizing that **safety is a subset of quality** and the infrastructure needed to ensure safety is materially the same as that needed to ensure high quality...
  - d. Ensure that a system of **performance measurement** and quality improvement is in place and that **credible results** enable the evaluating of the organization’s effectiveness.

[www.qualityforum.org](http://www.qualityforum.org) December 2, 2004



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

4

## Issue/Situation

### **Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors**

“The heightened attention being given to health care quality measurement and reporting obligations also increasingly impacts the responsibilities of corporate directors. Indeed, quality is also emerging as an enforcement priority for health care regulators.”

[...] compliance with standards and regulations applicable to the quality of services delivered by health care organizations is essential for the lawful behavior and corporate success of such organizations.

<http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

5

## Issue/Situation:

Foley and Lardner, LLP, in a “Top Ten Compliance Issues for 2008” newsletter, listed *Quality* as

“the number one compliance challenge facing hospitals in 2008...Both payment and compliance challenges face providers and payors struggling with how to address not just the “inputs” to the health care system, but the “results” as well.”

[http://www.foley.com/publications/pub\\_detail.aspx?pubid=4603](http://www.foley.com/publications/pub_detail.aspx?pubid=4603)



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

6

## Background: “Safety is a subset of Quality”

Institute of Medicine Definition of Quality:

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

7

## Background: “Safety is a subset of Quality”

### **2003** Rand Study: The First National Report Card on Quality of Health Care in America

#### Key Findings

- Overall, adults received about half of recommended care
- Quality of care was similar in all of the [12] metropolitan areas studied
- Quality varied across conditions, and across communities for the same condition
- No community had consistently the best or worst quality
- All socio-demographic groups were at risk for poor care
- System-wide investments in health information technology, performance tracking, and incentives for improvement are needed to improve care

[http://www.rand.org/pubs/research\\_briefs/RB905f3-2/index1.html](http://www.rand.org/pubs/research_briefs/RB905f3-2/index1.html)



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

8

## Background: “Safety is a subset of Quality”

Quality and Safety defects can be seen as both errors of

Commission—(*Overuse/Misuse*)

- Substantive risk of preventable iatrogenic adverse events (Injuries caused by a medical intervention related to errors of planning or execution)

Omission— (*Underuse*)

- Substantive risk of preventable disease related adverse events (Injuries arising from the patient’s underlying disease that could have been prevented by optimal care)

<http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1525-1497.2005.0152.x?cookieSet=1>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

9

## Background: “Safety is a subset of Quality”

Commonwealth Fund—US Healthcare quality

“A scorecard on the U.S. health care system developed by the Commonwealth Fund in **2006** showed the following results, among others:

- For 37 key indicators for five health care system dimensions (quality, access, equity, outcomes and efficiencies), the overall U.S. score was 66 out of a possible 100.
- Efficiency was the single worst score among the five dimensions. For example, in 2000/2001, the U.S. ranked 16th out of 20 countries in use of electronic health records.
- The U.S. is the worldwide leader in costs.
- The U.S. scored 15th out of 19 countries in mortality attributable to health care services.
- Basic tools (*i.e.*, Health IT) are missing to track patients through their lives.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

10

## Background: "Safety is a subset of Quality"

### Commonwealth Fund—US Healthcare quality

- We do poorly at transition stages —hospital readmission rates from nursing homes are high; our reimbursement system encourages "churning."
- Improving performance in key areas would save 100,000 to 150,000 lives and \$50 billion to \$100 billion annually.

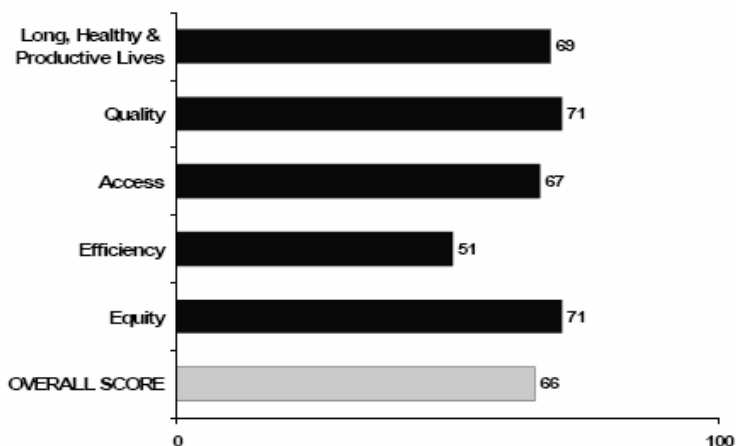
[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=401577](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=401577)  
(quoted in [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=401577](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=401577).)



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

11

### Scores: Dimensions of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

4



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

12

## Background: "Safety is a subset of Quality"

### Premier's Pay-for-Performance Study:

"Optimization of healthcare cost and quality is possible. Premier's Performance Pays study proves that when evidence-based processes are delivered, quality is higher and costs are lower. Premier's core competency is achieving the highest levels of quality while creating a cost-effective health system.

- Heart Bypass: Data show lower mortality rates for patients receiving better care
- Pneumonia: Data reveal lower hospital costs associated with patients receiving better care"

<http://www.premierinc.com/p4p>

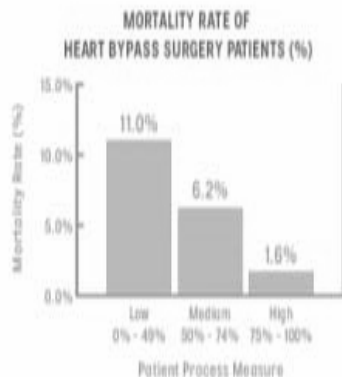


[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

13

## Background: "Safety is a subset of Quality"

**Heart Bypass:** Data show lower mortality rates for patients receiving better care.



**Pneumonia:** Data reveal lower hospital costs associated with patients receiving better care.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

14

## Background: "Safety is a subset of Quality"

### Five System Barriers to Achieving Ultrasafe Health Care

- René Amalberti, MD, PhD; Yves Auroy, MD; Don Berwick, MD, MPP; and Paul Barach, MD, MPH
- *Ann Intern Med.* 2005;142:756-764
- <http://www.annals.org/cgi/reprint/142/9/756>

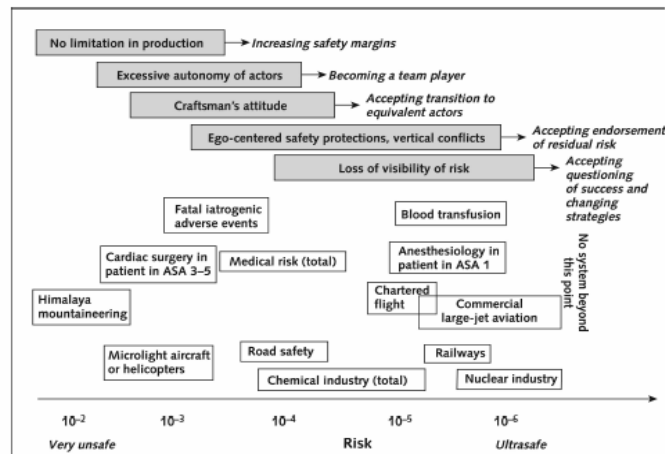


[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

15

## IMPROVING PATIENT CARE | Five System Barriers to Achieving Ultrasafe Health Care

Figure 1. Average rate per exposure of catastrophes and associated deaths in various industries and human activities.



The size of the box represents the range of risk in which a given barrier is active. Reduction of risk beyond the maximum range of a barrier presupposes crossing this barrier. Shaded boxes represent the 5 system barriers. ASA = American Society of Anesthesiologists.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

16

## Background: “Safety is a subset of Quality”

### Key Summary Points

1. In health care, the premium placed on autonomy, the drive for productivity, and the economics of the system may lead to severe safety constraints and adverse medical events.
2. Several key building blocks must be addressed before other solutions to the problem of unsafe medical care can be considered. Among these building blocks are the need to control maximum production, use of the equivalent actor principle, and the need for standardization of practices.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

17

## Background: “Safety is a subset of Quality”

### Key Summary Points

3. Safety in health care depends more on dynamic harmony among actors than on reaching an optimum level of excellence at each separate organizational level.
4. Open dialogue and explicit team training among health care professionals are key factors in establishing a shared culture of safety in health care.
5. The notion of a 2-tiered system of medicine may evolve logically by distinguishing between health care sectors in which ultra safety is achievable and sectors that are characterized by ambition, audacity, and aggressive efforts to rescue patients, in which greater risk is inherent in the goals.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

18

## Background: Culture

**A culture that is mindful about quality and safety will be mindful about compliance to standards and regulations.**

- High reliability cultures
  - Nuclear power industry
  - Aircraft carrier
  - Air Traffic Control
- “High reliability organizations—which have less than their fair share of accidents—recognize that human variability is a force to harness in averting errors, but they work hard to focus that variability and are *constantly preoccupied with the possibility of failure*”
  - Human Error, Models and Management, James Reason, BMJ 2000\
  - <http://www.bmj.com/cgi/content/full/320/7237/768>
- VA as example in Healthcare: “In 1995, the rate of Pneumococcal vaccination in eligible VA patients was 29%. Today, it is 90%. The trends are identical in each of the preventive services encompassed by the prevention index.”
  - <http://www1.va.gov/cprsdemo/docs/AJMCnovPrt2Perlin828to836.pdf>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

19

## Background: Current Issues

- Mandatory Adverse Event Reporting
  - Many states have adopted the National Quality Forum list of adverse events.
    - <http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf>
  - Find out what the requirements are in your state
- Disclosure when an event occurs
  - Joint Commission and ASHRM
    - <http://www.ashrm.org/ashrm/resources/files/Disclosure.2001.pdf>
  - AAFP
    - <http://www.aafp.org/online/en/home/policy/policies/c/clinicaloutcomes.html>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

20

## Background: Current Issues

- “Never Events”
  - CMS has adopted a list of events that will not be reimbursed
    - Object Left in Surgery
    - Air Embolism
    - Blood Incompatibility
    - Catheter-Associated Urinary Tract Infections (UTI)
    - Pressure Ulcers (Decubitus Ulcers)
    - Vascular Catheter-Associated Infection
    - Mediastinitis after Coronary Artery Bypass Graft Surgery
    - Hospital Acquired Injuries



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

21

## Background: Current Issues

- “Present on Admission” Coding
  - To support CMS’ non-reimbursement for “Never Events”
- Pay for Reporting/Pay for Performance
  - PQRI
    - <http://www.cms.hhs.gov/pqri/>
  - HCA/Hospital Compare; Home Health Compare
    - [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
    - [www.medicare.gov/HHCompare/](http://www.medicare.gov/HHCompare/)
- Healthcare Acquired Infections
  - National Healthcare Safety Network (CDC)
    - <http://www.cdc.gov/ncidod/dhqp/nhsn.html>
  - Mandatory in many states



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

22

## Assessment/Analysis

The Compliance Committee/Program has a role to assure quality and safety, as well as traditional compliance to billing and coding standards

- The Compliance Program is in an excellent position to facilitate synergy among the various groups and individuals that are monitoring and auditing for a myriad of reasons within your system
- Clinicians will want to know that the work they are doing is rooted in “doing the right thing” for patients, not just an exercise in satisfying regulatory requirements, or out of fear of the OIG



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

23

## Assessment/Analysis

- The Compliance Committee/Program Auditing sub-committee can take a leadership role in developing and tracking an organization-wide strategy for auditing and monitoring, as well as reporting
  - Facilitate standardization of auditing methodology—many clinicians don’t have the background in these methods
    - Standard template for audit development (sample size, selection criteria, etc.)
      - IHI sampling methodology  
<http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Sampling.htm>
    - Standard reporting template (summary of findings, recommendations, where and when to report)
      - SBAR as template
      - Reporting calendar



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

24

## Assessment/Analysis

- The Compliance Committee/Program should verify:
  - That Adverse Events are reported as required in your state
  - That a system is in place to ensure that “Never Events” are not billed
  - That disclosure occurs appropriately when an adverse event occurs
    - State-specific requirements
  - That your PPS hospital is complying with the “Present on Admission” coding.
    - Critical Access Hospitals are “exempt” by CMS, but other insurers are also requiring this information.
    - We will have the same moral obligation to track and respond



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

25

## Assessment/Analysis

- The Compliance Committee/Program should verify:
  - That your facility participates in HCA, NHSN and other key “nationally agreed-upon priorities”
  - That your organization is measuring aspects of culture related to attitudes and perceptions regarding integrity, safety, quality, reporting and other key aspects of a “just culture”
    - AHRQ survey
    - <http://www.ahrq.gov/qual/hospculture/>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

26

## Assessment: Tools

- IHI Global Trigger Tool—provides a method of seeking evidence of adverse events by looking for “triggers” that indicate that an event may have occurred
  - Quantifies the “total burden of harm” that may be expected within an organization
    - Calculated as adverse events per 1000 patient days, or 100 admissions
  - Allows for trending over time



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

27

## Assessment: Tools

- “Traditional efforts to detect adverse events have focused on voluntary reporting and tracking of errors. However, public health researchers have established that only 10 to 20 percent of errors are ever reported and, of those, 90 to 95 percent cause no harm to patients. Hospitals need a more effective way to identify events that do cause harm to patients in order to quantify the degree and severity of harm, and to select and test changes to reduce harm.
- The IHI Global Trigger Tool for Measuring Adverse Events provides an easy-to-use method for accurately identifying adverse events (harm) and measuring the rate of adverse events over time. Tracking adverse events over time is a useful way to tell if changes being made are improving the safety of the care processes.”
- <http://www.ihl.org/IHI/Results/WhitePapers/IHIGlobalTriggerToolWhitePaper.htm>



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

28

## Assessment: Tools

- Interdisciplinary team to look at the same sample selected for the Trigger tool analysis for documentation accuracy and completeness as well as coding accuracy and completeness
  - Develop combined Quality/Compliance Dashboard
  - Total Burden of Harm, trended by month
  - Documentation accuracy and completeness
    - % of expected/required documentation elements
  - Billing and coding accuracy and completeness, including measures such as
    - Unbillable hours/procedures (dollars) due to lack of documentation
    - % Bills that must be reworked to enable submission
    - Turn-around-time (TAT) for claims submission
  - Improvement efforts and follow-up



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

29

## Recommendations/Summary

- A Compliance Program must account for the quality of care provided by its organization
- Clinical quality auditing should be integrated into the Compliance Work-Plan
- Work with teams that have already been established, or design the work of auditing and monitoring to include an interdisciplinary team
- Streamline and look for economies of scale—this type of work meets Joint Commission, State Department of Health, Medicare Conditions of Participation requirements, as well as OIG compliance requirements.



[www.hcca-info.org](http://www.hcca-info.org) | 888-580-8373

30