

Quality and Compliance: The Dual Responsibilities of the Chief Medical Officer

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In this article...

Chief medical officers are at the center of the quality-compliance dyad of the health care provider organizations and should report directly to the board to allow freedom to properly protect organizations and their medical staffs.

You are the chief medical officer of a 300-bed teaching hospital.¹ At your bi-weekly meeting with the chief compliance officer, you are shown a patient's physician bill. The patient complained that the physician never saw her on two of the dates billed. The bill was sent to the CCO from the CEO as a billing complaint with the message: "fix it."

Quality of care and compliance reflect the organization's core values, especially its integrity. But their inter-relationship is such that the chief medical officer of a provider organization must have considerable accountability for both. The other key players in the direct oversight of quality and compliance are the chief compliance officer and the formal legal adviser to the organization.

The CEO and CMO each have a fiduciary responsibility for the proper utilization of resources with an implication that the interests of the patient are first. Compliance, on the other hand, is defined by adherence to regulations as promulgated by federal or state regulatory bodies, certifying organizations and various payers.

Regulatory and legal expectations are such that the board is ultimately responsible for both the compliance and quality programs.

Medicare's "Conditions of Participation for Hospitals" states: "The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution" (§482.12).

The American Health Lawyers Association/OIG white paper "Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors" (2007) states:

"The fiduciary duties of directors reflect the expectations of corporate stakeholders regarding oversight of corporate affairs.... This oversight (of quality of care) obligation is based upon the application of the fiduciary duty of care board members owe the organization and, for non-profit organizations, the duty of obedience to charitable mission." (<http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf>)

The board usually delegates responsibility of quality to the medical staff via the medical staff bylaws while it looks to the administration of the organization for compliance and margin matters. The CMO serves both the medical staff and the administration and works closely with physician and administrative leadership, and thus should have strong oversight function for quality and compliance.

Physician leaders are well versed in quality. Many, however, are unaware of their role in compliance—and, in fact, may be left out of the compliance loop by an equally unaware administration.

Compliance officers needed

You meet with the physician to ask his side of this issue. The allegation is denied. You thank him for his cooperation and inform him that you must investigate further. You specifically advise him that you wanted to present the issue to him before any further inquiry.

You then pull the chart and find the physician visit notes for the dates in question. Upon discussing the issue with the floor nursing staff, you learn that the visits cannot be confirmed or denied on the days in question.

Later, when talking with the chair of the department, you are informed, for the first time, that ER physicians have had concerns about the physician's responsiveness to their calls and his ethics of writing notes that they felt were postdated. Despite concerns being raised to the chief, no formal complaint or investigation has ever been initiated.

Within the organization, there should be a chief compliance officer, a specific individual charged with the



administrative oversight of compliance. While a compliance program may have a compliance officer and a compliance department, ultimately operational management has the responsibility to ensure an effective program. Most compliance challenges, in fact, are operational (e.g., paper flow, documentation, coding practices and billing).

But there are significant, but sometimes unrecognized, overlaps between compliance and quality. Both are stakeholder issues of great importance. Some compliance problems are accompanied by potentially serious quality of care issues, but the compliance department may not be aware of the connection.

Documentation and coding are the most common problem areas. Documentation of care that was not actually provided, while fraudulent,

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can be evidence of undertreatment or even neglect. Inaccurate charting can lead to misdiagnosis. Inadequate documentation, whatever its form, inevitably leads to inadequate coordination of care.

Excessive or unnecessary treatment and procedures, even when executed with skill, cause quality of care for that patient to decrease. At the very least, there will be unnecessary exposure to the normally expected morbidity and mortality of the unneeded medical care. Billing for these may be found to be fraudulent.

CMS' lists of "Never Events" and "Hospital Acquired Conditions" for which there may be "No Pay" and/

or required reporting is growing and becoming universal among other payers. Also, additional revenues for meeting quality measures will require proper supporting documentation. This will be a new source of false claims.

It will be necessary to learn the significant changes in documentation and coding practices—similar to what was seen with the initiation of the various E&M levels. The compliance department is an important partner in successful accommodation to this new requirement.

Quality and compliance issues are easier to correct when those involved in day-to-day patient care, coding and billing work on the solutions.

Waste, misuse and errors in the allocation of health care payments have profound effects on all stakeholders.

Certainly peer and coding reviews within the organization, when performed correctly, are always more effective and efficient than when done by third parties.

Costs up, compliance and quality down

Health care represents a disproportionately large and growing portion of the nation's GDP. As compliance and quality go down, costs to the provider, the patient and society rise. Waste, misuse and errors in the allocation of health care payments have profound effects on all stakeholders. Premiums to patients and employers rise, there is less money in the pool available to providers and there are fewer resources for society to pay for other significant needs.

This nation's ability to function effectively in its role in the global society is threatened. Indeed, the viability of the current health care payment system itself is at risk. Physicians and other caregivers are also subject to increasingly onerous rules because of cases of abuse or misuse.

The significant quality-compliance overlap demands effective and efficient communication between the CMO and CCO. They can report individually to the board, but their own internal communication is of paramount importance. Legal advice is necessary to determine what the CMO can share because of state-regulated peer review confidentiality.

In general, facts are not protected either in peer review or attorney-client privilege, so they can usually be shared relatively freely. The CCO

needs to appreciate that compliance issues raise quality issues. The CMO must be informed of all of the CCO's physician concerns. Conversely, the CMO needs to advise the CCO when quality issues involve billing as well.

Because of peer review issues, you perform an independent investigation. You later report to the CCO that the physician may have been poorly responsive to his ER responsibilities, his notes were not always contemporaneous with his visits, and there were questions as to whether the visits were actually made.

Quality and compliance are tough issues, often involving significant conflict. Success demands aligned agendas and cooperation between the medical staff and the administration. The primary goal of the medical staff is quality with a minimal but adequate organizational margin.

The challenges of the CEO, primarily financial in nature, are directly focused on that margin. A proper balance necessitates that persons directly responsible for one aspect of organizational mission are not in a position to be overruled by those responsible for conflicting aspects. It is the responsibility of the board to ensure that the organization's values and mission are properly served along with the attainment of an appropriate margin.

Placing people responsible for these conflicting aspects on an equal footing, by having each report to the board, allows a balanced view of the challenges. Quality and compliance issues may reflect negatively on the CEO. To have the CMO and the CCO report to the CEO will allow the CEO to filter their reports.

The CMO and CCO could compromise their values.² The board will then get a biased perspective of these important issues as well as make the CMO and CCO dependent upon the CEO for their job.

You meet with the hospital attorney to see if self-disclosure is needed.

The CCO and you separately and confidentially present the information to the CEO on a need to know basis.

You and the CCO separately present this situation in your quarterly reports to the compliance committee of the board (fortunately, the meeting is just a week after you first heard of the issue and thus an urgent presentation was not necessary). The chief of staff, as an ex officio member of the compliance committee is informed of the matter.

This scenario requires answers to the following questions:

- *What are the issues?*
- *Who is responsible for correcting the problem?*
- *What action should be taken and who has the authority to take such action?*
- *Who is accountable for the problem(s)?*

In association with counsel and the CCO, the following is determined:

- *Is there a refund and to whom—what does cover letter say—who writes the cover letter?*
- *Is self-reporting necessary?*
- *What further investigation is required and who should be responsible for its various aspects.*

Options for the CMO to consider are:

- *Meeting with the physician, with the chief of staff and/or the department chair in attendance.*
- *Initiating a focused professional practice evaluation ("FPPE") of the physician.*
- *Monitoring the physician's hospital visits*

- *Alerting the ER staff to inform him immediately of any further unresponsiveness or questionable notes.*

Demonstrated high quality of care and strict adherence to compliance defines the successful provider organization. Leadership must demand and model those values for the organization's culture. "The talk must be walked."

While rules requiring compliance are indispensable both legally and organizationally, rules don't create compliance. When rules and culture clash, culture always wins." Culture means "this is how we do things around here" — and there is no better place to demonstrate this than at the top.

Culture is not something that changes by thoughts or words alone. Actions matter. Board, administrative and physician leadership need to be involved. Rules have both to work and be workable. When organizations develop their compliance protocols with input from those who will have to do the complying, the results are uniformly favorable because it works in their real life. The compliance system becomes their system, not that of the compliance office.



1. This article is simplified by using the example of a single independent hospital as the provider entity. Should that CMO be in a hospital that is part of a multi-hospital system, then we recommend a dotted line relationship to the system CMO who, in turn, should report to the system board and not to the system CEO.
2. Mellman, DL. The Reality of the Hospital: Physician Leaders in Harm's Way. *The Physician Executive*, 33(3):22-3, May-June 2007.
3. E. Dauer, J. Voorhees and R. Zall, *Corporate Directors' Ethics and Compliance Handbook* Washington, DC: National Association of Corporate Directors 2003.

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