

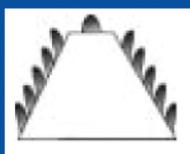
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Applying Sarbanes-Oxley to Healthcare Quality

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

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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.

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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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