Help! I Have To Eat an Elephant

Being a Compliance Officer Is No Easy Job, But for Those in a Rural Setting, It's Probably Only Part of Your Job

Sharon L. Taylor

I am a health care compliance officer. I said it. Sometimes I feel overwhelmed with my role. Sometimes I feel as if I don't know enough to properly do this job. I wake up at night thinking, "What have I missed that would be detrimental to my organization?" That's why I come into work with hastily scribbled notes written in the dark in the middle of the night and try to make sense of them the next day. Sometimes I just want to call the whole thing off!

So … am I really any different from any other compliance officer for any other health care organization? I'd have to argue yes and no. No because well, compliance is compliance. All health care organizations, whether the final regulations are published or not, should be following the model guidance of an effective compliance program, which means your program should be more than those nice policies that were put together maybe years ago in the 1990s or maybe recently after the passage of the Affordable Care Act (ACA). All compliance officers and their respective organizations need to be working hard at having an effective compliance program. So no, in that respect, I am no different than all of the thousands of other health care compliance officers.

But, what about the "yes, I am different?" Let me end the first sentence of this article differently. I am a health care compliance officer in a rural hospital. Now the "yes, I am different" begins to be explained. I am also the privacy officer, the risk manager, accreditation director, and infection control and prevention director. I not only manage all the roles, I am the only person in these roles. And, I have all these roles not just for the hospital but also for the organization's home health/hospice, four physician clinics, and two retail pharmacies. Good thing multi-tasking is in my blood. This is where the rural health care compliance professional differs from those who may have several roles within a compliance department, but it is unlikely that they have several different roles within the organization.

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Before anyone thinks I am complaining, I am not (truthfully, maybe once in a while). Really, I am not much different than the many compliance officers at rural facilities where the majority of those in the compliance role also have at least one, if not several, other roles they are performing equally as well. To be able to perform a myriad of roles requires some special talent on the part of these individuals.

I don't take this responsibility lightly. As a matter of fact, I frequently wrestle with the knowledge that an important best practice is for the compliance officer to have independence. Can I be independent and objective when I also must perform other duties? Can I perform all of my duties well? How do I stay current in so many areas? How do I know I have at least a minimum level of compliance competency? Can I find ways to accomplish what I need to for my organization to be in compliance without several different specialists in a variety of compliance roles? All of these are questions that I frequently ask myself.

One question I have been repeatedly asked by others from the rural health care setting is who should be the compliance officer? Being a compliance officer is not easy. It takes attention to detail and ability to digest regulations into "real" language for others to understand. Persistence to push ahead when others may deem doing so is not necessary is a must. Being the one who continually asks: "What do we do here"? "What happens here"? "How do I know that happens"? and "What if"? over and over again. It also takes someone who is confident enough to be able to stand up to administration's view of what has happened, should that ever become necessary.

All of this adds up to how a rural facility with limited resources determines who would be the best compliance officer. Most time it is my experience that this person is chosen by job function. An individual who perhaps also has quality, health information management, risk management, human resources, finance (since some seem to believe compliance is about billing, right?) is tapped with the "tag you're it" baton. While this works in many facilities (except for probably the choice of finance) given the myriad of attributes necessary to successfully manage a good compliance program, I would say that it is best to choose the correct person for the compliance job based on personal attributes instead of current job function.

This being said, the marriage of compliance officer with privacy officer, risk management, accreditation specialist, and quality is frequently a good fit. Remember, this person must be able to change direction at the drop of a hat. This does not mean just change projects within the compliance area of responsibility but totally change direction to a vastly different area of responsibility. Not knowing what is at the other end of that phone call and being able to answer or rapidly get the answer if the situation warrants it takes a person who can do that in order to best serve the organization's needs at that time.

What else might the compliance officer at a rural facility need? Most items are no different than what any other compliance officer at any facility might need. It is just that obtaining them may be harder. One of the first items that comes to mind is education. Joining compliance officer groups, viewing Webinars, reading journals, and attending conferences is necessary. Unfortunately, many of these take a budget. It is imperative that rural chief executive officers (CEOs) understand this.

In order to be an effective compliance officer, an individual must be able to access education. Fortunately, in this Internet environment, accessing quality seminars is easy. However, choosing the ones that are promoted by those with correct knowledge is imperative. This is where I give my first plug for the Health Care Compliance Association (HCCA). As a new compliance officer over 10 years ago with bare minimum knowledge of what compliance was, HCCA saved my sanity. Their educational resources, print, face-to-face,

and Internet-based resources are all excellent. This is not to say that there are not other high quality educational resources out there, but I needed to get my education from those who I knew were telling me the correct information. HCCA was and is invaluable. I have told numerous compliance officers in our rural district to join HCCA. I always preference it with "this is a non-paid commercial."

Without basic compliance education and constant continuing education, it is highly likely that the organization's compliance program is one of those contained in the nice set of policies that sits on the shelf never to be opened after they were written. That is not acceptable in this day and age.

All compliance officers, but especially compliance officers in the small rural facility with no other compliance staff, need support. I referenced a district compliance officer organization. This is one way of networking and getting support from other compliance officers on a face-to-face basis that does not entail a lot of expense. Several years ago a number of us from rural hospitals were talking about needing to network. After discussing it with our respective CEOs, we formed a district compliance officer's group. We are not limited to only rural; all compliance officers are welcome, but most of us have a common theme, and that is that we fill more than just the compliance roles at our organizations. We meet quarterly at member hospitals and generally have a program and then time for networking. Our motto is "don't re-invent the wheel." In other words, if I've got it and you need it, I'll certainly share. This group has proven to be an invaluable support to me, and I believe the others would echo my sentiments.

Here is another plug for joining professional organizations. HCCA's list serve with the ability to ask questions of a myriad of experts and peers at the click of a mouse is invaluable. Don't forget journals. *Compliance Today* and the *Journal of Health Care Compliance* cover topics in a timely fashion. Sharing these articles with the appropriate department managers and with the organization's compliance committee is helpful in educating them on what their role is in compliance as well as effectively pointing out that the compliance officer is not the person who "does compliance" at the organization; everyone does.

Speaking of the compliance committee, remember those individuals are also likely to fulfill several roles within the organization and therefore have multiple priorities as well. They, like members of a compliance committee in any organization, need to understand the role of compliance and their reason for serving on the group. They especially need to understand their role in guiding the compliance officer and program. In this capacity, they serve as a major support arm for the compliance officer.

I believe it is important to choose the compliance committee not only by job function, though it is very important to have multiple functions represented, but also to look at the correct type of person as well. I have seen rural hospitals where, either not wanting to hurt any manager's feelings or just not taking the time to analyze who is best fitted for the job, every department manager is on the compliance committee. Some of these organizations have had as many as 16 to 20 individuals at the table. Many of them really do not understand why they are there and what they are supposed to do, nor does their job function fit within the role of compliance guidance for the organization.

This, of course, does not mean that they are not important in the culture of compliance throughout the organization. It simply means that their work duties are important in guiding and supporting other organization functions instead of steering the compliance program. All departments and employees are responsible for compliance.

Innovation is another attribute that I feel is necessary for a rural organization's compliance program. Most rural hospitals are not fortunate enough to have an internal

audit department to perform auditing, which is, of course, one of the elements of a compliance program. This is where innovation comes in. With good audit tools and managers willing to work together, departments can audit other department's documentation or, depending on the manager's understanding of the need for accuracy, such as a health information management (HIM) manager with coding experience, audit the organization's coding accuracy. Finance has external audits, but clinical areas frequently do not. Yet, clinical documentation is the basis for billing.

Another innovation is to include compliance items in some audits already being done. While auditing charts for critical access review, which requires that 10 percent of records be audited, why not include some bills to be sure documentation for all items billed is present. Is there a physician order? Are there items billed but not documented, thus causing overbilling? There are ways to accomplish this. It just requires teamwork and an understanding of why it is necessary. Compliance also frequently conducts its own audits, such as: is the Notice of Privacy Practice given to all new patients? Is the copy of patient's rights and advance directive information given upon admission? What about auditing to be sure Medicare secondary payer is handled correctly or infusion and injection billing and coding? These audits, as all audits, may or may not turn up problem areas for the organization or point to the need for monitoring certain processes.

Keeping the board apprised of compliance activities is one area that all programs are most likely looking at stepping up a notch given the Office of Inspector General's (OIG's) recent publication, "Practical Guidance for Health Care Governing Boards on Compliance Oversight." While annual reporting to the board is frequently done, having other lines of communication may not be the case if there is not a separate board committee that has compliance oversight. One option is having a board member who attends compliance meetings and is the board liaison. Perhaps there are other innovative ways to assist the rural institution in meeting the intent of this guidance. As with most items in rural organizations, it is necessary to find innovative ways to accomplish tasks.

After I had been a compliance officer for several years, one thing kept nagging at me. How did I know I had good baseline mastery of compliance? This was not the first time I had had this feeling, and I had responded by studying and taking the certification examinations for infection control and prevention (CIC) and healthcare risk management (CPHRM). I set out to study for and take the compliance certification exam from the Compliance Certification Board. I passed the compliance certification exam, CHC, and then last year I also passed the healthcare privacy certification, CHPC. Not only did I learn a lot while studying for these exams, I also satisfied myself that I, at least, had baseline knowledge of these subjects. I feel this is important. How can I impart a culture of compliance to employees and guide the program for the hospital if I don't know that I have a basic mastery of the subject? Not everyone feels this is necessary, and I certainly respect that. I, however, have always been one that needs to prove it to myself.

What are my struggles? Maintaining objectivity is one area about which I constantly worry. I continually remind myself that my role is to assist in interpreting regulations for managers and thus assisting them in making the correct decision for the organization while meeting the regulatory intent. I cannot allow myself to get wrapped up in all the potentially emotional details that may be involved in the situation.

In small organizations in rural areas where many people know or know of each other outside of the work environment, this can more easily happen. One case in point is in following the disciplinary policy when it comes to HIPAA/security violations. The staff members involved are most

likely good people, but a violation such as sharing your password is a violation. Good person or not the situation warrants following the disciplinary policy.

I also frequently remind myself of the reference to the compliance program/plan residing in a nice policy or group of policies sitting on a shelf. This is no joke. There are health care facilities, not necessarily all rural, that developed a set of policies or adopted a set of policies they obtained from someone or another facility when compliance programs were first discussed as voluntary within health care. Unfortunately, because of the work involved in implementing the program, it just never became a priority. Policies alone don't make a compliance program. So, I struggle constantly with the question: have I promoted an effective compliance program? Yes, I make sure that the organization follows the seven elements of an effective program. An annual risk assessment is completed resulting in an annual work plan. The work plan is a living document not cast in stone. I inevitably add items to it through the year. I will be working with our board liaison and the compliance committee to get the board more involved. But…is it good? Is it where it should be? This is a struggle I think every compliance officer has.

So, it's an early afternoon; I made it through the morning. My scheduled activity for the afternoon is to begin to get everything assembled and the agenda together for the quarterly compliance steering committee meeting. I am just getting started when I receive a phone call that there is a suspected case of Neisseria meningitidis in a patient on the medical surgical inpatient unit. This patient was brought in by ambulance last night and has been on the unit having been admitted from the emergency room. This is quickly followed by a phone call from the lab director again that the reference lab just said yes they are quite sure it is Neisseria meningitidis. There goes prep time for probably at a minimum the next two days while I put on my infection prevention and control hat, deal with the proper notification of state officials and prophylaxis of exposed staff, and ensure the proper education of all involved so those who were exposed as well as those around but not exposed are assured that they will be all right. This is my priority right now, as it should be, and in its way it is also about compliance.

How do I, a rural compliance officer, eat the compliance elephant while eating several other department elephants at the same time? Just like any of us eat anything else; one bite at a time!

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