E-Briefings

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Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute.

In this issue:

Effective Physician Compensation in the Movement from Volume to Value

By Timothy J. Cotter and Mark Ryberg, Sullivan, Cotter and Associates, Inc.

The healthcare industry is undergoing transformational change to deliver better value to customers. The pressure to simultaneously improve the health of populations, enhance the patient experience, and reduce the total cost of care has spurred fundamental change in the funding and delivery of healthcare. Today, healthcare organizations clearly operate in two worlds: one that is still fee-for-service and the new world of pay-for-outcomes. As the industry transitions from one world to the next, board members and executives face uncertainty around the degree and pace of change.

Recent announcements from CMS and a major coalition of providers and insurers signal acceleration in the transition from volume-based to value-based reimbursement. According to Health and Human Services Secretary Sylvia Burwell, CMS has set a goal of transitioning 30 percent of Medicare fee-for-service-based payments to a value-based performance model by 2016, and 50 percent by 2018. Within the same week, the Health Care Transformation Task Force committed to shift 75 percent of its members' business into contracts with incentives for health outcomes, quality, and cost management by January 2020. A recent study by McKesson indicated that payers anticipate fee-for-service reimbursement to decline from 56 percent of total reimbursement today to approximately 32 percent in just five years.[1]

These changes have significant implications for the way healthcare organizations pay their employed physicians. Physician compensation models must evolve to achieve greater alignment with future value-based payment methods (e.g., pay-for-performance, episodes of care, bundled payments, shared savings, etc.). The question is what will they look like in the near term to effectively operate in both the volume-based and value-based worlds?

Physician Compensation in a Volume-Based World

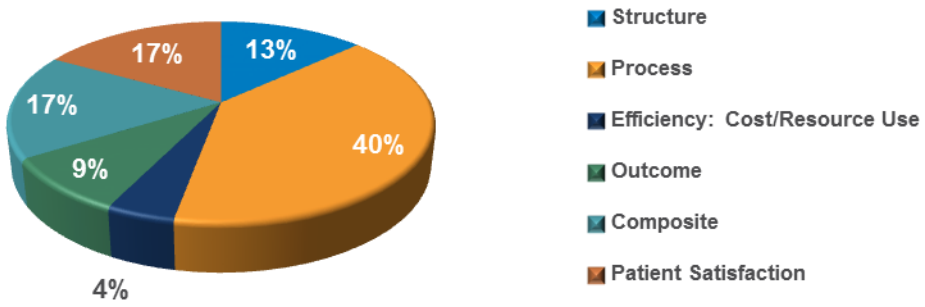
With the exception of a small subset of highly effective organizations that have achieved great success with pure salaried models, most healthcare organizations currently pay physicians under a production-based model with small opportunities for quality-based incentives. The typical employed physician of a hospital, health system, or large medical group has a package of total cash compensation (TCC) that includes:[2]

- A base salary combined with a modest incentive opportunity (median of 13 percent of base salary).
- TCC based heavily on productivity, with volume measures (wRVUs and professional collections) driving much of pay determination.
- Little pay linked to quality outcomes with less than 5 percent of TCC dependent on measures of quality. Often process measures and patient satisfaction are used as proxies for quality.

[1] *McKesson Health Solutions: The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014* (available at http://mhsinfo.mckesson.com/rs/mckessonhealthsolutions/images/MHS-2014-Signature-Research-White-Paper.pdf).

[2] *Physician Compensation and Productivity Survey,* SullivanCotter, 2014.

Exhibit 1: Performance Metric Prevalence in Internal Medicine Quality Incentive Plans



Source: 2014 Provider Performance Incentive Survey.

Evolving to Pay-for-Value

In the near term, the transition in physician compensation models is likely to be gradual. More compensation will be placed at risk relative to achieving specific outcomes, with appropriate variability between primary and specialty care. We expect a change in the mix of TCC with less fixed and more variable compensation. Performance measures will shift from process to outcomes and include a component for team-based performance, not just individual results. Productivity measures (e.g., wRVUs) will still play a significant role in determining TCC but will gradually decline with the continued introduction of value-based measures.

Currently, the bulk of qualitative incentive development is occurring in the primary care setting and has focused on metrics related to patient satisfaction as well as clinical process measures. SullivanCotter has conducted research on incentive plans across 22 specialties for physicians employed by large health systems or medical groups. As shown in **Exhibit 1**, the study shows that 70 percent of performance measures used in qualitative incentive plans for internal medicine physicians—a proxy for primary care—are related to patient satisfaction, process, and structure.[3]

The evolution of these measures is largely a product of what organizations are capable of reliably measuring. However, in the near term the effective primary care model will include more holistic metrics, to include some or all of the following:

- Patient access
- Panel size
- Patient satisfaction
- Efficiency and cost of care
- Clinical quality outcomes

Structural, process, and outcome measures have been more challenging to develop for medical and surgical specialists. The process for measure identification, testing, reporting, and benchmarking will take time to evolve. In the meantime, specialist compensation models will continue to focus on wRVUs, to ensure adequate access, and will include basic measures of patient satisfaction and quality process. As more advanced measures are adopted, they can be blended into the model.

As physician compensation models evolve, organizations face new administrative challenges and will need sophisticated, agile IT systems to measure and manage quality-based incentive plans. Tracking, reporting, and communicating results to physicians in an understandable way, using data they trust, is a vitally important part of creating an effective compensation plan. As measures continue to evolve from structure and process measures to true outcomes measures, reporting systems will need to adapt quickly.

When designing an effective compensation plan, organizations would be well served to consider other emerging trends, reflecting the competitive physician labor market:[4]

- Sign-on bonuses are used by almost 80 percent of physician employers. Typically, such payments are subject to repayment if a service period is not fulfilled (typically two years).
- Growing rapidly in the past year, retention incentives are used by 27 percent of physician employers to keep key talent in place.
- Student loan repayment assistance is provided by 30 percent of organizations to assist with the recruitment of early career physicians.

[3] *Provider Performance Incentive Survey,* SullivanCotter, 2014.

[4] *Physician Compensation and Productivity Survey,* SullivanCotter, 2012–2014.

- Nearly 50 percent of physician employers provide more generous benefits to physicians than other employees, up from 37 percent in 2012.
- 64 percent of organizations pay physicians to supervise advanced practice clinicians as organizations strive to improve access and reduce costs.

Guiding the Transition

In a rapidly changing environment, physician compensation plans have a relatively short shelf life and, as such, the goal for today should not be to develop the perfect model for the next 10 years. Rather, organizations should strive to develop a model that can evolve over time, in sync with the pace of change in reimbursement, care delivery, and quality measurement. In doing so, an effective compensation model should:

- Balance volume (wRVUs and collections) with measures of value.
- Be flexible to adjust to changes in payer requirements over time.
- Integrate with existing measurement systems, while working to develop next generation measures.
- Be overseen by physician leaders capable of managing the cultural and operational change necessary to support the model.

It is critically important that future model design reflect the realities of reimbursement in order to maintain financial sustainability. Organizations must appropriately balance a continued focus on current mechanisms that are well suited to a fee-for-service environment (e.g., wRVUs) with an emerging need to take a broader view as to how they measure physician performance (e.g., value-related measures, including access). In short, don't lose sight of what works today in your efforts to hedge on the future.

Our experience suggests there is no one-size-fits-all solution or perfect compensation model. Healthcare organizations will need to consider a number of factors to identify the "best fit" solution for their unique situation and design it with the flexibility to adapt to a changing environment. In the design process, you should consider the following factors:

- **Culture/values:** What are the organization's fundamental beliefs about pay and competitiveness? How important is individual vs. group performance? Should pay be primarily fixed or variable? How much differentiation in pay is desirable?
- **Organizational objectives:** What other objectives does the organization want the compensation model to support, beyond the shift from volume to value? Are there specific needs around recruitment and retention of physicians, EHR implementation, financial goals, etc.?
- **Leadership support:** Does the organization have strong executive and physician leadership with the appetite to engage in the change process? Does the leadership team have the trust of the physicians? Has the organization developed the necessary processes and communication tools to effectively manage change?
- **Physician engagement:** How do physicians view the sustainability of their current model? Are they aware of the changing market dynamics? Are physicians actively engaged or interested in driving change? Are they involved in determining which measures of performance are impactful, fair, and within their span of control?
- **Measurement systems:** Does the organization have the administrative systems, technology, and processes necessary to reliably measure and assess performance under these new value metrics? Are existing performance measures suitable for a value-based environment?

Conclusion

When developing new models for physician compensation, the program design is just one part of the equation—the process for getting there is equally important and often overlooked. Successful organizations recognize that big changes take time. By asking yourself the right questions, engaging leadership and physicians in a two-way dialogue, setting realistic expectations on the pace of change, and evaluating the ability to administer and communicate new programs, you can develop an effective physician compensation model that bridges both worlds and lays a foundation for the future.

The Governance Institute thanks Timothy J. Cotter, Managing Director, and Mark Ryberg, Consulting Principal, with Sullivan, Cotter and Associates, Inc. for contributing this article. They can be reached at timcotter@sullivancotter.com and markryberg@sullivancotter.com.

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Using Data to Drive Culture Change

By Richard Corder, M.H.A., FACHE, CRICO Strategies

Sir Arthur Conan Doyle, the Scottish writer and physician most noted for his stories about the adventures of Sherlock Holmes and Dr. Watson, wrote, "The temptation to form premature theories upon insufficient data is the bane of our profession."

Whenever I read this quotation, I wonder to which of his professions he was referring. Was it the prolific writer of fantasy, science fiction, plays, romance, and poetry, or was it the practicing ophthalmologist in the heart of London? I'm inclined to think that it was a little bit of both. An observation that, as an author it was part of how he could enthrall a reader as he led them down the path of premature theory, and as a physician it reads as a reflection of the professional reality that without sufficient data, it is easy to form an inaccurate diagnosis or an inappropriate plan of care.

Through my experience at CRICO Strategies, I work with hospital and clinic leaders and executives to improve patient and provider safety. I hear numerous stories that relate to this temptation to form premature theories, or accounts of the data being ignored entirely. We are living and working in a world where access to outcome, clinical, harm, experience, and event data (and the information and knowledge that can be derived from it) is ubiquitous and can be used more effectively.

In an effort to strive for shared understanding, below are definitions of "data" and "culture" in healthcare, as well as an explanation around the power that data has to positively impact a hospital or health system's culture.

Data is a set of values of qualitative or quantitative variables; another way to think of data is as individual pieces of information. Data is measured, collected, reported, and analyzed. Data can be shared and can be visualized using graphs, images, pictures, and stories. Data as an abstract concept can be viewed as the lowest level of abstraction, from which information and then knowledge are derived.

Data can be gathered from listening to a patient or colleague as much as from reading a report or interpreting a graph. When presented in a way that we understand, data can be the feedback that connects us to the efficacy of our efforts and actions.

Organizational *culture* has many definitions, but is best captured by the somewhat informal, "How we do things around here." It is the way we behave, talk, and act; it is what we reward and how we hire, retain, promote, and fire. At a fundamental level, culture is made up by the habits and actions of those people that lead and work in the organization.

Culture in hospitals and other healthcare entities is often cited as an excuse as to why change is so difficult to come by. But if culture is a series of habits and behaviors, than it can therefore be measured, and hence changed. People can learn new habits, develop new patterns of work, and use different language.

Data must be a critical part of our discussions when we are talking about culture change. It should start the conversation, direct the course we take, and ultimately be a way to determine whether we "got there."

Culture as a Superordinate Goal

If organizational culture is a set of beliefs, habits, and behaviors that can be measured, then it is reasonable that improving or changing a culture can be set as a goal, with all the trappings of being specific, measurable, achievable, realistic, and timely (SMART). We can think of improving or changing culture as a superordinate goal and we can craft subordinate goals that we can communicate, measure, and share as we pursue our future state.

Below are three ways to measure culture. The question for healthcare leaders is what is going to be the best measure of their culture, and what is the appropriate mix of data sets, goals, and efforts against the backdrop of other competing priorities?

Three Types of Data for Measuring Culture

1. Perception Data

When we administer surveys that seek to capture the experience that a person had in a specific

environment with a group of colleagues or caregivers, we are measuring perception—at the psychological level.

Examples of this include the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that captures a patient's perspective of aspects of care, and the surveys on patient safety culture from the Agency for Healthcare Research and Quality (AHRQ), a tool that assesses the physical and psychological "safety" of the work environment. There are also a growing number of organizations that have assessed stress and burnout using the Maslach Burnout Inventory (MBI).

These surveys provide valuable data regarding the perception of the care we provide, the environment we create, and the organizations that we lead.

2. Performance Data

Data to assess performance include measures of historical performance, such as serious reportable events, hand-washing compliance, fall rates, and employee turnover.

This level of data can be shared through performance dashboards, reports, and other mechanisms. It can be frequently updated, benchmarked against, and reviewed over time. It also provides a record of facts that can be used to track performance.

3. Observing Practice Data

The observation or inspection of elements associated with design and practice includes the assessment of activity against agreed-upon practice. For example, if we have made the decision that as an organization we will adopt a "daily safety huddle," we can inspect against this expectation. It either happens or it does not—the observation or inspection is binary in measurement.

There are many attributes associated with operating a safe, just, and transparent organization that have been "borrowed" from other industries. Crew Resource Management and the use of checklists are just two adapted from aviation. If, as an organization, we have been clear regarding the implementation of these practices, then we can observe whether they occur.

Data as a Catalyst for Change

My colleagues Dana Siegal, RN, CPHRM, and Gretchen Ruoff, M.P.H., CPHRM, recently published a series of data-driven stories about how specific system and process failures put providers and patients at risk.[5] These stories are drawn from the data-sharing community of CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions, Inc. CRICO's data-driven strategy uses intelligence from thousands of medical malpractice cases across the country to examine what went wrong and why, and to help members and clients manage their risk and provide better care.

Data captured in CRICO's Comparative Benchmarking System (CBS), a national database of more than 300,000 medical professional liability (MPL) claims from more than 400 hospitals and 165,000 physicians, demonstrate that many of the issues related to patient harm that were captured in the Institute of Medicine's report, *To Err is Human*, still exist to this day.[6]

Here is a sample of the stories that Siegal and Ruoff share where data has been used as a catalyst for change:

- A study of diagnostic failures in the emergency department resulted in the development of strategies to improve doctor–nurse communication.
- A review and analysis of medical malpractice data from an obstetric service revealed variability in the interpretation of electronic fetal monitoring (EFM) readings between physicians and nurses—resulting in having the M.D.s and RNs attend the same class, together, to learn the same terminologies and communication expectations. The data also revealed that this service was faced with a larger proportion of prenatal-related malpractice claims than its peers, providing opportunities for better collaboration and follow up with patients, an opportunity that could have been lost were it not for the data.
- A deep analysis of surgery claims data revealed communication breakdowns in the post-operative period, specifically identifying resident–attending communication as a serious patient safety opportunity. The analysis and data presentation was the stimuli for the development of a pocket reminder card clearly articulating the expectations for contacting an attending, such as specific vital sign changes,

[5] Dana Siegal and Gretchen Ruoff, "Data as a Catalyst for Change: Stories from the Frontlines," *Journal of Healthcare Risk Management*, Vol. 34, No. 3, January 2015.
[6] *To Err is Human: Building a Safer Health System*, Institute of Medicine, November 1999.

unplanned intubation, and transfer in/out of the ICU.

Using Your Data

Data is a powerful tool to start a conversation and tell a story because it allows us to be results-driven as well as to analyze what works and what doesn't, and, therefore, positions us to use that information to change our programs and organizations—to change our cultures.

While data cannot alone solve issues, data offers us the clarity to make resource allocation decisions more effectively and to drive results and performance. Indeed, as Atul Butte, M.D., Ph.D., the Director of the new Institute of Computational Health Sciences (ICHS) at the University of California, San Francisco, explained, "Hiding within those mounds of data is knowledge that could change the life of a patient, or change the world."

That, for me, captures the value of data. In and of itself data has no use. But when we analyze it, share it, and use it as a part of the stories we tell, the goals we set, and as a measure against what we do, then it comes to life. With this insight and application, data can not only change a life, it has the power to save a life.

The Governance Institute thanks Richard Corder, M.H.A., FACHE, Assistant Vice President, Business Development, CRICO Strategies, for contributing this article. He can be reached at RCorder@rmf.harvard.edu.

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Get and Keep the Right People on the Board

By Linda Galindo, Galindo Consulting, Inc.

In today's complicated healthcare landscape boards need directors with the right blend of knowledge, experience, and diversity to successfully govern their organizations. This article explores changing the makeup of the board, using a talent/skill matrix, mapping board talents to the mission and vision of the organization, and holding board members accountable for getting and keeping the right people on the board.

Changing the Makeup of the Board

Whenever an organization's leadership is reflecting on what needs to change in order to be effective and relevant going forward, it is important to listen carefully. What is instigating the reflection that may result in change? For example, a board member returns from a conference filled with new ideas that seem to be working for other healthcare organizations, and says, "We need more women on our board. The data, evidence, and examples presented all demonstrate that in every case the organization's results were better when the number of women on the board was 50 percent or greater."

No doubt this enthusiastic board member was convinced about the importance of changing the makeup of the board, but it is much more complex than adding a few women to the board. Ensuring boards have the right mix includes not only looking at ethnicity and gender, but diversity of skill, talent, and background as well. Healthcare organizations must also consider the communities they are serving. What ethnic groups reside in the community? What are their health needs and unique cultural perspectives? Do we have someone on the board that understands and can address those needs and perspectives? The right mix of directors will be a reflection of the community the board serves.

When the board is reflecting on the importance of changing its makeup, and is committed to being a reflection of the community, consider Marshall Goldsmith's admonition in *What Got You Here Won't Get You There*.[7] In this book, Goldsmith emphasizes appreciating diversity as a leadership skill. His leadership inventory includes these qualities:

- Embraces the value of diversity in people (including culture, race, sex, or age)
- Effectively motivates people from different cultures or backgrounds

[7] Marshall Goldsmith and Mark Reiter, *What Got You Here Won't Get You There: How Successful People Become Even More Successful*, New York: Hyperion, January 2007.

- Recognizes the value of diverse views and opinions
- Helps others appreciate the value of diversity
- Actively expands her/his knowledge of other cultures (through interactions, language study, travel, etc.)

As boards are contemplating their diversity, they should take a moment to ask: Is diversifying our board and shaking things up to ensure the right skill mix important or imperative? That which is identified as *imperative* will be followed through with accountability. That which is merely *important* will continue to be no more than a discussion for a long time to come. If a board does not identify making certain the right mix of skill and community representation as an imperative—of vital importance, crucial to its success, indispensable, and urgent—change will continue to proceed at its current glacial rate.

What Does Your Skill and Diversity Matrix Look Like?

Getting the right people on the board begins with defining what "right people" means. If the prevailing consensus is that there is no need to consider race, gender, and ethnicity differences, tell the truth about that and adopt a talent and skill matrix that will best serve the organization. This talent/skill matrix generally includes a list of competencies the board has identified as critical to the success of the organization. The board talent needs should be connected with the strategic plan and future vision of the organization. This can be used to do a talent gap analysis to identify talent that may be necessary for the future. Any knowledge gaps that have been identified using this matrix should be considered when recruiting new members.

The board should also examine its existing talent. Long-term board members whose skills have not kept up must redefine their contribution. This may yield insight that although one's contribution in time and expertise is significant, it is no longer relevant. Redefining one's contribution isn't necessarily age or term related. Change is happening so fast that anyone can come up short. For example, Ed had been a director for two years. He retired from his role as Chief Information Officer in a publicly traded corporation shortly after joining the hospital board. The board matrix includes "technology" as a needed knowledge/competency area. But after going through a redefinition of his board member contribution, he realized the board would be better served by someone currently active in a technology role. He helped the board locate and onboard the right person as he transitioned off, and he remained a committee member as opposed to a voting member of the board.

All board members need to be relevant in their role as directors. The community counts on it. Every director must be able to state: "Here is where I am on the matrix of skill, talent, and diversity for this board."

Mapping the Board's Composition to the Mission and Vision of the Organization

According to legend, a janitorial employee at NASA, when asked what he was doing, is said to have replied, "I'm helping to put a man on the Moon." True or not, I love this story. If someone asked you what you are doing on the hospital board, is your answer as clear as this janitor's? What if your hospital or health system's Web site had the headshot of each board member and beneath that headshot a clear statement of what each director was doing, stated as clearly as, "I'm helping to put a man on the Moon." Too simplistic? I would challenge that with *brevity is clarity*. Our communities are starved for this level of clarity. This level of clarity can only help the community help the hospital.

If you search the name of your hospital or health system online, can you easily find the vision or mission statement? What if pictures of the board were right below with a clear role statement? The mission and vision of the organization, as well as the board's makeup and how it helps achieve the mission and vision, should be clear and public.

What would it look like if you mapped the board's makeup to these mission/vision statements?

> *Our hospital is dedicated to providing high-quality healthcare. We meet that standard through changes in upgrading technology and advanced procedures. While these changes may be constant, our tradition of caring and healing will never fade.*
>
> *To become a destination hospital for selected tertiary and quaternary clinical services by delivering best-in-class quality, educating healthcare leaders and providers, and engaging in research.*
>
> *Providing a comprehensive range of high-quality, reasonably priced healthcare services to the community.*

A terrific board exercise would be to identify what is published to the public as the organization's mission/vision, publishing the board matrix mapped to the diversity of the community and skill matrix needed for a relevant and vibrant board, with every board member pictured with a statement of contribution. To do this, you would need to create a clear and transparent matrix, easily accessible, and accountable to the community. Most vision statements for hospitals and health systems are difficult to find, and directors may be listed, but their role and contribution have to be inferred based on their title. Why?

Accountability

Who is accountable for getting the right people on the board? A clear answer to this question boils down to "each of us." Every director has a part in retaining valuable board members and getting new ones. In addition, they have to be certain that they are the right person in their role as a director. This is where board evaluations play a critical role as a non-negotiable for any healthcare board. In this day and age with the complexity and amount of change in healthcare, letting any grass grow under a lack of director performance is a huge strategic mistake. Directors can't change what they don't know isn't working about their performance.

Accountability also points to the need to show the talent/diversity matrix the board has agreed to at *every* board meeting. The knowledge and wisdom available from the right mix of board members can create a dynamic, interesting, and relevant working board that successfully governs the organization into the future. It must remain at top-of-the-mind awareness. Board members who see themselves as accountable for the right people and the right mix will run across individuals that should be considered for the board. Continually reminding all directors and the community of what is being sought, and continually evaluating one's own relevance is a huge asset to a hospital or health system board. This kind of board culture can attract the best and the brightest to serve the community. All board members should be committed to getting and keeping the right people on the board. It is an individual and collective effort.

As you reflect on what needs to change in order to be effective and relevant as a director going forward, decide if change is imperative, continually define your contribution and keep it transparent to the community, and be accountable to the role you accepted to get and keep the right people on the board.

The Governance Institute thanks Linda Galindo, President, Galindo Consulting, Inc., for contributing this article. She can be reached at linda@lindagalindo.com.

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New Publications and Resources

Governance Notes (Governance Support, February 2015)

BoardRoom Press, Volume 26, No. 1 (*BoardRoom Press*, February 2015)

Loma Linda University Health Reaches Out to Share Its Vision (Case Study, January 2015)

Moving Your Organization toward Strategic Cost Transformation (Webinar, January 2015)

E-Briefings, Volume 12, No. 1 (E-Briefings, January 2015)

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