Coordination of Quality of Care & Compliance across an Institution and across - County Hospital System & Academic Medical Center

HCCA Compliance Institute 2014

Game plan:

• Kevin Andrews
  • Vice President Quality & Patient Safety, Jackson Health System, Miami, Fl.
  • Quality and patient safety issues for compliance officers
• Diana Salinas
  • Senior Vice President and Chief Compliance Officer, Rideout Health, Yuba City, Ca
  • Former Chief Compliance Officer, Jackson Health System, Miami, Fl.
  • Practical approaches for aligning quality and compliance priorities
• Dr. Jennifer McCafferty
  • Assistant Provost, University of Miami, Miami, Fl.
  • Former Chief Medical Compliance & HIPAA Privacy Officer, University of Miami Health System, Miami, Fl.
  • Leveraging data for quality improvement & compliance efforts
• Panel Discussion
  • Challenges in quality and compliance efforts when multiple organizations are involved in delivering the care
  • Public and private partnerships
  • Where have the data gone?
    • Impact of outsourcing revenue cycle, IT support
The Decade to Come in American Healthcare: Provide Value or We will be Left Behind

Kevin C. Andrews  
Vice President, Quality and Patient Safety

Our agenda:

1. The payment crisis
2. The quality imperative
3. Quality meets compliance and finance
4. The role of the Board; the role of the Medical Staff
5. A roadmap for success
6. Q & A
The U.S. Health Care System is the Most Expensive in the World.

Total Expenditure on Health Per Capita (in U.S.$)


“Is it Safe?”
The Quality Imperative
Doctors' care often deficient, study says; Proper treatment given half the time


Copyright USA Today Information Network Jun 26, 2003

On average, doctors provide appropriate health care only about half the time, a landmark study of adults in 12 U.S. metropolitan areas suggests.

Such deficiencies "pose serious threats to the health of the American public" that lead to tens of thousands of preventable deaths each year, researchers report in today's New England Journal of Medicine.
Fatal Drug Mix-Up Exposes Hospital Flaws

By TOM DAVIES
Associated Press Writer
One Doctor’s Crusade For Hospital Reform
Dr. Donald Berwick’s Institute for Healthcare Improvement Hopes To Save Lives By Making Hospitals Safer

NEW YORK, Feb. 6, 2007

(CBS) Dr. Donald Berwick, a Harvard-trained pediatrician, has dedicated his life to tracking a killer in a place that’s supposed to save you well. CBS Evening News anchor Katie Couric reports.

“Hospitals are very dangerous places. I don’t know how to explain this to the public in a way that doesn’t create too much fear. But they need to be realistic, and the technologies that help you can also hurt you — and they do it every single day.”

Dr. Donald Berwick

Berwick estimates that for every 100 patients admitted to hospitals, there are 49 to 50 incidents in which patients are harmed — ranging from bruises and bed sores to much more life-threatening situations.

“Between 44,000 and 98,000 Americans die in hospitals each year, killed by their care, not by their disease,” Berwick says.

The Value Equation: Quality Meets Compliance and Finance
But consider…

• A 66 year old patient is hospitalized for routine orthopedic surgery.
• The patient acquires an infection.
• Her stay in the hospital is prolonged for 4 days.
• What is the effect on your bottom line? ($60,000 -$100,000)

From the Advisory Board:
December 10, 2005

About $9.5 billion and nearly 57,000 lives would be saved annually if all of the nation's acute care hospitals performed as well as the country's top hospitals, finds a new study released this week by Solucient.
The Value Equation

Value = Quality of outcome / Unit of cost / Compliant

“R.O.I.” is not just about the income line!

Critical Concepts:

• Improving systems -- beyond the “Bad Apple” approach
• Integrating attention to quality, safety, risk, and service
• Integrating quality into operations through compliance, finance
Hospital Medical Staffs play a vital role in monitoring and improving hospital care to ensure that it is safe, beneficial, patient centered, timely, efficient, and equitable. Indeed, hospital Medical Staffs are responsible for ensuring the quality of healthcare provided in their institutions. To fulfill their role in ensuring quality…

1. Focus on quality, safety and compliance
2. Dedicate time
3. Be proactive
4. Assure that quality measurement and performance improvement processes are in place
5. Understand physicians role
6. Explicate staff and physician responsibilities
7. Ensure management’s focus (Compliance can assist)
8. Align financial resources
9. Support payment contracts aligned with this focus
Hospital Medical Staffs should develop a “quality literacy” regarding patient safety, clinical care, compliance and healthcare outcomes.

Peer Review

THIS IS NOT AN EASY ASSIGNMENT FOR PHYSICIANS!

As Compliance Officers:
• How are you aligned with Quality and Risk Management?
• Do you know how rigorously peer review is practiced in your hospital?
• What are the indications for external peer review?
• Are summary results presented to the Board?
• Are you assured a neutral body is reflecting the community’s interest?
• Are you assured of the fairness and consistency of the process?
And there is more to quality than these particular physician-driven activities:

- Tracking and trending process, compliance and outcome measures
- Integrating...
  - Patient safety
  - Risk management activities
  - Sentinel event reporting and analysis
- Contracting
- Compliance

“Be All That You Can Be”:
A Roadmap for Success

- Commit
- Collaborate
- Align incentives
- Build structures
- Enlist patients
- Track progress
- Create identity
Commit

• Get the Board’s attention
• Must be your Institutional strategic priority
• Medical Staff priority
• Transparency keeps us honest
• Focus the workforce on value, compliance and service
  – High quality
  – Better than the national average
• Quality processes…resulting in clear and compliant, succinct report cards
• Physician outreach
• Joint Conference Quality and Audit & Compliance Committees

Board Scorecard

<table>
<thead>
<tr>
<th>Jackson Health System (JHS)</th>
<th>PHT Board Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUALITY</strong></td>
<td></td>
</tr>
<tr>
<td>Evidence Based Medicine (EBM) Composite Score</td>
<td></td>
</tr>
<tr>
<td>Reporting Period</td>
<td>JHS Goal</td>
</tr>
<tr>
<td>July</td>
<td>97%</td>
</tr>
<tr>
<td>Infection Composite Score</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>2.00</td>
</tr>
<tr>
<td>Readmission Composite Score</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>72%</td>
</tr>
<tr>
<td>HCAHPS - Willingness to Recommend</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>70.7%</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
</tr>
<tr>
<td>Safety Composite Score</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>3.14</td>
</tr>
<tr>
<td>PEOPLE</td>
<td></td>
</tr>
<tr>
<td>% of Manageable OT</td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>2.00%</td>
</tr>
<tr>
<td>% HAC Completed</td>
<td></td>
</tr>
<tr>
<td>FY 2013 Q3</td>
<td>100%</td>
</tr>
<tr>
<td><strong>FINANCE</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Admissions</td>
<td></td>
</tr>
<tr>
<td>Reporting Period</td>
<td>Goal</td>
</tr>
<tr>
<td>September</td>
<td>4,258</td>
</tr>
<tr>
<td>Observation Days</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>841</td>
</tr>
<tr>
<td>Deliveries</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>562</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td></td>
</tr>
<tr>
<td>Full Income (as of 10/31/2011)</td>
<td></td>
</tr>
<tr>
<td>SYSTEMWIDE ALOS NO EXCLUSIONS</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>5,511,221</td>
</tr>
<tr>
<td>SYSTEMWIDE ALOS (Medicare)</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>7.70</td>
</tr>
<tr>
<td>CMI</td>
<td></td>
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<tr>
<td>September</td>
<td>1.69</td>
</tr>
<tr>
<td>CMI (Medicare)</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>1.60</td>
</tr>
<tr>
<td>CMI Adjusted LOS</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>3.94</td>
</tr>
<tr>
<td>CMI Adjusted Medicare LOS</td>
<td></td>
</tr>
<tr>
<td>September</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Notes

EBM Composite - Average(AAMI, HP, PEC, PFP, Composite Score); Goal 90th percentile
Infection Composite Score - Average(CUTB, CAUTI, VAP Infection)
Readmission Composite Score (Average Readmission AMI, HP & PN Rates); Goal 90th percentile
Safety Composite Score - Average(Medication Errors, Falls, Falls until injury & HAC Pressure Ulcers); Goal 90th percentile
JHS Net Income (Sum of three entities: JHC, JNS, JPHS) (NNC, JAH, PAC, Physician Services, Tugaris)

N.E.: Not Established - National rate has not yet been established
- Under consideration for an internal metric to be established after a six-month internal reporting period
**System Based Scorecard**

### Hospital Scorecard

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Period</th>
<th>Measured Value</th>
<th>Target Value</th>
<th>Variance</th>
<th>Variance %</th>
<th>Yearly Variance</th>
<th>Yearly Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Medications Error Rate per 1,000 Patient Days</td>
<td>December</td>
<td>0.00%</td>
<td>7.50%</td>
<td>7.50%</td>
<td>8.75%</td>
<td>21.00%</td>
<td></td>
</tr>
<tr>
<td>Falls per 1000 Patient Days</td>
<td>December</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Operating Expense per APD (Net of Bad Debt)</td>
<td>November</td>
<td>2,069</td>
<td>2,092</td>
<td>0.00%</td>
<td>0.00%</td>
<td>11.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td>November</td>
<td></td>
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**Jackson Health System (JHS)**

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<tr>
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<td>November</td>
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</tr>
<tr>
<td><strong>System Based Scorecard</strong></td>
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</tr>
</tbody>
</table>
Enlist patients

- Loyalty is transient…
- But can be earned by
  - Inclusion and engagement
  - Education and training
  - Service
- Patients as members of the quality team.
- But be careful of abandonment masquerading as empowerment.
Track Progress

• The “report card” concept
• You want to see the follow up
  – Quality
  – Compliance
  – Malpractice
  – Service
• Don’t be afraid to ask !!!

Create Identity

• Increasingly, hospitals are posturing on issues of quality and service

• Skeptical audiences, in an era of transparency, will see through posturing

• Define ourselves by our commitment.
Questions?

Transcending Departmental and Institutional Silos to Exchange Quality-Of-Care Information & Analytics

Diana Salinas
Senior Vice President and
Chief Compliance Officer
Rideout Health
Transcending Silos

▪ Overall goals of healthcare reform and the Affordable Care Act is to get us moving from a fragmented healthcare delivery system to a less cost and more efficient integrated model.

▪ Working in silos can be a threat for hospitals to deliver the coordinated care that will be/is required to meet the growing quality, compliance and cost demands of reform.

▪ Transcending silos MUST happen to help hospitals achieve coordinated delivery of care that will improve quality and overall efficiency of the institution.

Transcending Silos: How do we do this?

▪ Mindset – recognizing that something needs to be different, a need for change

▪ Root Cause – develop an infrastructure that provides opportunity to address root causes without sacrificing quality

▪ System Aim – need for a hospital system aim to change mindsets toward transcending silos, integration of care and outline goals and strategies to accomplish system aim

▪ Departments – fostering collaboration among departments to look beyond the department
Development of a Compliance Program Charter

- Formal establishment of Compliance Program
  - Sets out the organization’s responsibility with regard to participation in government health care programs;
  - Furthers the organization’s goal of establishing an organization that (a) fosters and maintains the highest ethical standards among all of its employees, officers and trustees, and contractors that furnish health care items or services; and (b) values its compliance with all state and federal laws and regulations as a foundation of its corporate philosophy.

Development of a Compliance Program Charter Con’t.

- Sets out the responsibility of the governing board
- Sets out responsibility of management including a budget for Compliance Program
- Sets out responsibility of Compliance officer and program
- Establishes that the Compliance Program is not the compliance office alone but the entire system’s program
- Establishes the Executive Compliance Committee (ECC)
- Built in collaboration from all department through a Regulatory Compliance Committee (RCC)
Establishing a Regulatory Compliance Committee (RCC) in addition to Executive Compliance Committee (ECC)

• An interdisciplinary approach to compliance

• A centralize and improved communication forum that introduces improvement opportunities as well as celebration accomplishments, not only in the compliance department, but also inter-departmentally throughout the entire hospital

• Joint accountability

Designing the Regulatory Compliance Committee Infrastructure

• Key Institutional Partners:
  - Chief Compliance Officer / Privacy Officer
  - VP Quality and Patient Safety
  - VP Revenue Cycle
  - Corporate Director IT / IT Security
  - Director HIM and Coding
  - Director Patient Access
  - System Risk Manager
  - System Case Manager
  - System Pharmacist
  - System Pathology Lab
  - Internal Audit
  - Associate Chief Medical Officer
  - Chief Nursing Officer
  - Member of the Legal team
  - System Hospital Education Lead
  - System Credentialing Lead
  - System Managed Care Lead
  - Public Safety Lead
  - Lead System Physician Resident
  - Associate Chief Financial Officer
Through the RCC you can start to build collaboration by developing an Operations Support Critical Incidents Manual

ISSUE: ____________________________
Responsible Person: ___________________
Indicators of Potential critical situation:

*Satisfaction of one or more of the following preconditions indicates that a critical situation may exist. If one or more of these preconditions is met, you should take the immediate actions listed below, including notifying the responsible person identified above for guidance on appropriate next steps beyond those immediate actions.*

1.
2.
3.

Immediate Actions:

*Take the following actions immediately or as soon as practicable:*

1.
2.
3.
4.
Through the RCC you can start to build collaboration by developing an Operations Support Critical Incidents Manual

Description of Departmental Roles
Lead department (department of responsible person):

Roles of support department to be involved:

<table>
<thead>
<tr>
<th>Department</th>
<th>Role in resolving issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

What you can accomplish through the Regulatory Compliance Committee (RCC)

• Compliance Work Plan development – joint effort and accountability

• Collaborative teams or Task Forces evolve to address compliance issues together (everyone’s problem)

• All operation support departments are at the table

• Generates an increased collaborative practice for the healthcare professionals in an interdependent system health care delivery environment.
Transcending Silos:

• By breaking down silos between departments, hospitals can create collaborative teams that can effectively improve patient safety, especially during transitions of care, quality, compliance and protect reimbursement. The many intersections between Patient Access, Quality, Credentialing, HIM, Coding, Risk Management, Compliance and Revenue Cycle make them ideal departments to integrate, and staff from these departments can work together to reach common goals of efficiency, quality and compliance. This integrated model will be a key feature of hospitals on the cutting edge of care delivery as the healthcare industry moves toward a more coordinated system of care.

Transcending Silos:
MAY - JUNE 2012 www.chausa.org

• The idea of “working together” is not new. Forty years ago, the Institute of Medicine asserted that a major barrier to “health care that is efficient, effective, comprehensive, and personalized is our lack of a design for the synergistic interrelaishment of all who can contribute to the patient’s well-being.”

• In its 2001 report, Crossing the Quality Chasm: A New Health System for the 21st Century, the Institute of Medicine called on academic institutions to promote quality and safety in health care by educating health care professionals to work collaboratively.

• Two years later, the institute released its landmark report, Health Professions Education: A Bridge to Quality, and identified five core competencies integral to the education of all health care professionals.

• Focusing on the need for outcome-based education in the health professions, this report concluded that all health care professionals must be prepared to provide patient-centered care as members of interdisciplinary teams, employ evidence-based practice, apply quality improvement approaches and use informatics.
Organizational data to drive improvement and compliance

• Evidence clearly shows that more care does not necessarily mean better care. An estimated 30 percent of healthcare spending goes toward ineffective or redundant care (Fisher and Wennberg, 2003). In real terms, this means as much as $750 billion of America’s $2.5 trillion annual healthcare spending may not be well spent. We need to change what we do to promote higher quality, evidence-based care for all patients.

Transcending Silos: Challenges Across Institutions

• Public versus Private: Numerous and challenging differences
  ▪ Government in the sunshine issues
    ▪ Communication:
      ▪ Public organizations are structured to operate in an atmosphere of promoting transparency, open for all communications to be scrutinized, whether internally or externally, the interest “of all” is considered and regulated
      ▪ Private organizations tend to be protective of their trade secrets and often will only provide the specific necessary information to those people directly involved. Information is overly-protected and does not flow freely amongst channels and departments.
  ▪ Legal constraints:
    ▪ Public administration communications, especially those written are under much greater restraint. Especially under consideration are verbiage which may affect ethnic or cultural tones, discrimination of any kind, and countless other interpretive areas. Public administration communications will often tend to simply follow the stability of “legalese.”
    ▪ Private organizations have the freedom to communicate ideas and philosophies more openly and freely without the fear of reprisal, excepting of course anything that is blatantly hateful or illegal.
  ▪ Private organizations tend to communicate in a market environment in order to gain maximum productivity or profit.
  ▪ Communications in public organizations tends to be directive and aimed toward implementing policy.
  ▪ The private sector may be goal-aligned with efficiency while the public sector may be managing multiple constituents toward effectiveness.
“Big data” - leveraging institutional data for quality improvement & compliance

Jennifer McCafferty, PhD, CCEP, CHC, CHRC, CHPC
Assistant Provost
University of Miami
Miami, FL

Appreciating the relationship between quality, risk management, patient safety and compliance is not new
- 1999 - To Err is Human: Building a Safer Health System
- 2001 - Crossing the Quality Chasm: A New Health System for the 21st Century
- 2012 - Best Care at Lower Cost - The Path to Continuously Learning Health Care in America

Assuring data is available, accurate, and interpretable is an ongoing challenge
- 2012 - Best Care at Lower Cost - The Path to Continuously Learning Health Care in America
- 2013 - Core Measurement Needs for Better Care, Better Health, and Lower Costs: Counting What Counts
IOM - Best Care at Lower Cost

TABLE: Characteristics of a Continuously Learning Health Care System

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Science and Informatics</td>
<td>• Real-time access to knowledge—A learning health care system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality.</td>
</tr>
<tr>
<td></td>
<td>• Digital capture of the care experience—A learning health care system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.</td>
</tr>
<tr>
<td>Patient-Clinician Relationships</td>
<td>• Engaged, empowered patients—A learning health care system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.</td>
</tr>
<tr>
<td>Incentives</td>
<td>• Incentives aligned for value—In a learning health care system, incentives are actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.</td>
</tr>
<tr>
<td></td>
<td>• Full transparency—A learning health care system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients, and their families.</td>
</tr>
<tr>
<td>Culture</td>
<td>• Leadership-instilled culture of learning—A learning health care system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.</td>
</tr>
<tr>
<td></td>
<td>• Supportive system competencies—in a learning health care system, complex care operations and processes are constantly refined through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.</td>
</tr>
</tbody>
</table>

Compliance-Quality connection is vital to the essential purpose of the health care enterprise.
“Tsunami of measurement”
• Overlapping federal, state, and programmatic measurement requirements
• Harmonization to reduce administrative burden and focus attention and resources on those measures that drive improvement.
• Inappropriate and duplicative metrics that increase burden without adding value must be avoided.

Stakes are high:
• Unnecessary services (includes costs due to unwarranted variation/overuse)
• Fraud
• Excessive administrative costs
• Inefficiently delivered services
• Prices that are too high
• Missed opportunity for prevention

From: Core Measurement Needs for Better Care, Better Health, and Lower Costs: Counting What Counts; IOM Workshop Summary 2013
Compliance can find itself isolated from the strategic and operational center of the organization.

**Tucker House case**
- Facility paid $535,000 and agreed to apply clinical practice guidelines for the treatment of bedsores when the government charged the facility with false claims for every day of care it had been paid for patients who had developed aggravated decubiti.
- Applied to additional 40 settlements nationwide, often instigated by whistleblowers.
Unnecessary Services
• In 2003, a hospital in Michigan pled guilty to criminal charges and paid a $1.05 million fine when a prolific anesthesiologist on staff performed unnecessary pain management procedures for which the hospital was paid the associated facility fees.
• Patients suffered significant complications from the unnecessary surgeries around which claims arguments were fashioned.

Board engagement
• Develop metrics and regular reporting to keep the Board informed about quality improvement activities and the relationship to compliance:
• “Quality is also emerging as an enforcement priority for health care regulators.”
OIG, Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors

How can a compliance officer effectively integrate quality-oriented issues into workflow?

• Teamwork
  • Develop a strategy to work with the risk management and quality improvement departments to determine where compliance ought to be involved.
  • Participate in efforts to monitor how standardization of care along good clinical practice guidelines can facilitate meeting the new standards
• Quality data needs to be a critical focus of attention.
  • Become familiar with the quality metrics, report card, and transparency initiatives applicable to your enterprise.
  • Find out who is reporting what, to whom, and how often.
  • Develop effective techniques to monitor these reports over time for accuracy, completeness, and as sentinels or leading indicators of risk.
Be mindful of the potential liabilities associate with data quality.
• Poor data quality is the basis for compliance liabilities on their own,
• Identified quality failures often point to other process problems.
• If the data are not accurate, how can you be sure that the proper controls are in place to comply with the appropriate regulations?

Where’s the data?
What’s the quality?

Metadata Analyses
- Characterizes or organizes data such that data can be understood and more readily consumed by an organization.
- Metadata answers the:
  - who
  - what
  - when
  - where
  - why
  - how

- Required to place the data into proper categories for determining which regulations apply
Examples of Metadata Analyses:

- SOX applies to financial data
- HIPAA applies to health care data
- FERPA applies to student data

Some data will apply to multiple regulations and some data will not be regulated at all.

Without proper metadata definitions, it is impossible to apply regulatory compliance to data.

**Compliance should be knowledgeable about how the organization organizes data – best case scenario compliance officers are central members of the team that develops and manages the organizational metadata definitions.**

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Data Quality & Data Profiling

- Data quality
  - Business responsibility
  - Accuracy
  - QA, technology controls, etc.

- Data profiling
  - Examines existing data and collects statistics and other information about that data.
  - Can discover/reveal data quality, characteristics, and potential problems of information.
    - Characteristics of the data compared to what is expected in a field
    - Facts about the data (e.g., occurrence of null values)
    - Fields that need further investigation
  - Data profiling does have **limitations.** It will not convey:
    - Accuracy of the data (e.g., procedure miscoded)
    - Rules that apply to the data
    - Efficiency of data capture process
Examples of Data Profiling

- **Phone number variations:**
  - 9999999999
  - (999)999999
  - 999-999-9999
  - 999-999-AAAA
  - 999-999-Aaaaa

- **EHR field labeled “temperature”:**
  - May contain data in the correct type and format (nn.n – nnn.n) but the range of values may exceed what is logical from a clinical perspective – such as a temperature exceeding 500.

- **EHR field labeled “vaccine dose”:**
  - Might comply with reference table values and expected percentage of null values, but the dose amount may be incorrect (e.g., 0.5 ml vs. 5 ml).

- **Identify duplicative fields:**
  - “Tobacco Type” may have a pick list for the type of tobacco utilized (e.g., cigarettes, oral, cigar, pipe)
  - Individual fields that indicate a Yes/No response for field names “Cigar use,” “Oral Tobacco Use,” “Pipe use.”

**Compliance should be knowledgeable about how data quality is controlled and monitored – best case scenario compliance officers/offices receive regular reporting on data quality.**

Data Governance

**Oversight for management of the availability, usability, integrity, and security of enterprise data. Typically includes:**

- Governing body or council
- Defined set of procedures
- Plan to execute those procedures

Allows for data to be treated as an organizational asset

- data elements are defined in business terms;
- data stewards are assigned;
- data is modeled and analyzed;
- metadata is defined, captured, and managed;
- data is archived for long-term data retention.

**Compliance should be active in data governance programs.**
Interoperability – creating meaningful connections among disparate data sources

Example of coding data analysis for billing risk & revenue opportunity / business strategy review
• As health care gets more and more patient centric and quality driven this will increase in importance.

• Shared responsibility for building a continuously learning health care system.

• Current waste diverts resources.
  • IOM estimates $750 billion in unnecessary health spending in 2009 alone.

• The stakes are high.
  • Every missed opportunity for improving health care results in unnecessary suffering.
  • Estimated that ~ 75,000 needless deaths could have been averted in 2005 if every state had delivered care on par with the best performing state.

Compliance-Quality connection is vital to the essential purpose of the health care enterprise.
Panel Discussion:

- Challenges in quality and compliance efforts when multiple organizations are involved in delivering the care
- Public and private partnerships
- Where have the data gone?
  - Impact of outsourcing revenue cycle, IT support
  - Legacy system updates