coronis health

Coronis Focus

A quarterly publication providing topics of interest to the healthcare industry

MiraMed has recently merged with Coronis Health, creating a leading platform that provides end-to-end technology-enabled solutions to healthcare companies across the US. We are excited to start this next chapter and continue bringing the best thought leadership to our esteemed colleagues in healthcare.

SUMMER 2024

Using Data to Understand Social Determinants of Health

BY LAURA LEGG, RHIA, RHIT, CCS, CDIP and AHIMA-APPROVED ICD-10 CM/PCS TRAINER

Vice President of Coding, Enterprise Division, Coronis Health, Jackson, MI

The Centers for Medicare & Medicaid Services (CMS), the World Health Organization and other governing bodies have made the pursuit of equitable health outcomes a fundamental goal worldwide. However, achieving health equity requires more than just advancements in medical technology and access to healthcare services. It demands a comprehensive understanding and addressing of the social determinants of health (SDOH).

Social determinants of health are the conditions in which people are born, live, work and age. Key factors include socioeconomic status, education, physical environment, employment, social support networks and access to healthcare services.

Here are a few examples of the social determinants of health, which can influence health equity:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality

On Jan. 1, 2024, CMS began requiring healthcare organizations to screen for five social risk drivers, a task that was voluntary in 2023. Healthcare teams are expected to ask patients questions pertaining to the five domains at any point during their hospital inpatient stay with yes/no answers and a field to note if patients were unable or declined to answer.

CMS is introducing two new inpatient quality reporting measures in 2024: screening for SDOH and positive rate for SDOH. Healthcare teams screening for SDOH will assess how many patients aged eighteen and older were screened and report the positive rate.

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INSIDE THIS ISSUE:

The Not So Lazy Days of Summer

BY TONY MIRA
Interim CEO

For some reason, many associate the middle months of the year with lying in the sun, lounging around the house or generally letting things slide a bit. They're called the lazy days of summer for a reason, but just how accurate is that description? True, the kids are out of school for several weeks, and adults will often take off work for individual or family vacation. But a lot of kids get summer jobs or have sports or other activities, and some trips to the beach or the mountains are so stressful that many need a vacation from their vacation. And to be honest, with smart phones, tablets and email always at the ready, who really disconnects in full?

The business of America doesn't stop just because we've hit June. And that is especially true for the healthcare sector. People will still have a need to see their doctor and to schedule procedures; and health emergencies don't always wait until the fall. Because hospital workers can't afford to call it quits when the temperatures rise, we offer this array of helpful articles for your summer reading. They are both educational and we hope inspirational.

To kick off this edition of *Focus*, we have Laura Legg, a vice president at Coronis Health, addressing the social determinants of health. This is especially timely as the Centers for Medicare and Medicaid Services (CMS) now requires healthcare organizations to screen patients relative to five socioeconomic factors. Pay close attention to this article.

Next, we have Professor J. Bryan Bennett, who always manages to provide relevant and hard-hitting data that healthcare entities need to consider if they intend to stay successful in their overall mission. "The Impact of Toxic Leaders" is an instant classic, and hospital executives will not want to miss what Mr. Bennett has to say on this subject.

Our own Justin Vaughn, a compliance department vice president at Coronis Health, provides two offerings in this issue of *Focus*. First, is an article that deals with the extent to which doctors and other clinicians are allowed to use text messaging in the hospital setting—in the context of passing on patient information. Does this or can this constitute medical record documentation, for example? Justin brings home the facts. Mr. Vaughn then provides an article that stresses the importance of a viable compliance program for hospitals and other healthcare entities. This will act as a definite heads-up for decision-makers.

Attorney Christopher Ryan talks about the Corporate Transparency Act (CTA) in an article that is sure to inform. Everything a hospital administrator would need to know about the CTA is logically and cogently laid out. Each anticipated question is asked and answered. We are fortunate to have Christopher's legal expertise available to our readership.

Finally, Daniel Douglas, vice president of operations for Coronis Health's Hospital Division, presents a piece entitled, "Community, Collaboration, Critical Access and Cash." Daniel demonstrates the interaction of these elements and the important part Coronis Health plays in tying them all together.

We hope you enjoy this issue of *Focus*; and, if you do find yourself with some time this summer to laze around the pool, make sure to take along some reading material. You can tell yourself and others it's a working vacation!

Using Data to Understand

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Healthcare professionals must be able to recognize and address these determinants to ensure that all individuals can attain their highest level of health. Leveraging data gathering techniques is essential for understanding and addressing these determinants effectively.

Data serves as a powerful tool for uncovering patterns, trends and disparities related to social determinants of health. By collecting and analyzing relevant data, healthcare professionals can gain insights into the social, economic and environmental factors that influence health outcomes within communities.

Electronic health records (EHRs) offer a valuable platform for integrating SDOH data into clinical practice. Healthcare professionals can utilize EHR systems to capture information on patients' socioeconomic status, housing stability, access to transportation and other social factors. By standardizing data collection processes and incorporating SDOH metrics into EHR templates, providers can systematically gather valuable information.

Incorporating SDOH screening tools and surveys into routine clinical assessments enhances data gathering efforts. These tools enable healthcare professionals to systematically identify patients' social needs and vulnerabilities. Screening instruments such as the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) tool offer structured frameworks for gathering data on SDOH domains, facilitating comprehensive assessments and targeted interventions to address underlying determinants effectively.

Population health data sources provide valuable insights into community-level SDOH trends and disparities. Analyzing population health data enables healthcare systems to develop targeted strategies that address the unique needs of diverse communities, promoting health equity on a broader scale. Collaboration and data sharing among healthcare organizations, community agencies, and government entities are essential for comprehensive SDOH data gathering. By sharing data and resources, stakeholders can enhance their understanding of local SDOH dynamics and coordinate efforts to address systemic barriers to health equity.

Data gathering is integral to understanding and addressing social determinants of health effectively. By harnessing data from diverse sources, healthcare professionals can identify disparities, inform targeted interventions and advocate for policy changes that promote health equity. Empowering healthcare professionals with robust data gathering tools and resources is essential for advancing efforts to address SDOH.

New SDOH Reporting Requirements Expected to Impact HI Workflow, Staffing, https://journal.ahima.org/health-data/details/new-sdoh-reporting-requirements-expected-to-impact-hi-workflow-staffing

LAURA LEGG

Laura Legg, RHIA, RHIT, CCS, CDIP and AHIMA-approved ICD-10 CM/PCS Trainer, is a HIM professional with experience in acute care hospital coding, auditing and CDI. Ms. Legg serves as Vice President of Coding for the Enterprise Division of Coronis Health and has worked in a variety of positions across her career. She is passionate about the industry and mentoring new HIM professionals. Laura has a bachelor's degree in Health Information Administration from Stephens College in Columbia Missouri.

Laura is an active member of HFMA, AHIMA, AAPC and the National Association for Revenue Integrity. She speaks regularly at regional and national AHIMA events, is an advisory board member for Briefings for Coding Compliance and is an AHIMA mentor. She can be reached at **Laura.Legg@coronishealth.com**.

The Impact of Toxic Leaders on Your Healthcare Organization

BY J. BRYAN BENNETT, MBA, CPA, LSSGB
CEO & Chief Leadership Innovation Officer, Elite Leadership Academy, LLC., San Diego, CO

Toxic leaders are like weeds in your garden or lawn. If you don't remove them right away, they will infest your entire organization, resulting in stifled growth, reduced morale and the departure of quality employees.

Toxic leaders are everywhere, whether organizations want to admit it or not. They can be found in organizations with as little as 100 employees or found in multitudes in larger ones.

Unfortunately, they are usually ignored and allowed to choke the growth of those around them, namely, their subordinates and their peers. They are usually accepted and described in satisfactory terms such as hard-working, results-driven or persistent. On the surface, these traits could describe great employees; but, when taken to the extreme, they result in negative outcomes, such as abuse, intimidation and manipulation.

Toxic leaders have a negative impact not just on the team they're managing but can impact the entire organization through attrition or lack of productivity. Toxic leaders can be identified by several behaviors, including:

- Stifling creativity among their team
- Accepting accolades for any successes but blame others for any failures
- Managing through fear and intimidation
- No interest in their team members' personal or professional lives
- Refusing to accept any negative feedback, constructive or otherwise

The employees led by toxic leaders will also show behavior modification as a result of toxic leadership, such as:

- Energetic employees become reserved and no longer show initiative
- Employees begin to withhold innovative ideas
- Increased sick and vacation requests
- Increased turnover

Peers that surround a toxic leader can be drawn into increased accountability for employees and productivity outside of their own team in an effort to "rescue" the team. Employees may start to vent to the leader of their choice, isolating the toxic leader from the manager/employee relationship. This creates a cycle of increased control from the toxic leader, which pushes the employee further away, which then pushes the leader into more toxic behavior.

Working with a toxic manager usually leads to burnout, attrition and lower productivity. A recent study put the cost of bad managers at US companies at over $900 billion annually. Healthcare organizations need to identify these managers and take immediate appropriate action.

HOW TOXIC LEADERS SURVIVE

Believe it or not, you are probably complicit in the toxic leaders surviving in your healthcare organization. The same people you call hard-working, results-driven or persistent are some of the same people who are abusers, intimidators and manipulators. Toxic leaders survive because they are allowed to survive. This "head in the sand" approach to leading will not help the people who report to them or their peers who have to work with them.

Toxic leaders are usually also politically savvy. They know how to handle anyone who could be a threat to their job or

control. So, while you may be seeing someone who's always smiling and saying the right things, their direct reports and peers may perceive them as an upset Godzilla crossed with the Predator.

If you suspect someone might be a toxic leader, they probably are; so, you should take action before it's too late.

IDENTIFYING AND REMOVING TOXIC LEADERS

In a healthcare organization, once a toxic leader is identified, there are two paths that can be chosen:

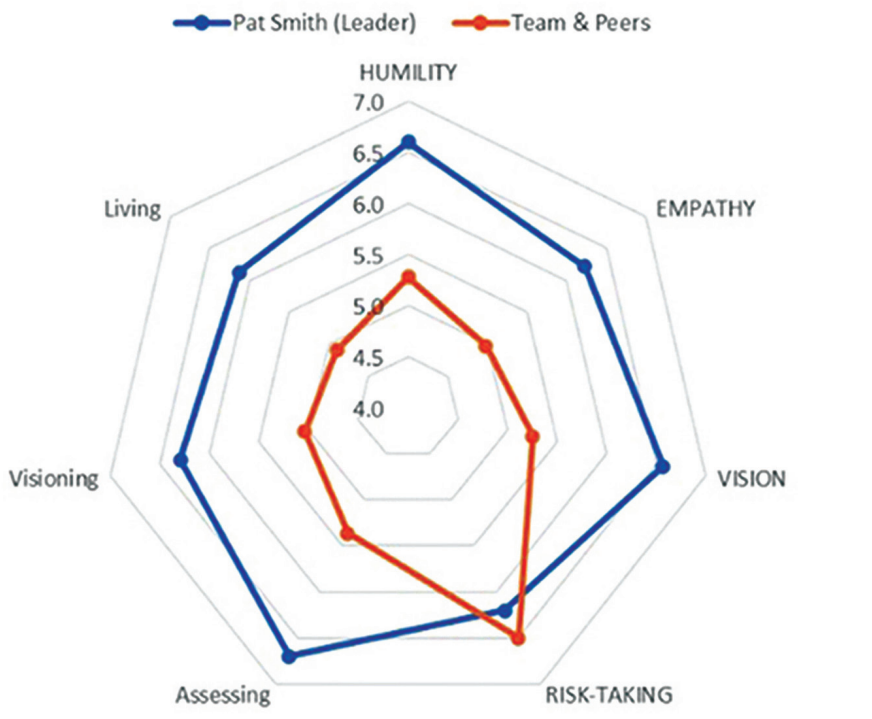
1. Coach them for improvement if they are salvageable
2. Counsel them to move on

Identifying toxic leaders can be very challenging, especially the politically savvy ones. Communication and observation are effective leadership tools that can be used to better understand challenges facing a department or group leader's team members, but they take a longer time to receive actionable information.

For communication, focus on listening versus talking by getting to know basic information about the team members, such as their career goals, family life, outside interests, etc. When they see a general interest, they may feel comfortable enough to open up about other topics.

For observation, watch how people interact with their supervisor, fellow team members and the support staff. Do they largely interact in small groups or as a team? How do they interact with their supervisor? Understanding the team dynamics will help the group leader gather information about their members.

CHART 1: DATA-INFORMED 360 TOOL



Many organizations turn to 360 reviews to identify toxic leaders. The problem with most 360 reviews is that they are not completely anonymous. Since most responses are text-based, readers can usually determine who provided a comment based on writing style or previous comments, which can lead to retaliation—an action toxic leaders willingly take. Reviewers may also be intimidated by the leader and not provide honest feedback. Lastly, the comments are open to interpretation by the person or persons reading the feedback.

A more effective approach is using data-informed 360. A data-informed 360 is quantitative-based, using proven research methods and is completely anonymous. Reviewers answer questions about a person's leadership behavior using a seven-point Likert scale. The tool can then be used to measure the leader's perception of their leadership against the team's perception of their leadership. This provides a comprehensive picture of the leader, enabling the organization to identify potential toxic leadership behaviors and take action. This tool has been used to assess individuals for several years, thus also creating a statistical data pool to benchmark the leader's results against.

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The Impact of Toxic Leaders

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For example, when actually used as part of a healthcare system's team assessment, it very easily detected a toxic leader as a leader's team, peers and supervisors assessed their leadership behaviors. The results were very clear and provided the department leader with the ammunition to have a very specific conversation with the leader. The results were supported by the department leader's prior engagement with the communication and observation techniques previously discussed, which had pointed to a potential problem.

Healthcare organizations have no excuse to continue accepting toxic behavior. A data-informed assessment tool provides the hard evidence needed to support suspicions derived from the effective use of communication and observation. It will support the hard choices that need to be made and verify any suspicions the healthcare organization has about their

leaders. Toxic leaders must be identified and "weeded out" for the betterment of the healthcare organization.

J. BRYAN BENNETT MBA, CPA, LSSGB

Professor Bryan Bennett, MBA, CPA, LSSGB, is the founder and Chief Leadership Innovation Officer for the Elite Leadership Academy, a privately funded leadership research, training, coaching and advisory organization established to help individuals and organizations improve leadership with measurable results.

Professor Bennett has been a faculty member at Northwestern University since 2013. He has also been an adjunct faculty member at the University of Chicago, Judson University and West Virginia University. His academic experience includes developing and teaching courses in business analytics, leadership and marketing to domestic and international students both online and in classroom environments.

He is the author of the books, *The Path to Elite Level Leadership: The 5-Step Program for Measurable Leadership Growth* (2021), *Prescribing Leadership in Healthcare: Curing the Challenges Facing Today's Healthcare Leaders* (2017) and *Competing on Healthcare Analytics: The Foundational Approach to Population Health Analytics* (2015).

His work has been recognized by Gartner and published in several academic and professional journals.

Professor Bennett is a highly requested international speaker on the strategic implementation and use of analytics in healthcare, leadership improvement and population health management.

He has been recognized by *Becker's Hospital Review* as one of the top African American Leaders in Healthcare for three years in a row.

He has a Master of Business Administration from Northwestern University's Kellogg School of Management and a Bachelor of Science degree from Butler University. He is a Certified Lean Six Sigma Green Belt, Certified Data Scientist, Certified Public Accountant, Certified Adjunct Faculty Educator and trained project manager. He can be reached at **bbennett@eliteleadershipacademy.com**.

Are Clinical Texts Acceptable?

CMS Weighs in

BY JUSTIN VAUGHN, MDIV
Vice President of Anesthesia Compliance, Coronis Health, Pineville, LA

We all do it. Unless you're physically impaired or living off the grid in the wilds of Alaska, most adults will communicate by way of texting at some point in a given year. For many of us, it is a daily occurrence. In the 1970s, Brownsville Station had a breakout hit with "Smoking in the Boys' Room"—a high-octane song about teenage rebellion. In the 2020s, it's more likely that they'd be *texting* in the boys' room.

Interesting how methods for delivering the written word have morphed over the years, isn't it? From carrier pigeon to postal rider to email and so on; and now we have distilled this delivery down to a few informal pecks on a hand-held smartphone. And by informal, I refer to the propensity on the part of some to make use of a new short-hand lingo that involves an array of abbreviations and a unique indifference to the rules of grammar and punctuation. With this in mind, one has to ask: is appropriate for medical professionals to clinically communicate via texting? That's the question that the U.S. government decided to address earlier this year.

On February 8, 2024, the Director of the Quality, Safety and Oversight Group (QSOG)—an agency within the Department of Health and Human Services (HHS) sent an official memorandum to state survey agency directors, with the understanding that the guidance given therein would be effective within 30 days. The subject of the memorandum was as follows: "Texting of Patient Information and Orders for Hospitals and CAHs." In this communication, David R. Wright, the director of QSOG, provides these surveying agencies the department's position on the propriety of utilizing text messages within the clinical context.

THE PREVIOUS GUIDANCE

Director Wright began with a reminder that the Centers for Medicare and Medicaid Services (CMS) had released in 2018 a previous memorandum on this topic, entitled "Texting of Patient Information among Healthcare Providers in Hospitals and Critical Access Hospitals (CAHs)." That memorandum acknowledged that the use of texting had become "an essential means of

communication among hospital and CAH healthcare team members." However, CMS noted at that time that the practice of a provider texting patient orders to other members of the care team would not be compliant with the Medicare conditions of participation (CoPs). The agency cited concerns with record retention, privacy, confidentiality, security and the integrity of systems at that time.

When CMS developed the 2018 guidance, most hospitals and CAHs did not have the ability to use secure texting platforms to incorporate these messages into the medical record. Now, that situation as markedly changed.

THE NEW GUIDANCE

The hospital and CAH medical record CoPs are found at 42 CFR 482.24 and 485.638, respectively. Among other

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Are Clinical Texts Acceptable?

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provisions, they require inpatient and outpatient medical records to be accurately written, promptly completed, properly filed and retained, and accessible. The hospital is further required to utilize a system of "author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries." As the February 2024 memorandum points out, these requirements do not specify a precise method or system that a facility must incorporate for such purposes. That lack of specificity on the part of the CFRs and the existence of new text-related technology has put the ball back in QSOG's court. That is, Director Wright and his team are left to grapple with the question of whether or not texting can now be appropriately incorporated into the medical record.

While computerized provider order entry (CPOE) continues to be the preferred method of order entry by a provider, Director Wright recognizes that alternatives now exist. His agency also acknowledges that there have been significant improvements in the "encryption and application interface capabilities of texting platforms" that relate to the transfer of data into an electronic health record (EHR).

CMS has historically taken the position that a physician or advanced practice provider should enter orders into the medical record via a handwritten order or CPOE. An order entered via CPOE, and immediately uploaded into the hospital's or CAH's EHR system, is permitted under the requirements because the order is dated, timed, authenticated and promptly placed in the medical record. Nevertheless, QSOG's latest instruction holds out the possibility of using texting in the medical record creation process. Here is the salient section from the memorandum in this regard:

> *To comply with the CoPs, all providers must utilize and maintain systems/platforms that are secure and encrypted and must ensure the integrity of author identification as well as minimize the risks to patient privacy and confidentiality, as per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Providers should implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized to avoid negative outcomes that could compromise the care of patients. CMS expects that providers choosing to incorporate texting of patient information and orders into their EHR will implement a platform that meets the requirements of the HIPAA Security Rule and the HITECH Act Amendment, as well as the CoPs.*

So, to text or not to text is the question, and it turns on whether or not your facility has the functionality that allows it to conform to the CFRs, CoPs and the HIPAA privacy and security measures.

HOW THIS WORKS

For a better understanding of what these requirements practically entail, let us examine the Joint Commission's take on

texting. The nation's premier hospital surveying organization has published a set of FAQs wherein the following statement is made:

> *[H]ealthcare organizations that implement a secure texting platform (STP) may text patient care information and orders among members of the care team. While computerized provider order entry (CPOE) remains the preferred method of order entry for providers, organizations are permitted to text orders via an STP that can transfer the information into the electronic health record (EHR).*

The Joint Commission goes on to clarify the requirements that must be met by the hospital before such texting takes place. Those requirements are as follows:

- Implement an STP that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule, the HITECH Act Amendment 2021, and the CMS Conditions of Participation addressing medical records. The STP must be secure, encrypted, ensure the integrity of author identification, and minimize risks to patient privacy and confidentiality.
- Implement policies and procedures to routinely assess the security and integrity of the STP.
- Confirm that texted orders transmitted via the STP are dated, timed, authenticated, and promptly placed in the medical record.
- Make sure that the information transmitted into the EHR is accurately written, promptly completed, properly filed and retained, and accessible.

Texting is what we do. It's the way we increasingly communicate; and, so, it is only natural that doctors, nurses and other practitioners are going to use the text capability of their phone to send out instructions and information. They can do this, as long as they adhere to the rules and standards set forth by the federal government and its associated surveying agencies.

If you have questions relating to this guidance, you are invited to contact members of QSOG by going to the following link: **QSOG_Hospital@cms.hhs.gov**.

JUSTIN VAUGHN, MDIV

Justin Vaughn, MDiv, serves as Vice President of Anesthesia Compliance for Coronis Health. Mr. Vaughn has over 20 years of experience in anesthesia compliance and has been a speaker at multiple national healthcare events. He has written two books on compliance-related issues and is the author of numerous articles relevant to the hospital space. Justin can be reached at **Justin.Vaughn@coronishealth.com**.

The Corporate Transparency Act: What It Means For You

BY CHRISTOPER H. RYAN, ESQ.
Taft, Southfield, MI

The Corporate Transparency Act (CTA) took effect in January, 2024, and it is likely to impact the vast majority of businesses of all shapes and sizes and in nearly every sector of the economy. Given how new the law is, combined with mounting legal challenges questioning its legitimacy, questions are being raised about nearly every aspect of the Act. One thing is certain: businesses, including healthcare organizations, need to pay attention.

WHAT IS THE CORPORATE TRANSPARENCY ACT?

The CTA was enacted in 2021, but the main provisions of the act only recently took effect. The CTA is a federal law that requires most business entities to report Beneficial Ownership Information to the United States Department of Treasury's Financial Crimes Enforcement Network (FinCEN). As explained in more detail below, the law essentially requires companies to disclose the names and contact information of the individuals who own or control the business entity.

WHAT IS THE PURPOSE OF THE CTA?

Proponents of the CTA state that under the current—mostly anonymous—structure of businesses, criminals have been able to hide behind and launder money through shell companies. They claim doing so has facilitated illegal activities such as human trafficking, corruption and tax fraud. The CTA is designed to correct this by requiring entities to report the identities of the individuals "behind" the company.

WHAT TYPES OF ENTITIES HAVE TO REPORT?

The CTA has two types of reporting companies: domestic and foreign. The definitions of each are very broad. Domestic reporting companies include corporations, limited liability companies and all other entities created by filing a document with a secretary of state or other similar office. Foreign reporting companies are entities formed in a foreign country but registered to do business in the United States.

ARE THERE EXEMPTIONS?

Yes. There are 23 categories of entities that are exempt. Although the list (and the particular requirements to fit into each category) is far too long for this article, major categories of exempt entities include insurance companies, accounting firms, public utilities, certain inactive entities, banks and tax-exempt entities. Each of the 23 categories contains specific requirements that must be present in order to fit within the exemption. Although there is no express exemption for medical practices or hospitals, that does not necessarily mean that a medical practice or hospital would not be exempt if it fits within a different category (such as a tax-exempt entity).

WHEN IS THE REPORT DUE?

A reporting company that was created prior to January 1, 2024 has one year (until January 1, 2025) to file its initial report. A reporting company that is created during 2024 has 90 days to file its report. A reporting company created after January 1, 2025 has to file within 30 days.

WHAT NEEDS TO BE REPORTED?

For the most part, the report captures information about the beneficial owners of the reporting company. The

term "beneficial owner" is not just the individuals who ultimately own the company. A beneficial owner is anyone who directly or indirectly (1) exercises substantial control over the company, or (2) owns or controls 25% or more of the company's ownership interests.

An individual exercises "substantial control" where he or she is a senior officer (e.g., president, CFO, COO, etc.), has the authority to appoint or remove a senior officer, directs or has substantial influence over important decisions made by the reporting company, or is an individual with any other form of substantial control. An individual can have direct or indirect substantial control through various means including board representation, rights associated with a financing arrangement, and control over intermediary entities that exercise substantial control over the reporting company.

For each beneficial owner, the reporting company generally needs to report his or her full name, residential address and date of birth. The reporting company also has to provide FinCEN with an image of a document that identifies each beneficial owner (e.g., driver's license, passport, government issued identification, etc.). Reporting companies are also required to disclose information about the reporting company, including where it was formed and its current address.

WHERE CAN THE REPORT BE MADE?

Many businesses are engaging legal counsel to navigate CTA compliance. At other times, businesses are asking accountants to perform the function. As indicated above, there are numerous exceptions to the reporting requirements and questions are frequently being asked about who qualifies as a beneficial owner. For those that want to handle reporting themselves, the report is available (as of the time of this writing) on the FinCEN website: **boiefiling.fincen.gov**. The FinCEN website also contains guidance documents with more specific information about reporting requirements and exemptions from reporting requirements.

WHAT HAPPENS IF A BUSINESS DOES NOT REPORT?

A person who willfully violates the reporting requirement can be subject to civil penalties of up to $500 per day. There are also criminal penalties of up to two years in prison and a fine of up to $10,000.

IS THE CTA BEING CHALLENGED?

Yes. Challenges have been brought by various interest groups. Most

notably, National Small Business United brought an action in the United States District Court for the Northern District of Alabama. The Court ruled that the CTA exceeded Congress's power and it enjoined the Department of Treasury and FinCEN from enforcing it against the parties to that lawsuit. FinCEN appears undeterred, as it has stated that, with the exception of the particular entities and individuals subject to the court order, all other entities must continue to comply with the reporting requirements. It is also appealing the Court's order.

THE TAKEAWAY

A lot about the CTA is in flux and may change as time goes on. One thing is for sure: businesses of all shapes and sizes, including healthcare entities, need to pay attention and have a plan in place to ensure CTA compliance.

CHRISTOPHER J. RYAN, ESQ.

Christopher J. Ryan, Esq., is an attorney and Partner at Taft. He is an experienced litigator who has spent most of his career representing individuals and businesses involved in the healthcare industry. Chris can be contacted at **CRyan@taftlaw.com**

Community, Collaboration, Critical Access and Cash

BY DANIEL DOUGLAS
Vice President of Operations, Hospital Division, Coronis Health, Boston, MA

No, the "four Cs" represented above are not categories for diamond characteristics or qualities. Although these qualities *can* lead to brilliance and treasured outcomes when performed the "Coronis Way" in this space.

Community, collaboration, critical access and cash represent the aspects and qualities required in Coronis Health's model, operating within our client partnerships in parallel. Coronis has navigated and operated successfully throughout the community hospital, critical access and rural hospital marketplace for many years. We partner with critical-access categorization migrations. Critical access hospitals (CAH) can be defined by a twenty-five bed or fewer facility. Critical access hospitals are a large part of our hospital portfolio, and we possess key expertise in this space with coding, revenue cycle management (RCM) and preservice authorization. Additionally, the hospital team is experienced with larger hospital partnerships, actively working with providers maintaining 75-600 beds, typically in a coding, and in certain cases, a full-lift partnership.

COMMUNITY

The facilities that we support are large-scale local employers, patient-supporting and small micro-communities in rural parts of America. It is common for hospital employees to be visible to patients and colleagues locally at farmers markets, public schools and at their local town- and or community-sponsored events. There may not be a Starbucks within two hundred square miles, let alone another healthcare provider. This environment creates a sense of community and develops buy-in with employees and patients supporting these services. The provider may be twenty-five beds in a critical access setting or seventy-five to two hundred beds in a rural community environment.

Our Coronis Health physician team supporting these partnerships has practical experience working onsite at a community hospital, which is typically independent, and has developed those experiences required to connect on any level with hospitals, from departmental level to administration. It is routine for our teams to travel onsite and review items in detail across the table with our hospital counterpoints, clinical departmental leadership and administration to aid in the developing of additional onsite strategies and synergies.

COLLABORATION

Our team's success is measured by collaboration on various levels and includes a partner facility that entrusts Coronis to deliver the best possible quality and fiscal outcome, creating a tangible synergy. Collaboration with our

global partners maximizes the efforts of all forces to combine and provide consistent best-practice delivery. Mutual respect from our partners, as well as our genuine teamwork exemplified by both shores, provides a predictable and consistent outcome to quality and service delivery. Coronis understands that if we do not collaborate with all parties, then the outcome will not be as successful. We believe that dedication, commitment and buy-in are the best strategies to create long-term relationships.

CRITICAL ACCESS

The critical access status conversion is trending, impacting many small, rural and community hospitals; and Coronis intends to continue to focus on this classification of facilities. The risk of closure with smaller, independent rural facilities is real without intervention from the Centers for Medicare and Medicaid Services (CMS). Congress

identified criteria promoting critical access conversion, supporting the fiscal outcomes of these providers. These facilities must be thirty-five miles from any other hospital, maintaining no more than twenty-five inpatient beds and typically provide service to underserved areas. The fact these health providers must maintain abilities to service these populations is real; and, without this service, many will have to go without care or travel significant distances even for routine care.

The benefits of critical access conversion and maintenance are as follows:

- Reduce financial exposure of rural facilities and maintain independence.
- Cost-based Medicare reimbursement and federal grant eligibility. Some states CAH's may receive cost-based Medicaid reimbursement as well.
- Capital improvement costs included in allowable Medicare reimbursement.
- Provide patients with access to essential services locally.

Coronis has successfully partnered with many providers transitioning to a critical access status and has continued to work with them for many years post-conversion. This navigation to CAH status can be incredibly challenging and can temporarily impact revenue or significantly delay reimbursement if not strategically mapped out. We at Coronis have a thorough understanding of regulatory requirements and the challenges that must be navigated prior to actual conversion. Additionally, we partner with facilities that have already achieved a CAH designation, continuing our subject matter expertise in this space.

CASH

All these aspects add up to cash. We cannot operationalize our clients to create cash without community, collaboration and our knowledge of critical access. Whether it is Coronis supporting an aged FTE, coding and/or RCM partnership or a full-lift operation, we capture all levels of revenue cycle operations from a day-one environment. This ranges from preservice authorization to coding, billing and RCM follow up. Like a diamond, this brilliance shines through when all these qualities are

performing in unison, creating partnerships and revenue that are referenceable and long term. change management provides a foundation to make change stick and helps organizations build the culture to support their continual improvement. Clearly, the investment in business relations with other healthcare systems and third-party vendors are key for the "new world" transformation of the financial health of revenue cycle management. In summary, all parties—internal and external—will be required to plan and act differently and harness the momentum of major cost containment trends. This is the new definition of collaboration.

DANIEL DOUGLAS

Daniel Douglas serves as Vice President of Operations for the Hospital Division at Coronis Health. Mr. Douglas is a thirty-year veteran of the revenue cycle industry and has worked in various roles including onsite at a large-scale for-profit acute care provider. Additionally, he has experience in all levels of revenue cycle with a concentration on front-end authorization, billing, coding and follow up. He currently leads a team that are experts in rural and community hospital partnerships. These relationships are making differences in these remote areas that are critical for patients access to care and facility solvency. He can be reached at **danieldouglas@coronishealth.com.**

An Ounce of Prevention:

The Increasing Priority of Compliance Programs

BY JUSTIN VAUGHN, MDIV
Vice President of Anesthesia Compliance, Coronis Health, Pineville, LA

Among the maxims we Americans have heard and repeated over the decades is one that lauds a common-sense approach to preparedness and self-preservation: "An ounce of prevention is worth a pound of cure." The old chestnut is actually profound for those who opt to ponder its ultimate meaning. "If only I had let the faucet drip during last night's hard freeze, I wouldn't have woken up to a busted water pipe." That's the kind of rue and regret that gets expressed when the adage above is not observed. It's always cheaper to prevent a disaster than the cost of the disaster itself.

FENDING OFF DISASTER

Are there disasters waiting to happen for those in hospital administration? You bet there are. But these can be significantly limited in size and scope where those facilities have a comprehensive and well-functioning corporate compliance program. Just like the compliance plan guidance that the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) has issued for medical groups, there are certain elements that should be a part of a hospital's or health system's compliance program. Indeed, the OIG has published at least two sets of compliance plan guidelines related to hospitals—one in 1998 and a supplemental document in 2005.

Part of a sound compliance program is identifying risk areas—especially those areas that could lead to fraud, waste and abuse in connection with a federal healthcare program, such as Medicare or Medicaid. Each facility should have a compliance officer who is tasked with identifying issues at their location that have a real potential for violating various federal regulations, such as coding, documentation of services, documentation retention, billing, etc. These risk areas should be identified, documented and disseminated in the form of training for appropriate personnel. Policies should be put in place to minimize these identified risks.

RATCHETING UP THE PRESSURE

In the fall of 2022, the U.S. Department of Justice (DOJ) promulgated new

crime guidelines applicable to U.S. corporations. Known as the Monaco guidelines (named for Deputy Attorney General Lisa Monaco who formulated the guidelines), the DOJ document is primarily seen as an attempt by the federal government to put more teeth into prosecuting non-compliant behavior by American companies, including individuals within such companies. In fact, this may be the big takeaway from the Monaco guidelines.

Specifically, the guidelines provide for "individual accountability" as the primary emphasis of its new enforcement policy. In other words, it won't be just the corporation's board held responsible for improper acts, but the individuals who directly perpetrated them, whether that be the CEO, CFO or lower-level staffer. The guidelines provide for expedited powers to go after such individuals once identified.

Timeliness of cooperation in the DOJ's investigations will also be taken into account when assigning penalties. It therefore will behoove the institution to move quickly to fully provide whatever information the government requests during its investigation into potential wrongdoing within the facility. Monaco stated that corporate leadership will be "on the clock," indicating an expectation that there should be no stonewalling the investigative activity.

History of misconduct will also be a component in the assessment of penalties by the DOJ. Prior wrongdoing by the same individuals will be deemed of special concern. The agency will also take into consideration the corporation's track record of response to inappropriate behavior among its personnel. Thus, it will be important for the hospital to ensure that its compliance plan contains real teeth when it comes to responding to bad behavior. That is, there should be documented consequences meted out to employees who engage in non-compliant behavior—up to and including termination.

So much unpleasantness can be avoided by simply having a compliance plan that actually works. It must target real areas of risk; it must have sufficient consequences for non-compliance; and it must be effectively communicated to staff members. After all, an ounce of prevention . . . well, you know.

JUSTIN VAUGHN, MDIV

Justin Vaughn, MDiv, serves as Vice President of Anesthesia Compliance for Coronis Health. Mr. Vaughn has over 20 years of experience in anesthesia compliance and has been a speaker at multiple national healthcare events. He has written two books on compliance-related issues and is the author of numerous articles relevant to the hospital space. Justin can be reached at **Justin.Vaughn@coronishealth.com**.

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255 West Michigan Avenue
Jackson, MI 49201
443.516.8725
CoronisHealth.com

Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
June 11th	Indiana Rural Health Association Annual Conference 24	French Lick Resort French Lick, IN	https://www.indianaruralhealth.org/annual-conference/annual-conference/26th-annual-indiana-rural-health-conference/?back=annual_conference
June 11-13	America's Health Insurance Plans 2024 Conference	Wynn Las Vegas Las Vegas, NV	https://www.ahip.org/conferences/ahip-2024/overview#content
June 24-27	Healthcare Financial Management Association Annual National Conference	Mandalay Convention Center Las Vegas, NV	https://events.hfma.org/event/91809b8d-2d40-4ce9-82a3-b7b296cd1d85/websitePage:a811c3e7-fb00-4c91-9503-014e6edb5639
August 4-7	American Healthcare Radiology Administrators 2024 Annual Meeting	Orlando World Center Marriott Orlando, FL	https://www.ahra.org/education-events/upcoming-events/2024-annual-meeting
September 10-12	GA RHC 24 Georgia Rural Health Conference 24	Jekyll Island Club Jekyll Island, GA	https://grhainfo.org/
September 25-27	National Rural Health Association Critical Access Hospital Conference 24	Sheraton Kansas City Kansas City, MO	https://www.ruralhealth.us/events/event-details?eventId=24

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