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Offering CME Incentives May Be Fraud

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Let's reward physicians who refer patients to our hospital by giving them free (or discounted) CME.

Sound like a good idea? It's not. It's fraud.

The Medicare and Medicaid antikickback statute [42 U.S.C. Section 1320a-7b(b)] penalizes anyone who offers or pays remuneration in cash or kind in return for referring a patient for services payable under the Medicare or Medicaid program. Between 1988 and 1994, the Office of Inspector General, Department of Health and Human Services issued five special fraud alerts related to the antikickback statute. Many individuals new to CME are not aware of the fraud alerts and the legal issue regarding CME.

Hospital Incentives to Physicians

The special fraud alert most relevant to CME, issued in May 1992, addressed hospital incentives to physicians. The fraud alert noted payment for a physician's continuing education courses as an example of remuneration in kind under the statute. In September 1992, the ACCME forwarded copies of the alert to all hospitals and medical schools that were accredited CME providers to inform them that certain hospital CME arrangements may be considered illegal.

The basic point is that hospitals cannot give more benefits to referring physicians than to nonreferring physicians. The differential benefits are viewed as kickbacks, that is, incentives to encourage physicians to refer patients on the basis of a benefit to themselves rather than on the basis of the patient's welfare. In addition to free or discounted CME, possible benefits include incentives such as direct financial payments, discounted office space or equipment, free office staff training, low-interest loans or travel expenses. Hospitals providing these benefits to physicians based on referrals are committing fraud.

Hospitals can provide benefits to physicians, but they cannot provide special benefits based on referring status. For example, a hospital can offer a free CME activity to all community physicians. In this situation, a physician's past and future referral of patients has no relationship to the personal benefit to the physician of free CME. (The CME course itself should provide information that helps the physician make better referral decisions based on the patient's welfare.)

The antikickback statute does not affect the indirect marketing of an institution's services that is an inherent byproduct of CME. All CME courses potentially affect participant's perceptions of the sponsoring institution's activities, including its other CME activities and clinical services. A good, objective CME activity reflects credibly on the sponsoring institution; a poor, biased CME activity detracts from the credibility of the institution. The marketplace rewards and punishes an institution based on the quality of services (including CME) that it offers.

Prescription Drug Marketing: Practices and Other Alerts

The other four special fraud alerts under the antikickback statute address joint venture arrangements, routine waiver of Medicare Part B copayments and deductibles, prescription drug marketing practices and arrangements for the provision of clinical laboratory services. Of these, the alert issued in 1994 concerning drug-marketing practices may be of interest to CME providers.

The basic point parallels that for referrals. Pharmaceutical manufacturers (and other suppliers) cannot give more benefits to physicians who prescribe a specific drug than to physicians who do not prescribe that specific drug. The differential benefits are viewed as incentives to encourage prescribing on the basis of a benefit to the prescribing physician rather than on the basis of the patient's welfare.

This fraud alert warns of legal sanctions for providing benefits based on prescribing products. The American Medical Association's ethical opinion on gifts to physicians from industry places more general restrictions on benefits from industry. The ethical opinion states that physicians should accept personal gifts from industry only if the gift is not of substantial value and entails a benefit to patients. The American Osteopathic Association, the Pharmaceutical Manufacturers Association and other national groups support this broader restriction on gifts to physicians from industry, even when the gifts are not linked to prescribing behavior.

The OIG HHS republished all five fraud alerts together in the Federal Register Dec. 19, 1994. The fraud alerts also are published together on the OIG HHS Web site for fraud alerts at http://www.dhhs.gov/progorg/oig/frdalrt/121994.html

Enhancing Educational Effectiveness in Videoteleconferencing: How To Increase Quality, Visuals in CME Presentations

By Jeanne E. Bitterman, Ed.D., Columbia University

The Challenge

Videoteleconferencing in CME gives complex multisite facilities an opportunity to share educational offerings, build community and upgrade professional quality. In the growing health-care climate of mergers and consolidations and with the rapid development of new information and technologies, reliance on this medium is expanding. When used effectively, videoteleconferencing fosters the sharing of information and culture through stimulated, ongoing dialogue and can showcase talents and skills, support systemwide standards of care and disseminate information. Through quality programs and staff encouragement, a learning community that medical staff is proud to be associated with advances. The challenge of the CME practitioner is then how to enhance and upgrade the quality of videoteleconferenced programs.

The Problem

Assessments of teleconferenced CME often indicate that physicians and presenters need further training in interactive methods and adult education basics. However, quite a few institutionally based problems are recurrent in remote-site evaluative feedback. Major thematic areas surface that are inclusive of, but not limited to:

- Attendance at the distance site is consistently lower than at the primary site, often even when participants sit outside of camera range, giving the visual impression of poor attendance.
- Audience participation is neither encouraged nor facilitated at the remote site. Sound may be poor, seating arrangements enable attendees to fall outside of the camera and audio range, and there are difficulties getting a speaker's attention during the questions and answers).
- The quality of televised images is lower at the remote site. X-rays and other nondigitized graphic images lose resolution in transmission, small square screens are used instead of large rectangular ones and an inadequate number or placement of screens prevail.
- Many speakers are perceived as talking heads with little use of visual reinforcements. The majority of speakers do not perceive any difference in, and hence do not prepare for, transmitted presentations. When using visuals, split-screen viewing is not enabled, final points are lost, lighting is poor and there is a lack of attention to the viewing location.
- Often a lack of coordination and disparity of service exists. Such problems include double bookings and lack of appropriate rooms, equipment or distribution of materials and refreshments to the remote site.

What Planners and Administrators Can Do

The appropriateness of any strategy or innovation depends on the context in which it will be implemented. Clearly, the degree to which a program may experience problems in sound, remote-site recognition, lighting, etc. depends on the particular audiovisual system including its resource personnel and the visual and communicative awareness level of the

staff and participants. However, many issues described above are quite prevalent in other institutions, including nonhealth-care education providers. The strategies recommended therefore have relevance for other continuing education programs. Despite the challenges that each setting presents, there are a few practical approaches that a CME program can initiate to improve quality, overcome systemwide problems and help presenters understand the implications of using this format and how they're engaged in a larger educational community. The following tactics were identified as an outgrowth of ongoing research in distance learning and from project work with a local hospital health center* in New York. The center seeks to upgrade CME offerings as it continues to undergo a series of mergers and partnerships, increasing its dependence on teleconferenced formats.

Strategies

- To ensure that educational opportunities are not lost, CME professionals can archive conferences for future viewing. Planners can schedule follow-up videoteleconferences for question and answer sessions (participants having viewed individually or in a small group an archived presentation at their convenience).
- To improve the quality of transmitted images, the use of digitized images should be encouraged; provisions may be made for in-house services for conversion to digitized presentations. This could be done on a fee-for-service basis or through training in endorsed packages.
- To ensure smooth functioning, CME leadership should oversee coordination of scheduling. This would alleviate problems in booking rooms with other hospital services. A systemwide form, which could be faxed or completed online, could be devised to include all teleconferenced rooms, capacities, equipment needs and so on.
- To enhance advancement and promotion of in-house talent and build institutional identity, CME should develop an in-house resource and speakers bureau. Talented personnel could be featured for presentations or training.
- To increase quality, CME professionals should provide training in interactivity to develop physicians' communications and presentations skills. Visual awareness training could teach use of visual aids and presentation software, audiovisual equipment and new technologies, including digitized networks.
- To help presenters develop awareness that they are presenting in a television setting and strengthen skills, the CME program should provide small podium-monitors to project images of the presentation, tapes of the program given to the presenters for their review and guidelines requiring presenters to repeat questions for the benefit of remote site.
- To assist in the recognition and involvement of the distance site (and to foster community identification), site facilitators can be designated. Facilitators could be those who would regularly attend the activities. With training, medical staff acting in this capacity could ensure:
  - introductions of the remote site and staff;
  - conducive seating arrangements distributing participants in camera range (semicircular arrangement, elimination of extra seats);
  - questions and comments from the remote site are recognized;
  - guarantee that materials are disseminated at both sites and that both sites have compatible refreshments, etc.;

    - speakers are positioned for proper or optimal lighting, using appropriate images (font size on visuals or flip charts), and audible (using lapel microphones, and so on); and
    - affirm the trust of community through mutual respect, demonstrated by having the capability to turn distance monitors off (should staff desire).
- To ensure optimal use of resources, including staff, the institution should develop:
    - a list of supported products;
    - capabilities and services of the audiovisual system (provided to course directors at least annually and sent to speakers prior to their presentation);
    - guidelines of procedures in dealing with the audiovisual system (including time frames for the delivery of slides and her visual materials to the audiovisual department); and
    - an endorsed desktop video package for services, departments and individuals who wish to move forward with new technologies and to ensure that they will be compatible with institutional use.
- To upgrade quality and educational value, speakers should be asked to provide supplementary materials for audiences to reinforce the information presented (slides, outlines, bibliographies, etc.). To ensure timely submission of supplementary materials, a checklist could be devised to accompany a speaker's receipt of the institution's capabilities and planning forms.

To share strategies for supporting videoteleconferencing or for more information on practices in distance learning and CME, contact Professor Jeanne Bitterman at jeb59@columbia.edu or fax 212/678-3743.

*A note of appreciation goes to Joseph Schappert, chair of the Medical Board Education Committee, St. LukeÕs-Roosevelt Hospital, for his interest and support of techniques for advancing quality in CME videoteleconferencing.

Trained Physician Observers in CME Evaluation - Part 2

By Anne Fredenburg Dolan, M.Ed., St. Joseph Medical Center, Towson, MD

This is part 2 of a two-part article. For recruitment issues and responsibilities of the CME department and trained physician observer, see "Trained Physician Observers in CME Evaluation - Part 1," Almanac, Vol. 20, No. 9, September 1998.

Content of Evaluations

Standard check sheets are a starting point and serve two purposes: to guide the observers' thinking, and to recap highlights of the CME activity. The key to comprehensive evaluations is to analyze content, currency of information and appropriateness and effectiveness of instructional methods. Observers should:

- Summarize content - What were the major points? Were objectives met? Report on any ensuing discussion prompted by the CME activity. Note verbal or written references to medical literature.

- Note personal observations - Inject opinions and support them with reasons. Rather than saying great presentation or good job, include descriptions of what made the presentation good.
- Analyze effectiveness of audiovisuals including size of type, color, amount of text per slide, syllabus, etc.
- Record or summarize questions asked to clarify concepts, reinforce ideas, point to gaps in participants' comprehension and serve as a resource to generate future topics.
- Describe environment and logistics noting general ambiance, noise and traffic.
- Determine appropriateness of title for actual content.
- Analyze delivery - Did organization and presentation reinforce learning or serve as a distraction?
- Determine if topics incorporate the overall conference theme (full-day or multiday activity).
- Describe participants' reactions and behavior, which may indicate their level of interest.
- Describe educational level and focus and their appropriateness for the target audience.
- Report problems that interfere with learning, such as with audiovisual equipment.
- Note bias toward products or services.

Value to Observer and Sponsoring Institution

Benefits of using a physician observer exist for the observer and the sponsoring institution. On one hand, an observer's reward is personal satisfaction for contributing to the educational process and outcome. On the other hand, an inducement such as a reduced registration fee may be appropriate on an ad hoc basis. One observer, a retired physician, remarked that, in addition to keeping up to date, he's learning a new trade. Another observer learned to identify good instructional techniques, thereby improving his own presentation skills.

Using a physician observer adds variety to evaluation and supports the idea that if one evaluative method is good then more variety is better. The importance of conducting multiple evaluations has been identified, and accreditation surveyors' comments support this view.

Responses of physician planners and program committees have been mixed; physician planners who value input from a different perspective and a depth of evaluation greater than the standard form are enthusiastic and find it useful in planning future CME activities. Ideally, if the trained physician observer is used appropriately, the sponsor capitalizes on an observer's particular clinical perspective, expertise and interests. CME activities and sponsor benefit at the convenience and discretion of the volunteer observer and a continually evolving working relationship with the sponsor contributes to improved, relevant CME.

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