Physicians and Compliance: Are They Oil and Water?

Presented by

CJ Wolf MD, COC, CPC, CHC, CCEP, CIA
Healthicity | Senior Compliance Executive
Physicians are...

• Busy
  *Learn key strategies for successfully engaging them in the compliance program.*

• Strong-willed
  *Explore approaches for resolving compliance conflicts with physicians.*

• Smart
  *Earn their respect by demonstrating how the program is implementing compliance intelligently.*
Personality Traits


- Complete data on personality were available for 1151 respondents. (Received 1178 surveys from 2957 physicians; 40% response rate).

---

**Physicians’ Self-Identification of Personality Type:**

- 53% workaholic
- 62% Type A
- 36% control freak

Approach

• Are you really there to help? If so, take an attitude of service with you.

• Don’t waste time…get to the point quickly.

• Provide practical tools and aids, not reams of paper with legalese.

• Stroke the ego if necessary, don’t try to tame it.

EHR Example

“While it may be good or bad that physicians are spending more time documenting care and communicating with other staff members than they are in face-to-face visits with patients, that fact highlights the misalignment of a payment policy that reimburses only office visits, lab work, and procedures while overlooking much of desktop medicine work.”

Source: Tai-Seale, M. et. al., Electronic Health Record Logs Indicate That Physicians Split Time Evenly Between Seeing Patients And Desktop Medicine, Health Affairs, April 2017
EHR Example

“The average total EHR time per weekday for a 1.0 clinical FTE was 355 minutes (5.9 hours), consisting of 269 minutes (4.5 hours) during clinic hours and 86 minutes (1.4 hours) after clinic hours.”

Source: Brian G. Arndt, et al., Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations, Ann Fam Med September/October 2017

<table>
<thead>
<tr>
<th>EHR Task Category</th>
<th>Time Spent per Day, min</th>
<th>Total Time Spent per Day, min (% of Daily Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Work Hours</td>
<td>After Hours</td>
</tr>
<tr>
<td>Clerical</td>
<td>64</td>
<td>20</td>
</tr>
<tr>
<td>Documentation</td>
<td>35</td>
<td>8</td>
</tr>
<tr>
<td>Order Entry</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Billing and Coding</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>System Security</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Subtotal</td>
<td>121</td>
<td>36</td>
</tr>
<tr>
<td>Medical care</td>
<td>47</td>
<td>13</td>
</tr>
<tr>
<td>Chart Review – Notes</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Chart Review – Medications</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Chart Review – Laboratories</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>EBM, Point of Care</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Chart Review – Imaging</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Subtotal</td>
<td>86</td>
<td>28</td>
</tr>
<tr>
<td>Inbox</td>
<td>41</td>
<td>14</td>
</tr>
<tr>
<td>Refills and Results</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Management</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Telephone Call</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Letter Generation</td>
<td>62</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>269</td>
<td>86</td>
</tr>
</tbody>
</table>
Between a Rock and a Hard Place


![Bar chart showing frequency of physician manipulation](chart.png)

Physician Incentives


“Medical education includes one of the most intense socialization processes of any profession, and the products of these programs bring strong professional values to the practice setting. These values include personal responsibility for patients as clients, a strong collegial peer orientation, and a strong commitment to patient care regimens based on professional judgments unencumbered by organizational imperatives. Consequently, incentives that are compatible with these professional values may be much more influential than incentives that conflict with professional values.”
Physician Incentives

“Individuals respond to what is measured and rewarded.”

“If individuals can game the reward system to their advantage, anticipate that they will do so.”

“Nonfinancial incentives, such as patient outcomes, autonomy, regret, and peer approval, may have as strong or stronger an impact on physician behavior than financial incentives.”

Physician Incentives

“The number and characteristics of performance measures are likely to affect the effect of incentives.”

“Research shows that changing behavior by changing incentives is easiest when the linkage between behavior and reinforcer is clearest, such as a one-to-one relationship. Changing behavior is most difficult when the linkage between behavior and reinforcer is least clear, such as in a variable reinforcement schedule.”
Difficult physicians

- Make sure the process/policy/regulation/activity is, or was, transparent
- Don’t make it personal
- Rely on data
- Speak in a sterile manner
- Tie compliance into quality of care as much as possible
- Consider their professional society’s clinical guidelines
- Ask them to teach you
- Document efforts for possible escalation

Physicians as Whistleblowers

Physicians as Whistleblowers

“Often physicians are knowledgeable about wrongful practices as a result of their involvement in meetings, discussions with other physicians and healthcare executives, and access to documents and information... They are considered reliable sources of information and are presumed to be credible because of their status as physicians and their medical knowledge to explain technical information. As a result, when physicians come forward as qui tam plaintiffs, prosecutors will listen…”

--McAfee & Taft

Physicians as Whistleblowers

Physician whistleblowers are motivated to bring qui tam actions for various reasons, including:

• Financial incentives available to qui tam plaintiffs;
• Disagreements and adversarial relationships with other physicians and healthcare providers;
• Exclusion from participation in business transactions, joint ventures, and arrangements in which other physicians may profit or benefit;
• Competitive concerns;

(continued on next slide)
continued

- Anger or disgruntlement following the termination of employment, revocation of medical staff appointment, or expulsion from joint venture participation;
- Perceived “self-preservation” or protection as a threat to other physicians or healthcare providers who assert claims or take actions against them;
- Poor treatment by healthcare executives;
- Protecting patients and patient safety;
- Stopping unlawful or fraudulent practices;
- Exposing wrongdoing.

--McAfee & Taft

3

How smart is your compliance program?
Provide Timely Information

- Policy updates (MAC, Medicaid, CPT/ICD changes, institutional)
- Audit feedback should be recent and frequent, such as billing audits
- Quick replies (good ol' customer service)

Use current tools and technology

- Make compliance as easy as possible
- Electronic Attestations
- Training (mobile friendly)
Demonstrate competence

• Be right, be certain

• Trust is earned in small steps but can be lost all at once

• Avoid opinion, cite references (let them read it for themselves)

• Use data to demonstrate a smart and efficient compliance program

COI Example


• “Conflict of Interest: Why Does It Matter?” Harvey V. Fineberg, MD, PhD
• “Payments to Physicians-Does the Amount of Money Make a Difference?” Bernard Lo, MD; Deborah Grady, MD, MPH
• “Physicians, Industry Payments for Food and Beverages, and Drug Prescribing” Robert Steinbrook, MD
• “Association Between Academic Medical Center Pharmaceutical Detailing Policies and Physician Prescribing” Ian Larkin, PhD; Desmond Ang, MS; Jonathan Steinhart, MA; et al
Questions?

cj.wolf@healthicity.com