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Applying Sarbanes-Oxley to Healthcare Quality

By Barry S. Bader

The Sarbanes-Oxley Act was passed in 2002 after unconscionable lapses in corporate integrity and governance oversight. Even though charitable organizations are largely not covered by its provisions, the law has unquestionably affected and strengthened board practices in not-for-profit organizations. Today, large- and mid-sized not-for-profit hospitals and health systems are likely to have a committee of independent directors responsible for audit oversight. At least one member is selected because of a background in audit or finance. At least annually, the committee meets privately with the external auditor, without senior management present, and has an opportunity for candid questioning. Few would disagree that the board's oversight of the audit process is more informed and effective as a result of these changes.

Could applying key elements of Sarbanes-Oxley to hospital boards' responsibility for oversight of clinical quality have a similar, positive effect? The idea has merit, argues David B. Nash, MD, Dean, Jefferson School of Population Health and an expert on quality who has chaired a large health system's board Quality Committee. Nash writes:

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“I believe we have not fully embraced the comprehensive nature of Sarbanes-Oxley on the hospital side, and envision a day when hospital boards will be held accountable for quality, in the same way that proprietary corporations are held accountable for the strength and comprehensiveness of their audit reports. Simply put, Sarbanes-Oxley for quality is around the corner.”¹

A Good Idea?

It isn't a far stretch to imagine that federal policy makers could decide that applying a form of Sarbanes-Oxley legislation to hospital quality would be a nifty idea. A recent study in the highly regarded policy journal *Health Affairs* raised questions about whether hospital boards are sufficiently educated about and engaged in oversight of quality. “Quality of care is often not a top priority for hospital boards,” said researchers.²

A recent study in *Health Affairs* raised questions about whether hospital boards are sufficiently educated about and engaged in oversight of quality.

Federal oversight agencies have already indicated that they want governing boards to take responsibility for overseeing the quality of care provided under federally funded programs. For example, in November 2008, a government-industry roundtable shared best practices for developing and using a “board of directors’ dashboard.”³ The Agency for Healthcare Research and Quality has cosponsored a study on effective practices for quality oversight by governing boards.⁴

Some healthcare lawyers have suggested that the federal government could argue that billing for poor quality or unnecessary care delivered to Medicare recipients, or reporting inaccurate quality data to the government, constitutes a violation of the False Claims Act, making quality lapses as much a matter for corporate compliance oversight as hospital billing.⁵ The Internal Revenue Service

recently adopted a much-expanded Form 990 that clearly articulates an expectation that boards of charitable organizations will exercise independence in their roles and carry out good governance practices for all of their responsibilities.

So, the government clearly has boards on its radar screen, but one would hope cooler heads will prevail and a SOX-styled law on hospital quality will not be adopted. It's doubtful that government regulation is the best way to enhance board oversight of quality.

Neither I nor Dr. Nash is arguing for new federal laws or regulations. Rather, hospitals can benefit by embracing Sarbanes-Oxley's core good governance principles and applying them to board oversight of quality. As an intellectual benchmark for good governance, Sarbanes-Oxley has a lot to offer.

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1 David B. Nash MD, MBA, Medical Executive Post, March 9, 2008. Available from www.healthcarefinancials.wordpress.com/2008/03/09/david-b-nash-md-mba-facp/.

See also: Royo, Marc B. and David B. Nash. 2008. “Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects,” *American Journal of Medical Quality*, 23 (1): 70-72.

2 Jha, Ashish K. and Arnold M. Epstein. 2010. “Hospital Governance and the Quality of Care,” *Health Affairs* 29 (1):182-187.

3 Office of Inspector General of the U.S. Department of Health and Human Services and the Health Care Compliance Association, “Driving for Quality in Acute Care: A Board of Directors Dashboard,” Government-Industry Roundtable. Available at www.oig.hhs.gov/fraud/docs/complianceguidance/RoundtableAcuteCare.pdf.

4 Jiang, H. J., C. Lockee, K. Bass, and I. Fraser. 2008. “Board Engagement in Quality: Findings of a Survey of Hospital and System Leaders,” *Journal of Healthcare Management*, March-April: 121-34, discussion 135.

5 For example, see “When Poor Quality Care Becomes Fraud,” presentation to Jewish Hospital, April 28, 2009, by Robert J. Benvenuti III, Esq., MPA, Barnett, Benvenuti and Butler, PLLC, Lexington, Ky.; and Betsy Hall, MPH, CHC, Compliance Officer & Privacy Officer, Jewish Hospital & St. Mary's HealthCare, Inc., Louisville, Ky. Available at www.compliance-institute.org/pastCIs/2009/PDFs3page/700s/708.pdf.

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Applying SOX Principles to Hospital Quality

Consider how a hospital or health system board might embrace the elements of Sarbanes-Oxley:

1. Public accountability. Sarbanes-Oxley underscores the responsibility of corporate governance to protect the interests of shareholders. Similarly, hospital boards have a fiduciary responsibility to represent the interest of the public in safe and high-quality clinical care. They should document that responsibility in a policy statement and in the board's position description, both of which could be made publicly available on the organization's Web site.

Hospital boards have a fiduciary responsibility to represent the interest of the public in safe and high-quality clinical care. They should document that responsibility in a policy statement and in the board's position description.

2. Transparency policy. Sarbanes-Oxley requires corporations to practice transparency in financial disclosures. Hospital boards could approve a policy statement committing the organization to helping consumers make informed decisions before choosing their providers by transparently disclosing understandable information about clinical outcomes, patient satisfaction, and patient safety. The policy should also address disclosure of adverse events to patients and their families.

3. Board Quality Committee. Sarbanes-Oxley recognizes the central role of the corporate audit committee in overseeing financial integrity. A board Quality Committee can play a similar role. Recent studies have shown that high-performing health systems are more likely than low-performing organizations to have a board committee responsible for quality oversight.⁶ They're also more likely to include quality as an important agenda item at most or all board meetings, and to spend a significant amount of board time on quality (usually 20 to 25 percent).⁷ These are practices all boards should consider, and most should adopt.

4. Independence and quality expertise. The Sarbanes-Oxley Act requires that each member of the company's Audit Committee be a member of the board of directors and be independent. Companies must disclose whether they have at least one "financial expert" serving on the Audit Committee. If they do not have

such an expert, they must disclose the rationale behind that decision. Many hospitals and health systems have embraced this concept by actively seeking directors with strong backgrounds in audit and finance.

The same competency-based approach to board selection can be applied to identifying members with quality expertise to serve on the board and its Quality Oversight Committee. Medical staff members are often valuable members of board Quality Committees, but a medical degree in and of itself does not constitute quality expertise. There is a distinction between clinical training and such disciplines as clinical quality measurement, quality improvement, evidence-based medicine, and population health management. The ideal physicians to serve on a board Quality Committee would have specialized training in medical quality management.

A hospital's own medical staff members are not truly "independent" when it comes to oversight of clinical quality.

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⁶ Lawrence Prybil, PhD, et al. 2009. *Governance in High-Performing Community Health Systems*.

⁷ The Governance Institute. *Governance Structure and Practices*, San Diego, 2009.

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In addition, a hospital's own medical staff members are not truly "independent" when it comes to oversight of clinical quality. Independence requires economic distance from the organization, regardless of whether a physician is employed or in private practice. Medical staff members gain financially from their association with the hospital and with their peers. This is not to say medical staff members can't serve on the board's Quality Committee—they can. However, a community hospital's board Quality Committee ideally should have at least one independent physician, such as a corporate medical director or retired physician, or perhaps a faculty member from a nearby (noncompeting) academic medical center or an accomplished physician executive from outside the community. In addition, the board should seek non-physicians with a background in quality, such as executives responsible for quality improvement, quality control, or customer service in private manufacturing, service, and financial companies. Local colleges and universities may be a source of faculty who teach quality improvement.

5. Active engagement. In the post-Sarbanes-Oxley era, boards are expected to actively engage in education, questioning, and discussion of the information that management provides. Hospital directors should ask how the organization's quality results compare not only to past performance and industry averages, but to the best in class. They should know what the organization's primary improvement goals are, why these goals have been chosen, and whether the organization is improving fast enough. If they see lagging performance with regard to a particular indicator, clinical service, or facility, they should ask whether management understands the root causes of underperformance, has a realistic plan to improve, and when improvement can be expected. Discussions should be characterized by candor, substance, and accountability, not by passivity or an acceptance of mediocrity.

6. Independent quality audit. Sarbanes-Oxley requires that the external auditor be selected by the board, and corporate Audit Committees rely heavily on the annual report from the outside auditor. The report typically includes key financial results, an evaluation of the organization's accounting practices, and recommendations for improvement.

Part of the rationale for having an independent financial audit is to reduce the likelihood that management could deliberately withhold or distort information that would materially affect the organization's financial reports. By mandating that the audit committee have unfettered access to an independent auditor, SOX

offers one more check on less-than-transparent management.

Does the same situation apply to healthcare quality? Not entirely. Examples abound of corporate management trying to keep their boards in the dark about financial irregularities. By contrast, there's no evidence of wide-scale, deliberate cover-ups of quality failures by hospital executives. Most hospital CEOs and chief medical officers work hard to ferret out quality problems and keep the board informed but not deluged by reports. What's more, quality results and sentinel events must be reported to public agencies, so hospital boards have ready access to this information.

In several ways, hospital boards can't be sure they're getting the whole story about quality.

However, in several ways, hospital boards can't be sure they're getting the whole story about quality. Information about quality and patient safety problems doesn't always make its way from medical staff peer review forums to the board's oversight agenda. In addition, the choice of indicators and reporting formats for the board's quality scorecard may or may not highlight the most important problem areas. As Thomas L. Garthwaite, MD, chief medical officer for Catholic

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Health East, notes elsewhere in this issue, boards ought to ask: “Is what they’re telling me the whole story? Are we just hearing the good news? Are we honest with ourselves about our performance relative to other hospitals?”

The financial audit report helps boards answer these questions about finances, but no outside report so explicitly fills the bill when it comes to a hospital’s clinical quality and patient safety. Instead, a hospital board receives “partial scores” from different sources at different times, including accreditation reports from the Joint Commission (as much as three years apart), state agencies, and clinical societies. The board also sees quantitative reports on clinical and patient satisfaction measures from Medicare, the American Hospital Association, the Institute for Healthcare Improvement, and the Joint Commission, among others. Baldrige Award aspirants receive feedback from visiting examiners.

Hospital boards typically do not retain an independent, outside auditor to assess the organization’s quality and deliver a comprehensive report, but this is a practice worth serious consideration. Where could such auditors come from?

One possibility is that large health systems could develop their own audit standards, manual, and methodology, and then train a cadre of physicians and other quality experts to audit their subsidiary hospitals. State hospital associations and various national

quality organizations could develop a similar service. Another option would be for the board to retain a highly respected quality consultant or consulting firm. These audits would be educational and supportive, not regulatory in nature, but they would add an independent layer of analysis to support governance and senior management.

Large health systems could develop their own audit standards, manual, and methodology, and then train a cadre of physicians and other quality experts to audit their subsidiary hospitals.

The outside quality auditor would compile quality results into a comprehensive report. The auditor would review current quality practices and measurements, conduct on-site interviews, and deliver an objective assessment and recommendations for improvement.

7. Private meeting with outside and internal auditors. In the spirit of Sarbanes-Oxley, the board would select an external quality auditor. The auditor or audit team would meet not only with senior leadership, but also privately with the board and the board Quality Committee, without any senior management present. Similarly, the

board Quality Committee should have an opportunity, at least annually, for a private session with the organization’s chief medical officer, chief quality officer, and chief nursing officer. These private meetings are an important tool of independent governance. They enable independent directors to ask pointed questions such as whether any material information about clinical outcomes or quality problems has been omitted from the reports the board has seen, and whether the organization’s top leadership is fully committed to quality and patient safety.

8. Attestation of quality performance. Sarbanes-Oxley requires that the chief executive officer and chief financial officer attest to the accuracy of publicly disclosed financial results. The state-of-the-art of quality measurement in healthcare does not yet equal the accuracy of the data produced on the financial side. Requiring certification of quality data would be premature.

That said, it is time for healthcare organizations to step up to the plate and vouch for the information that they provide to governmental agencies, the general public, and of course the governing board. Excuses that “the data are flawed” don’t cut it anymore. At a minimum, an organization’s CEO, chief medical officer, and chief quality officer ought to be able to tell the board that the organization has made a good-faith effort to assure accurate medical record-keeping and to produce reports that are in keeping with external requirements.

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Culture of Accountability

Sarbanes-Oxley hasn't made corporate governance perfect, but it has raised the bar for board performance to a much higher level. Corporate boards are no longer composed of a CEO's country club buddies. They're predominantly independent. They know they must do their homework, be informed, engage in discussion, challenge management, and make independent decisions to serve the shareholders. Many are as smart as and more experienced than the executives they oversee. They aren't all prepared to play the proverbial "skunk at the lawn party," but boardroom culture is very different from what was common in 2002.

When it comes to hospital quality and patient safety, however, the boardroom is still characterized by too much deference to the doctors and too little willingness to demand improved performance.

When it comes to healthcare quality and patient safety, however, the typical hospital boardroom is still characterized by too much deference to the doctors and too little willingness to demand improved performance. Several years ago, the Institute for Healthcare Improvement didn't care who was offended by its call to "save 100,000 lives." IHI raised the bar for patient safety and offered tools it thought would work—it was right to do so. (IHI later offered to assist boards, as part of its campaign to protect five million lives from harm.⁸) The board of Ascension Health called for "no preventable deaths" in five years.

Maybe unachievable, maybe not, but the progress is unmistakable, its leaders say.

Every hospital board should be willing and able to challenge management and physician leaders to achieve excellent quality results. Applying what's good about Sarbanes-Oxley (and ignoring what's less than helpful) can help create a board and top management culture of accountability, transparency, candor, and independence that in turn can propel the organization forward on quality and patient safety.

REACTIONS

We asked a number of quality leaders for their comments on *Applying Sarbanes-Oxley to Healthcare Quality*. Here's what they said: pro, con, and otherwise.

David B. Nash, MD, Dean, Jefferson School of Population Health, Philadelphia, Pa., and nationally recognized quality expert: "This commentary offers a tight synthesis of the issues in applying SOX to the nonprofit health care board. I would go one step further, however. Today, putting a doctor on the board Quality Committee is fine—but not to act as chair of the committee. If that same physician works at the hospital where he or she sits on the board and acts as a chair, reporting to other board members, this presents, in my view, a real or potential conflict of interest. It is at least a set up for problems if not an outright conflict and ought not to happen. How can a fox also guard the chicken coop? Not a good idea all around."

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8 Conway, J. "Getting Boards on Board: Engaging Governing Boards in Quality and Safety," *Joint Commission Journal on Quality and Patient Safety* 34(4): 214-220(7). Available from www.ingentaconnect.com/content/jcaho/jcqs;jsessionid=c5fe1h5bj2c4s.alice.

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Joseph R. Impicciche, Esq., Senior Vice President, Legal Services & General Counsel, Ascension Health, St. Louis, Mo.: “While I am generally supportive of the principles in this paper, I would be cautious about ‘SOX-type’ quality legislation. I would be especially concerned for small, not-for-profit hospitals in rural communities where compliance could be very challenging and potentially expensive, particularly in the areas of ‘expert independence’ and ‘quality audits.’ Moreover, one would need to consider the impact of imposing additional legal burdens on community volunteers who may not have medical backgrounds. This would likely create even greater challenges in connection with board recruitment.”

Robert Meyer, President & CEO, Phoenix Children’s Hospital: “I don’t think that a Sarbanes-Oxley analogy to healthcare quality is appropriate. The whole concept of SOX is to audit compliance against a set of well-developed and accepted financial auditing standards and governmental regulations, i.e., objective criteria. There is no similarly accepted and agreed-upon set of criteria under which you could audit a hospital’s compliance around quality and patient safety. Also, the concept of hiring unregulated and unlicensed consultants to complete the suggested audits leaves the door wide open for personal agendas and controversy. The time may come when there are widely accepted objective criteria related to hospital quality that could be used for compliance audits, but until then this concept is a reach. Other approaches will produce better results. For example, one of the major objectives for CHCA (Child Health Corporation of America, an alliance of children’s hospitals) is to develop standards for pediatric quality, and these will be of great help to boards.”

Rulon Stacey, President & CEO, Poudre Valley Hospital, winner of the Malcolm Baldrige National Quality Award:

“Most boards in the industry are well aware of Sarbanes-Oxley and have been working for years on how to make the principles of SOX active in their organization. So the concept will not be new. Applying it to quality will be. This article’s thoughts about outside pressure for quality improvement will ring true as most organizations have been wrestling with this for quite some time. I have never thought about using SOX as a guide as a board works to improve its response to quality improvement efforts. For example, the idea of an independent physician on the quality committee is very interesting. I don’t know that I agree that the need for this is due to an economic tie-in between local physicians and the hospital, since I don’t think that is a driving motivation for the quality discussion. However, I do hear many physicians in all areas of the country say that ‘we do things differently here’ or that ‘our patients are sicker’ or other things like that. An outside physician with knowledge of what is happening in another market would be a good resource to address discussions like that, although high-functioning quality committees already are past this.”

“The reason SOX has been effective in transforming compliance and behavior in corporate finance is because it applies structure and accountability that heretofore did not exist. And it is structure and accountability that are sorely lacking in our world of healthcare quality today.”

—Richard F. Afbale, MD, President and CEO,
Hoag Memorial Hospital Presbyterian

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Richard F. Afable, MD, President, and Chief Executive Officer, Hoag Memorial Hospital Presbyterian, Newport Beach, Calif.: “It would be easy to reject the concept that a formal, compliance-based process like Sarbanes-Oxley can apply to activities as variable and broad-based as quality of care in healthcare organizations. However, I believe these individuals may be missing the point. The reason SOX has been effective in transforming compliance and behavior in corporate finance is because it applies structure and accountability that heretofore did not exist. And it is structure and accountability that are sorely lacking in our world of healthcare quality today.

“I would be the first to acknowledge that physician behavior and medical decision-making do not exactly lend themselves to the sort of linear thinking, rigid operating statements and attestations required by SOX. However, while every element of Sarbanes-Oxley may not specifically apply to improving healthcare quality, the broader goal of structure and accountability applied to an imperfect process should assist us on our journey to a more perfect result.”

James Conway, MD, Senior Fellow, Institute for Healthcare Improvement: “This provocative discussion frames the larger search for healthcare governance systems for oversight and accountability that can assure dramatically improved health outcomes. Current performance gaps (between the average and ideal performance) and variations (between best and worst performers) are too wide, and many have declared the current state unacceptable: new expectations are being set from all directions. As a healthcare executive and trustee, I find the most painful part of the Jha and Epstein research referenced in this article is that trustee leaders of the worst-performing hospitals in the country believe their quality to be at least average. The information they are being given and the processes they are using allow for flawed, harmful, and costly conclusions about their hospital’s care. IHI is meeting thousands of committed, engaged, talented trustees already on boards who are, can, and want to fulfill their responsibilities. We need to position them to do so, educate them, and invite them into the conversation with data, language, stories, and our version of the SOX principles. The potential for those we are privileged to serve is enormous, as is documentation of fulfillment of accountability.”

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Ten Ways to Improve the Board's Use of Quality Measures

By Elaine Zablocki



Hospital and health system boards are being overwhelmed by hundreds of quality indicators from numerous sources. Many are required or linked to payment incentives, but some are part of voluntary improvement programs. Amidst the deluge of numbers, leaders could miss valuable, potentially actionable information.

“... while pursuing quality and patient safety the industry has tended to go a mile wide and an inch deep.”

—Christine Goeschel, RN, Director of Patient Safety and Quality Initiatives, Quality and Safety Research Group, Johns Hopkins School of Medicine

Christine Goeschel, RN, director of patient safety and quality initiatives at the Quality and Safety Research Group at the Johns Hopkins School of Medicine, is completing a doctoral thesis on the role of hospital boards in improving quality and safety.

“Boards are often handed a template or scorecard that lists hospital performance on many externally determined measures of care,” she finds. “While those measures are in fact important, often there aren’t sufficient resources to focus on all of them. My colleagues and I are concerned that while pursuing quality and patient safety the industry has tended to go a mile wide and an inch deep.”

“Both governance and management have to focus on the vital few,” says Maulik S. Joshi, DrPH, president of the Health Research and Educational Trust (an affiliate of the American Hospital Association). “Monitor the few measures that are most important to your organizational performance, where you have the greatest level of accountability, of leverage, of the

ability to improve. In some cases the data may be limited, and the measures may be imperfect, but we can still use that data to look at where we are, and where we want to be.”

How can a hospital or health system cut the tidal wave of measures to a manageable, improvable, and critical few? And how can boards use quality measures to drive improvements?

We put these questions to leaders at five hospitals and healthcare systems and to several industry experts. They offered these ideas:

1. Align measures with the organization’s strategic goals. Joshi says that each hospital’s strategic plan, and its major pillars related to quality and safety, should form the basis for establishing measures for board oversight of quality.

Michael D. Pugh, president and CEO of Verisma Systems, Inc., in Pueblo, Colo., and a senior faculty member at the Institute for Healthcare Improvement, says, “It’s the board’s job to ensure that they’re looking at quality measures that together create a picture of the whole organization and its effectiveness. I find that at the board level, organizations need an overarching strategy that knits things together. For example, the strategy might be ‘no needless deaths’ or ‘no harm to patients’ or ‘every patient gets the right care every time.’ Once you have a high-level theme for your quality efforts, it becomes easier to clarify priorities and to link specific measures to your vision of what you want care to be for your patients.”

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“You can’t report 200 quality measures to your board of trustees.”

—Stephen R. Grossbart, PhD,
Chief Quality Officer,
Catholic Healthcare Partners,
Cincinnati, Ohio

2. Look at the big dots. Boards are replacing narrow measures with composite indexes and “big dots,” designed to capture a great deal of information in a single number.

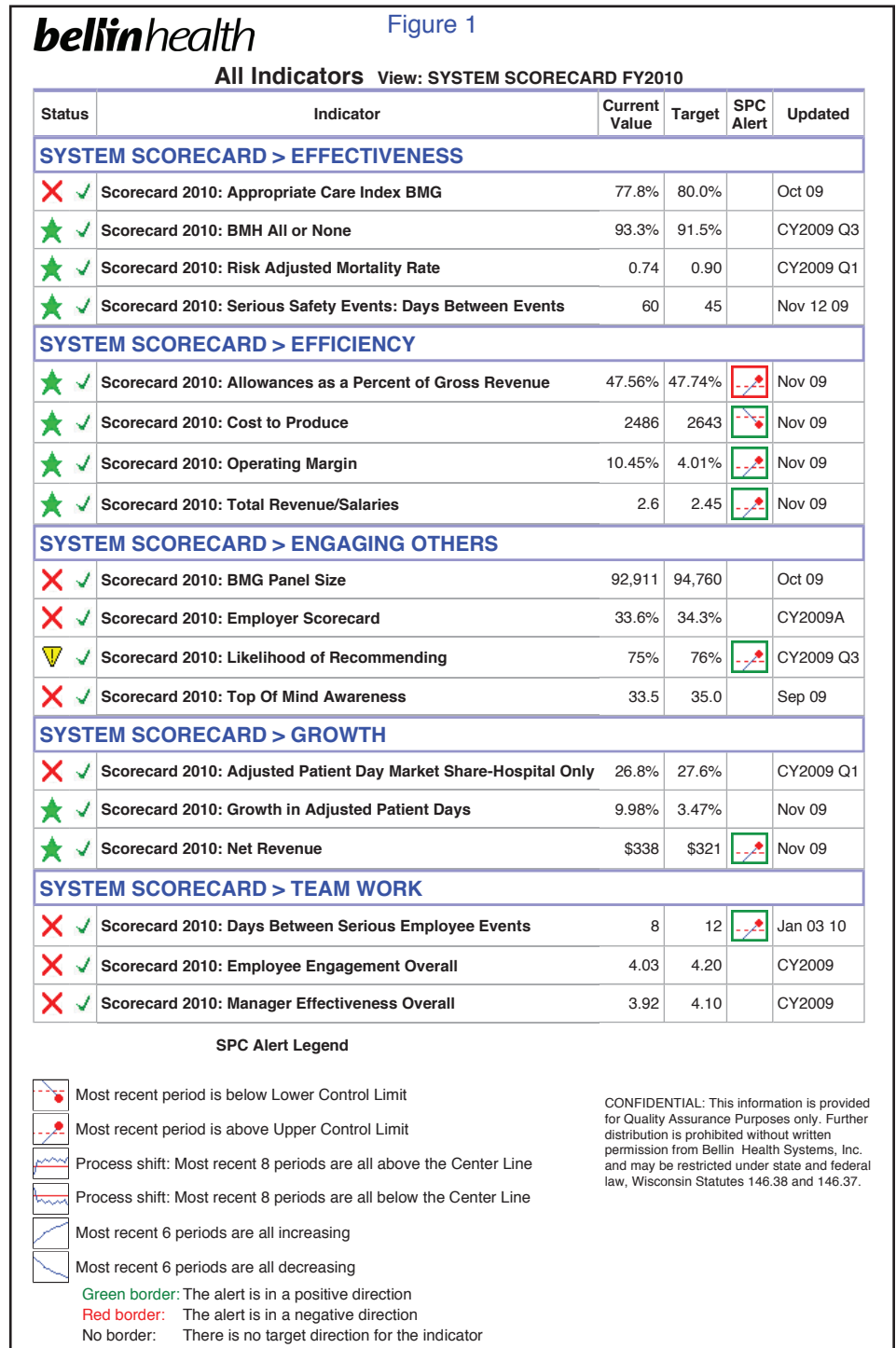
“We’ve embraced the concept that we will report and hold people accountable at a very high level,” says Stephen R. Grossbart, PhD, chief quality officer for Catholic Healthcare Partners, Cincinnati, Ohio. “We recognize each ‘big dot’ includes many different projects and activities and sub-measures, but you can’t report 200 quality measures to your board of trustees.”

Bellin’s “All or None” measure looks at the percentage of patients who received all appropriate aspects of care, not just some—no ifs, ands, or buts.

Bellin Health System, Green Bay, Wisc., monitors its five key strategic initiatives—effectiveness, efficiency, engaging with the community, growth, and teamwork—with just 18 measures, many of them representing “big dots” (see Figure 1). For example,

for clinical effectiveness, Bellin’s scorecard includes an “appropriate care index” for the outpatient setting which rolls up 11 measures, such as effective testing and control of cholesterol and blood sugar levels.

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Other effectiveness measures include the risk-adjusted mortality rate, the number of days between serious patient safety events, and “All or None,” which measures the percentage of patients who received *all* appropriate aspects of care, not just some—no ifs, ands, or buts.

“We decided to use a very simple formula: How many inpatients did you have in a given period of time, and how many of them died? That is the number that we’re going to report, because we want to challenge ourselves to understand any death in our hospitals.”

—Susan D. Keiler,
Chair of the Quality Task Force,
Covenant Health System,
Lexington, Mass.

3. Focus on reducing preventable injuries and deaths.

Increased emphasis is being placed on reducing preventable injuries and deaths. Over the past few years 27-hospital Providence Health System has been using two indices to summarize clinical quality, one of them based on the CMS core measures. “During the course of 2009, as we looked at our performance, we realized we needed to put more emphasis on reducing preventable deaths and eliminating injuries,” says Keith Marton, MD, chief medical and quality officer and senior vice president at Providence Health, Renton, Wash. “We concluded that simply focusing on the clinical reliability index wasn’t getting us where we needed to be, so we’ve moved to a more direct focus on mortality.”

“We knew our board members wanted to know about mortality, but there is a great deal of controversy over the exact indicator to use,” explains Susan D. Keiler, chief operating officer of St. Mary’s Health System, Lewiston, Maine, and chair of Lexington, Mass.-based Covenant Health System’s quality task force. After “healthy debate . . . in the end, we decided to use a very simple formula: How many inpatients did you have in a given period of time, and how many of them died? That is the number that we’re going to report, because we want to challenge ourselves to understand any death in our hospitals.”

One reason Covenant decided not to risk-adjust mortality is that it wanted dashboard data to be available as close to real time as possible. “Whenever you turn to an external

resource to risk-adjust data you lose valuable time,” Keiler says. System-wide data for all measures from the month of January will be entered and available by mid-February.

Other systems have grappled with this issue and reached different decisions. Providence has chosen to use risk adjustment as a way to compare itself to other top-performing systems; it is addressing the time delay issue by finding ways to speed up turnaround time for this metric. “A hospital or system needs to look at both raw mortality and risk-adjusted rates,” says healthcare quality consultant Steve Durbin, formerly system director for quality at Providence. “Tracking raw mortality is important, since it links to the drive to have fewer patients die in hospital. On the other hand, there are strong seasonal patterns in mortality rates, and the rate can vary substantially over time. Risk adjustment helps us understand these underlying patterns and see any unusual trends that need focused attention to improve.”

4. Think about the big picture. To choose measures of overarching performance, Joshi says leaders can look to the six “Aims for Improvement” detailed in the Institute of Medicine’s report, “Crossing the Quality Chasm.” These are safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. “This is a great framework, and since it exists, we don’t have to reinvent it,” he says.

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Joshi says boards should think not only about currently required metrics, but also about emerging issues. “Even though we may not have well-defined metrics or great trend data, we need to look at issues such as preventable readmissions, because we can already tell that this will be essential information in the foreseeable future.”

“An airplane has to constantly monitor wind speed, position of rudder, altitude, and fuel levels. That doesn’t mean the pilot has to pay attention every minute to each dial, except to confirm that they’re all green, not red.”

—Thomas L. Garthwaite, MD,
Chief Medical Officer, Catholic Health East

5. Build powerful, simple dashboards around big dots and other key measures. Boards are asking for quality measures displayed in more powerful dashboards that combine increased information with a simpler graphic format. “A hospital is a complex organization that must measure an enormous number of things,” says Thomas L. Garthwaite, MD, chief medical officer at Catholic Health East. “It’s just like an airplane, which has to constantly monitor wind speed, position of rudder, altitude, and fuel levels. That doesn’t mean the pilot has to pay attention every minute to each dial, except to confirm that they’re all green, not red.”

Bellin monitors thousands of measures, says president and CEO George Kerwin, but when it comes time to report to the board, those metrics are summarized in a few measures, related to every aspect of the organization. “This scorecard has been an incredible tool. It is so simple, and board members love it,” Kerwin says. Bellin’s scorecard also clearly indicates whether variation from the target is statistically significant or within normal “control limits.”

The Covenant Health System board specifically requested a redesigned quality dashboard. They felt that our current dashboard was too busy, with too many indicators, too many reds and greens,” says Keiler. The new dashboard, which took effect in January 2010, displays each metric as an individual graph, with six data points of trend in the initial view. Trend lines are oriented so an upward line always indicates a positive direction. This enables board

members to instantly identify a metric that isn’t showing improvement. Each system-wide metric includes a “drill down” function where individual facility performance can be viewed.

The Covenant Health System dashboard workgroup was an ad-hoc team comprised of system members plus outside experts, including Joshi. The group started out with a list of about 40 possible metrics for the dashboard, and eventually boiled it down to about 20. “We are a diverse system, including nursing facilities as well as hospitals,” explains Keiler. “We agreed to do a common system-wide dashboard, with some measures that are unique to hospitals, some that apply to nursing facilities, and some that apply system-wide.”

“When you discuss a financial report, you talk about certain aspects that require explanation; we do exactly the same thing with our quality report.”

—George Kerwin, President and CEO,
Bellin Health System

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6. Discuss quality measures actively in committee and with the full board. Boards shouldn't passively listen to quality reports and move on—they should actively discuss and constructively challenge what's presented.

At Bellin Health System, “we're not just going to toss out a bunch of weird numbers that people don't understand,” says Kerwin. “When you discuss a financial report, you talk about certain aspects that require explanation; we do exactly the same thing with our quality report.” At a recent board meeting, a primary care physician and a nurse discussed their frontline work, and the board questioned them closely about whether Bellin's metrics really captured the essence of primary care quality.

Providence Health System “consciously chose to eliminate” its system-wide board quality committee several years ago and instead “make the board a quality committee of a whole,” says Marton. “When the board meets these days they spend more time discussing quality than they do finances.” At the same time, the chair has asked an ad hoc group of Providence board members with particular expertise in quality and safety to meet regularly to review quality issues in greater detail than the board can do. By doing this they are able to refine the ensuing full board presentation and discussion to meet the board's needs.

CHE's Garthwaite, who also serves on the board of Catholic Healthcare West, suggests boards ask three questions about quality measures:

- Is what they're telling me the whole story? Are we just hearing the good news?
- Are we honest with ourselves about our performance relative to other hospitals?
- Is there anything additional we could be doing to improve performance?

7. Be sure the board has members who can really understand and discuss quality. Over the past four years Catholic Health East has expanded and revamped the board's Quality Committee, inviting new members with strong clinical backgrounds, including external quality experts. The committee now includes two members of the full board, and has frequent participation by the board chair. This committee meets face-to-face for two full days each quarter, has the time and expertise to review numerous quality metrics in detail, and then reports to the board.

“Consistent reporting of summary measures and comparisons to other health systems are the best-received reports,” Garthwaite says. “Boards tend to focus on assuring that action is taken to improve below-average performance.”

8. Set stretch goals. Organizations that aspire to excellence, not just average performance, need to set “stretch goals” that test their capacity to improve.

For example, in 2010, Catholic Healthcare Partners is focusing on four major quality goals: reducing length of stay, maintaining already low mortality rates, improving patient experience, and reducing patient harm by 25 percent. “That's a substantial stretch goal for us, and we are excited about it,” comments Grossbart.

The system analyzed its own data and identified five areas with substantial opportunities to reduce harm to patients: falls, post-surgery sepsis, central-line infections, pulmonary embolisms/deep vein thrombosis following surgery, and pressure ulcers. The measures were chosen based on high volume, strong evidence available on how to reduce the incidence of harm, and a significant impact on both mortality and cost. When they are reported to the board, they will be rolled up into a single measure: reducing patient harm.

9. Set “developmental” goals for measures the organization is just beginning to understand.

Executives and clinicians are often reluctant to commit to stretch goals or even incremental improvements when they don't fully understand the factors that affect performance. For example, hospitals are facing pressure to reduce readmissions, and may face financial penalties if

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they don't, but readmissions have multiple causes and many hospitals are still developing improvement strategies.

Catholic Healthcare Partners addresses this by setting what it calls a "developmental goal." This is a softer goal, explains Grossbart. For readmissions, he says, "we are developing the capacity to manage this aspect of the care delivery system and improve our performance, but we don't know enough at this time to set targets. At this point, we are working to develop measurement systems, set a target, and experience some reduction."

The system is currently writing program code to identify its current baseline readmission rates. At some point in the future, perhaps one or two years down the road, this developmental objective will become an operational objective. "At that point we'll be able to define processes and set targets for reducing readmissions," Grossbart says.

10. Tie executive bonuses to key quality measures. Four years ago Catholic Health East put 20 percent of top executive pay "at risk" based on quality, but over the past two years that has been increased to 50 percent financial indicators, 50 percent quality.

Until recently the CMS core measures were used as the basis for CHE quality incentives, but not anymore. "First, everybody is doing reasonably well on the core measures, and since they're made public, there's plenty of incentive to continue working on them," says Garthwaite. Starting in 2010, CHE is basing executive bonuses on nine clinical measures (with a lower threshold set at meeting at least three targets and a maximum incentive based on meeting all nine targets.) The measures include ventilator-associated pneumonia, catheter-associated urinary tract infections, falls, readmission rates for selected illnesses, and improved patient satisfaction.

As the hospitals profiled in this article demonstrate, today's health systems operate within a shifting economic and political framework. The pressure to improve quality, and to publicly report quality measures, will only increase.

In addition, improving the quality of care and avoiding harm to patients is at the core of every hospital's mission. By focusing on the most essential quality measures, by summarizing many measures in a single index, and by using simple but powerful graphic displays, boards can fulfill their responsibility to maintain high quality, and to probe deeply into areas where quality can be improved.

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The Board's Role in Compensation Oversight for Employed Physicians:

AN INTERVIEW WITH DAN GRAUMAN,
PRESIDENT AND CEO, DGA PARTNERS

By Elaine Zablocki

In August, 2009, Covenant Medical Center of Waterloo, Iowa, agreed to pay \$4.5 million plus interest to settle allegations of healthcare fraud arising from its financial relationships with five employed physicians. The Stark Law prohibits a hospital from compensating physicians for patient referrals, and can construe pay that is above market comparables as constituting improper payments to direct business its way.

The Justice Department alleged that the Covenant physicians—two orthopedic surgeons, two neurosurgeons, and a gastroenterologist—were among the highest-paid physicians in their fields in the entire country, making as much as \$2.1 million. These salaries were three times greater than the compensation paid to other physicians who referred patients to Covenant, according to the CEO of Cedar Valley Medical Specialists, a competing independent physician group in Waterloo, which brought the issue to the attention of federal regulators, according to an Iowa newsletter, *Health Capital Topics*. Covenant denied any wrongdoing, but decided to settle the case.

The Covenant case has drawn increasing attention to the question: How should hospitals determine appropriate compensation for employed physicians? How should not-for-profit hospital boards maintain appropriate oversight over physician compensation?

For answers *Great Boards* Editor Elaine Zablocki interviewed Daniel M. Grauman, president and CEO of healthcare management consultants DGA Partners. DGA's consultants help healthcare organizations and their legal counsel determine and document fair market value of physician compensation, and structure equitable compensation for employed physicians.

Government agencies are increasing their scrutiny of physician compensation arrangements.

NEW CONCERNS SURFACE ON PHYSICIAN COMPENSATION

Q. How significant is the Covenant Medical Center case?

A. It is definitely bringing new attention to the issue of physician compensation. There have been similar cases over the years pertaining to excessive compensation for physicians. However, the conventional wisdom right now seems to be that various government agencies are increasing their scrutiny of these arrangements. In part it's due to the underlying trend toward greater physician employment. As hospitals and health systems employ more physicians and develop physician enterprises, they must grapple with the question of how to set appropriate compensation levels.

Q. In the past hospitals have taken comfort because they believed that when they employ physicians, they won't face the same degree of governmental oversight as they do regarding financial arrangements with independent physicians. It now appears that there are risks even when physicians are employed.

A. The risks have always been there. In the past some hospital leaders did not fully appreciate those risks. They believed that the employer/employment relationship offered certain protections. It doesn't.

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Q. Do some hospitals have more latitude than others?

A. In fact, certain healthcare organizations do have broader options. Academic medical centers with faculty practice plans have additional choices in how they compensate physicians, and at what levels. Typically faculty physicians derive income from a range of functions, including research, clinical practice, teaching, and training, so compensation arrangements are complex. For the approximately 125 academic medical centers in the United States, there are probably 125 different ways that compensation is calculated. However, some observers may draw unwarranted conclusions based on arrangements at academic medical centers. They may assume that you can compensate in whatever way you wish in all hospital settings, which is definitely not the case.

To persuade government agencies that employed physicians are paid reasonable compensation, the hospital needs to consider the physician's roles and responsibilities, credentialing and training, the work effort involved, and whether the physician is employed full-time or part-time. Most importantly, the hospital needs to be aware of market-based compensation levels in each specific market.

Q. DGA Partners renders fair market value opinions on compensation arrangements, including compensation for employed physicians. What are the major elements necessary to persuade government agencies that employed physicians are being paid reasonable compensation at market rates?

A. The hospital needs to consider the physician's roles and responsibilities, credentialing and training, the work effort involved, and whether the physician is employed full-time or part-time. Most importantly, in setting a physician's compensation level, the hospital needs to be aware of market-based compensation levels in each specific market for comparable physicians in the relevant specialties. There are a number of publicly available physician compensation surveys, some at no charge and others on a commercial basis. However, these surveys only provide a benchmark, as they typically aggregate data at broader regional levels. It is always best to obtain local data, if at all possible. Or, if that isn't an option, it is probably best to combine the results of numerous surveys. These survey combinations should always be done consistently, not in a manipulative way. Finally, a hospital can seek guidance and an opinion from a healthcare valuation expert with experience in physician compensation.

TIME FOR A PHYSICIAN COMPENSATION COMMITTEE?

Q. What is the board's oversight obligation regarding physician compensation?

A. There's an analogy with executive compensation. The board is responsible for oversight of senior management compensation, and physicians are equally or even more highly compensated. While this may have been overlooked in the past, actually the governing board at a tax-exempt, not-for-profit hospital is subject to similar responsibilities, whether it's a CEO or a senior physician who is being paid at a high level.

Each board member has a fiduciary and compliance responsibility to ensure that all highly compensated employees, including physicians, are paid in a way that is reasonable and consistent with fair market value. If compensation levels are being set in a haphazard way, board members need to understand and appreciate that this means potential exposure for the organization.

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Q. Hospital boards often have executive compensation committees. Is it time for them to consider having a physician compensation committee?

A. Yes, they should consider this option carefully. Certain hospitals we work with already have board committees on physician compensation, and we find this leads to a more thoughtful, well-defined process.

However, it depends first on how many physicians you employ. If you just employ a few physicians here and there, perhaps in the ICU plus one or two additional areas, it probably isn't a priority. But if you are launching a strategy that depends on considerable physician employment (as many health systems are considering) or if you already employ many physicians, then it is appropriate to raise the issue to a new level and institute a board oversight committee on physician compensation.

Q. What are the responsibilities of the physician compensation committee?

A. First, it needs to develop a physician compensation policy, including specific guidelines on the process of determining appropriate compensation for each and every physician. It should also set policies pertaining to the actual physician compensation models, in terms of mechanisms used to compute compensation.

Once the board committee has developed guidelines and standards, then it needs to ensure that the resulting compensation levels make sense. They should be reviewed annually for consistency with fair market value. If certain physicians appear to be paid more than fair market value, the committee should check to see whether there are reasons that explain and justify these anomalies, or else instruct management to develop plans to correct the situation.

The physician compensation committee should look closely at higher-risk physician compensation arrangements such as physician executives, medical directors, and physicians who are key admitters to the hospital.

Q. What sort of situations should the committee review and approve?

A. It should look closely at higher-risk physician compensation arrangements such as physician executives, medical directors, and physicians who are key admitters to the hospital. It should look at physicians in leadership roles in high-profile product lines such as cancer care or neurosurgery. Special issues may arise when practices are being acquired, or when physicians are compensated based on productivity and then end up in high percentiles of market rates. The committee should also review situations where a physician is paid for multiple roles, such as a doctor who derives compensation from seeing patients and is also paid a separate consulting fee for managing a clinical department, recruiting physicians for a group practice or provider network, or helping the hospital build/enhance a clinical product line. The physician's compensation might come from multiple sources, such as the hospital and the hospital-owned group practice, but total compensation should make sense as a whole, reflect actual responsibilities, and be consistent with fair market value.

Q. In addition to overseeing high-risk employment arrangements, how should the committee be informed about other compensation arrangements within the organization?

A. The committee should review a table or graph that essentially shows the actual compensation level for each and every employed physician, and how that compensation compares to relevant fair market comparisons.

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Q. Should there be limitations on committee membership?

A. All or a majority of the members of the physician compensation committee, and especially the committee chairperson, should be independent directors, without any significant economic relationship with the organization. It is particularly important that employed physicians and other members of the medical staff should not be named to this committee.

Q. Should the general counsel attend committee meetings?

A. Yes, certainly during the initial meetings, up to the point where committee members are substantially educated and informed about all the relevant issues. After that, while the counsel doesn't need to be present at every meeting, he or she should certainly consider attending major meetings, such as an annual review of all compensation levels.

Q. Should the physician compensation committee rely on independent compensation consultants and outside legal advisors?

A. The ones that we know do this. Independent compensation consultants and external counsel generally offer a broad view of the marketplace. They are an additional signal to any potential oversight agencies that the hospital has made every possible effort to base compensation on fair market value.

From time to time we find specific circumstances where the desired compensation level goes right up against defensible limits.

INTERNAL CONTROLS NEEDED

Q. DGA Partners is familiar with compensation arrangements for employed physicians. Do you often find that employed physicians are paid at rates higher than the market would justify?

A. I wouldn't say it's often. However, from time to time there are specific circumstances at a particular hospital where the desired compensation level goes right up against defensible limits, given the available information on comparable salary arrangements.

Q. In many hospitals, the lines of authority over physician pay are unclear. Why is that?

A. In large hospitals you typically have multiple management players involved in physician compensation arrangements. You have the CEO, the CFO, the chief medical officer, and the executive for the employed physician group. You may have clinical chairmen, especially in academic medical centers. You have product line executives, senior vice presidents who are responsible for major aspects of operations, and then you generally have in-house legal counsel. In any given situation several executives may have a role in negotiating the compensation arrangement with a particular physician, or may have operational responsibility for certain employed physicians.

We see regularly that this leads to confusion. There are multiple people in the organization responsible for employed physicians, and they are not all equally knowledgeable about compensation arrangements and fair market value considerations. There's also a great deal of variability in what we might call the internal controls.

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The best situation would be to establish an internal process with appropriate checks and required approvals before hiring a new physician in an important role. That doesn't always exist.

Sometimes an operations person just embarks on the hiring process on their own, because they're really busy and don't think about an internal review.

Q. What would those internal controls look like?

A. You would have a documented process.

Suppose a senior vice president is responsible for a major product line, and needs to hire a new physician as assistant medical director. Before the executive starts talking with any physician about the job and potential compensation levels, there should be a formal requisition. Someone in finance and someone in the legal department should both sign off on the request and provide parameters on what compensation levels would be appropriate.

Now that sounds like a logical process, but I can tell you it doesn't always happen that way. Sometimes an operations person just embarks on the hiring process on their own, because they're really busy and don't think about an internal review. Then they get to the 11th hour, when they've already negotiated a tentative agreement, and someone in the organization notes that they have to check and review whether this is within fair market value.

Q. Have you ever had to tell a hospital that you couldn't write an opinion supporting compensation it had agreed to pay? If so, what happened?

A. Yes, this happens from time to time. We inform the hospital that the compensation level they are contemplating for the physician is not consistent with fair market value. We go on to tell them the level that would make sense, and offer suggestions on how to restructure the compensation arrangement. The hospital can point to us as the experts who have recommended these changes, and attempt to save the relationship. Hopefully, the draft or current employment agreement makes reference to the need to comply with relevant laws and regulations, including fair market value guidelines.

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