BoardBrief

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Knowledge Resources for Governing Effectiveness

Corporate Responsibility and Health Care Quality

Infusing the board agenda with a focus on quality invites another perspective on the board's responsibility for quality and patient safety: assessing compliance and avoidance of "quality fraud." "Quality fraud" is a term not often understood, but it is one that every board should understand.

Both the Office of Inspector General (OIG) and the Department of Justice (DOJ) have increased their attention to quality and patient safety. Quality is increasingly being linked to reimbursement, and these government agencies want to ensure that patients receive the quality (and quantity) of care that the federal government and other payers are reimbursing.

Payment for poor quality can be viewed as a false claim. Failure to accurately report quality data may be considered potential fraud. In addition, both the OIG and the DOJ (as well as the Centers for Medicare and Medicaid Services) place the responsibility for quality of care squarely on the shoulders of the board.

Quality Fraud

Prosecution for quality fraud may be determined by the following factors:

1. Has there been a systemic failure by management and the board to address quality issues?
2. Has the organization made false reports about quality or failed to make mandated reports?
3. Has the organization profited from ignoring poor quality or ignoring providers of poor quality?
4. Have patients been harmed by poor quality or given false information about quality?[3]

Corporate Responsibility and Health Care Quality: Oversight Recommendations

Boards can't simply be passive recipients of quality and safety information. Trustees must be actively engaged in oversight. In 2007 the OIG and the American Health Lawyers Association (AHLA) co-sponsored *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*.[1] The purpose of the publication was to equip boards with the rationale and tools necessary to understand and execute their obligations for quality and patient safety.

The OIG/AHLA publication included a series of recommended questions and explanations for boards to use in understanding and governing quality. The OIG and the DOJ will increasingly examine governance to ensure that boards of trustees understand quality and patient safety issues, as well as effectively monitoring performance to ensure that the care provided by their organization exhibits the highest quality and efficiency.

In the pursuit of "reasonable inquiry," the OIG and

AHLA recommends that boards ask and have solid answers to the following ten questions:

1. What are the goals of the organization's quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals? How are these expressed in annual budgets and operating plans? How is each goal specifically linked to management accountability?
2. How does the organization measure and improve the quality of patient/resident care? Who are the key management and clinical leaders responsible for these quality and safety programs?
3. How are the organization's quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?
4. Does the board have a formal orientation and continuing educational process that helps members appreciate external quality and patient safety requirements? Does the board include members with expertise in patient safety and quality improvement issues?
5. What information is essential to the board's ability to understand and evaluate the organization's quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the board receive reports about the quality improvement efforts?
6. How are the organization's quality assessment and improvement processes coordinated with its corporate compliance program? How are quality of care and patient safety issues addressed in the organization's risk assessment and corrective action plans?
7. What processes are in place to promote the reporting of quality concerns and medical errors, and to protect those who ask questions and report problems? What guidelines exist for reporting quality and patient safety concerns to the board?
8. Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?
9. Do the organization's competency assessment and training, credentialing, privileging and peer review processes adequately recognize the necessary focus on clinical quality and patient safety issues? How are leaders held accountable for this?
10. How are "adverse patient events" and other medical errors identified, analyzed, reported, and incorporated into the organization's performance improvement activities? How do management and the board address quality deficiencies without unnecessarily increasing the organization's liability exposure?

What are the goals of the organization's quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals?

Sources and Additional Information

1. Arianne N. Callender, Douglas A. Hastings, Michael C. Hemsley, Lewis Morris, Michael W. Peregrine. Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors. United States Department of Health and Human Services Office of Inspector General and American Health Lawyers Association. September 2007. www.oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf.
2. OIG Report on Board Oversight and Quality of Care: What it Means for Health Care Boards of Directors. Foley & Lardner LLP. October 16, 2007. www.foley.com/publications/pub_detail.aspx?pubid=4515.
3. Alice G. Gosfield, J.D., James L. Reinertsen, M.D. Avoiding Quality Fraud. *Trustee*. September 2008.

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