The Governance Institute's
E-Briefings

A service of National Research Corporation

Volume 11, No. 1, January 2014

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. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

In this issue:

News, Articles, and Updates

Ten Trends That Will Drive Healthcare Priorities in 2014

Last year was the warm-up act and 2014 is the main event for healthcare reform implementation. Milestone activities to watch include Congress' appetite to follow through with a fix to SGR (physician Medicare reimbursement) before the next expiration date at the end of March 2014. In the first quarter of the year, also monitor Medicaid expansion and enrollment growth in insurance exchanges (marketplaces) by state and region. Mid-year, we will hear politicians' positions on healthcare reform and related issues in the build up to the mid-term elections on November 4. ICD-10 will go live on October 1. Throughout the year, top priorities for health systems, hospitals, and physicians will center on successfully navigating payment reform to increase revenues, managing (reducing) per unit costs, achieving Medicare breakeven, economically aligning with physicians, and continuing to redesign clinical care systems and processes. Following is our best advice for setting policy priorities and monitoring progress in the boardroom, C-suites, and leadership councils for 2014.

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1. Physician Engagement/Alignment: "More, PCP-Focused, Selective"

Aligning clinical and financial incentives with physicians has moved to the top of most hospital and health systems' strategic priorities. The number of employed/closely aligned physicians will continue to increase in 2014 as the economics of private practice deteriorate and as newer physicians enter the workforce. At the other end of the age spectrum, more mature physicians will seek alignment to facilitate their transition from full- to part-time, then to retirement. To facilitate this, it will be essential to have practice support as well as alignment infrastructure capabilities that include co-management agreements for key service lines (cardiac, orthopedic, oncology, and other specialty areas), shared savings models (e.g., ACOs), and risk pools. Top of mind issues for board members will include ensuring that physician compensation models and contracts can accommodate new payment methods (value-based revenues, shared savings, quality incentive rewards, and bundled payments) and refining strategies that clinically integrate independent as well as employed physicians (e.g., technology, coordinated care management processes, clinical information systems). An effective governance and leadership model for aligned physicians is a critical building block to build commitment and buy-in to clinical integration, care process redesign, and cost-reduction strategy implementation.

In the boardroom:

- Monitor physician retention and recruitment activities to ensure that the organization sustains and grows an adequate supply of primary care physicians, nurse practitioners, and other key specialties as expected future physician shortages may impact medical staff needs.

- Are your alignment models oriented to address the needs of independent as well as employed physicians?
- Do your compensation models incentivize desired behavior (e.g., maintain productivity, reduce costs, improve quality and patient satisfaction)? Does the compensation plan put enough physician income at risk for performance? Our experience shows that 15 to 20 percent of total compensation must be at risk to truly influence behavior.
- Do you have a governance and leadership development model (or plan) relative to your employed medical group?
- Are you surveying and monitoring physician satisfaction or engagement? These are different, and engagement levels are becoming an essential measure of alignment, culture buy-in, and support among medical staff members.

2. Clinical Integration/Care Delivery Redesign: "Double Your Efforts"

Physician leadership (with clearly defined financial and clinical incentives) is the foundation to effective clinical integration and the redesign of clinical care delivery processes. Collaboration among physicians and other clinicians is essential to create a team approach to support the redesign of clinical care, using advanced technology, real-time access to relevant data, streamlined and integrated coordinated care delivery processes, and efficient transitions across care settings. New care models must be proactively developed to respond to commercial payers, Medicare, and Medicaid as they seek high-quality, consistent outcomes, and lower-cost care. Patient-centered medical homes will evolve to "medical neighborhoods," with the integration of specialists and other providers in the community. If you can achieve this level of clinical integration, employers will also be interested in direct contracts with you.

In the boardroom:

- Has the organization conducted a clinical integration assessment? What are areas of strength that can be built upon? What significant gaps exist, and is there a prioritized plan to facilitate your organization's response to payer and employer strategies?
- Have you tested new models of care with your own employees and dependents to reduce costs and improve health outcomes?
- Have you developed an ACO or have you explored developing or joining one with other provider partners? (Shared ACO models among providers are being developed in urban, as well as rural markets.) Is this a way for your organization to minimize risk and gain greater market presence?

3. Insurance Exchanges (Marketplaces): "Wait and See"

The formula for success in the exchange plans is simple—sufficient number of enrollees in each plan type, balanced demographics of enrollees (more young than older), and health status (healthy vs. sick and with pent-up demand for services or adverse selection). At this point, providers have already decided either to participate in exchange networks or to "sit out" year one. Low reimbursement and adverse selection are cited for not participating. Participation will be market-specific, and should be based on a careful analysis of the projected financial, volume, access, and other impacts. Each contract must be examined individually, and multi-year contracts should carefully take into account the confidence level of enrollment projections (consider requesting enrollment guarantees) and expected use rates.

In the boardroom:

- Carefully monitor each active exchange contract for enrollment levels, inpatient and outpatient service use rates, cost-of-care, payment rates, bad debt levels, deductibles, and co-pay collection experience.
- Establish measurable performance thresholds and standards to catch potential problem areas quickly (e.g., utilization, disenrollment/ineligibility, length of stay, bad debt, inappropriate levels of service use).
- Watch the impact of Medicaid expansion and identify strategies to respond: reducing costs, evaluating access points, and impact on market dynamics.

4. Employers: "Go Direct"

The year 2014, while looking at 2015, will be the eye of the storm for small employers considering if and how they will provide their employees with healthcare insurance benefits now and into the future. If they do provide healthcare benefits, will it be through a defined benefit or contribution model? Will they choose to encourage employees to access insurance through either public or private exchange options? More and more, hospitals and health systems in large and small markets are working with employers to directly contract for healthcare services. Many of these relationships involve some type of shared savings, medical and disease management, guaranteed spending

threshold, and/or preferred pricing arrangements to create more closely aligned incentives for ensuring high-quality, lower cost, and more accessible care for their covered employees. Typical arrangements used by employers offer tiered benefit levels, narrow provider networks, service carve-outs, reference pricing models, and other incentives to change behavior toward wellness and use of in-network services. Some may be deployed in partnership with payers as a "private label" product. Many arrangements with employers include on-site primary care and other outpatient services. Employers will seek to contract with providers who can be flexible, innovative, highly effective, and willing to share risk for financial and clinical outcomes under appropriately configured programs. Providers with health plan licenses and organized care delivery networks will be well positioned to respond to employers seeking willing partners to pursue high-quality, cost-effective healthcare services for their employees.

In the boardroom:

- Have employers approached your organization to explore direct contracts for specific services or to go at-risk for managing their healthcare services?
- Work with your physicians to assess your market to determine target employers who are most likely to benefit from a direct contract arrangement. Meet with them to discover their interests and needs (before a competitor does so).
- Assess your ability to provide services through direct contracts—what are your strengths and what gaps need to be filled. Your case for direct contracting will be stronger if you have prior experience, or if you have a positive track record managing the cost and quality of care for your own workforce.

5. Consolidations, Affiliations, Mergers: "Growth in Scale"

Is a minimum of $6 billion in revenues the "new normal" size for an ideal health system? 2014 will continue the current pace of mergers and acquisitions of hospitals, health systems, medical groups, and other provider organizations of all sizes across all markets. A primary driver for many of these mergers is to create scale and greater market presence. Scale is critical for greater access to capital; for growth in geographic markets; for creating economies of scale to lower operating costs; and for leveraging information technology, knowledge transfer, contracting, recruiting, and other areas. While some affiliations will be cases of "last resort," many will be opportunistic and proactive. These will be formed by strong partners with compatible cultures, missions, future visions, complementary physician engagement models, and other aligned components. Some alignments will be to develop and acquire key capabilities or service components such as health plans, post-acute providers, population health management capabilities, and others. Many states are becoming dominated by a few large healthcare systems. Since we expect this trend to continue, it is essential that your organization's future vision and strategy are clear regarding current and future partnerships.

In the boardroom:

- Are you part of a system now or do you expect to be part of one in the future? If you are an independent organization, the board should be willing to openly address the questions: Can we remain independent? Should we remain independent? What are our goals and needs? Will we be better off with a system than as an independent?
- If you are a health system with multiple entities, do you have a clear vision for what the system will look like in the future? What is your target size? Have you optimized efficiencies and resources across all facilities?
- Does the board have an "ideal partner" checklist of characteristics? Are you clear on what strengths and resources your organization brings to a potential partner?

6. Transparency and Accountability: "Price, Outcomes, Satisfaction"

This is the year that transparency begins to have teeth. Data collection and use is proliferating. Technology is facilitating instant access to data on pricing, outcomes, utilization, satisfaction, and access. Does this excite or frighten you? Hospitals, health systems, and payers must learn to turn data into useful information for clinicians and patients to facilitate better decisions and more effective care delivery. One nationally recognized medical group currently participating in ACOs and coordinated care risk contracting has set a high-priority goal regarding access to data: "Any Data, Any Time, Any Person (authorized user), Any Device or System, Anywhere in the World"—with sub-second response times, in the appropriate clinical context. This goal for transparency and data access translates into a powerful tool that is designed to create a patient–provider partnership in care decisions and delivery.

In the boardroom:

- How "transparent" is your organization? Are performance measures posted and compared against benchmarks?
- Is there a plan and process in place to enhance accountability for performance across all aspects of the Triple Aim (cost, quality, and patient experience)?
- Is executive leadership compensation driven in part by performance in these critical areas?

7. Information Technology: "Big Data, Big Opportunities"

Most hospitals, health systems, and medical groups have already made significant investments in information systems and technology. In 2014, the focus must be on data warehouse and health information exchanges as the backbone required to support clinical integration and population health management efforts. It is not only about the data; it is about what you can do with it. One healthcare provider has labeled its enterprise data warehouse the "single source of data truth," and treats it that way. The key is to have the capability to integrate clinical, financial, and administrative data from all sources, including electronic medical record systems, clinics, contract providers, diagnostic centers, pharmacies, health plans, and other third-party data sources. The system must be used to aggregate, harmonize, and normalize the data to inform physicians, patients, caregivers, senior management, and analysis teams through scorecards, dashboards, decision support reports, and *ad hoc* analytics. From a practical standpoint, the system should provide point-of-care reminders for physicians regarding their patients, which will reduce variability in care, improve consistency of care, and encourage use of best practices. The provider can then work with patients to engage them in their own care and make following a best practice care plan simpler. Competitive advantage will come from "big data" if it can be used by clinicians to improve care for patients at the bedside and identify health status indicators in the population to assist design of interventions to improve outcomes.

In the boardroom:

- Does the organization have a clear vision and plan for data management and use?
- Is your IT system accessible to all relevant user groups through specific portals for patients, physicians, other providers, employers, and payers?
- Is your IT system providing meaningful data and trending reports that support ACOs, bundled payment, shared savings models, and population health analytics?

8. Revenues and Expenses: "Doing Less with Less"

Fitch Ratings and Moody's both recently predicted revenue growth for providers will decline through 2014. The decline in revenue growth is attributed to lower Medicare payments, declining inpatient volumes, increasing high-deductible health plans, SGR unresolved, and uncertainty around insurance exchange enrollment coupled with low payments and implementation. In light of these factors, 2014 will see increased focus on improving efficiency, utilizing tools like Lean, Six Sigma, and other process improvement methods. Much of the low-hanging fruit of cost cutting has been picked. More focus and creative effort will be required to take expense reductions to the next required level. Quality improvement and clinical integration initiatives with physicians will be an essential part of these efforts.

In the boardroom:

- Does your organization breakeven on Medicare reimbursement? If not, is there a plan and timeline for achieving that target?
- Continue to monitor key financial and operating metrics, including shifts in payer mix, per unit revenue and expense trends, staffing, bad debt levels, and financial performance of employed physicians.
- Ensure that you have a robust revenue management process; monitor bad debt due to the insurance exchange.
- Do you have an initiative in place to measure and reduce the total cost of care per episode? Have you engaged physicians in this effort via co-management or bundled payment initiatives?

9. Labor/Workforce Issues: "Culture and Change Management"

Financial pressures and volume declines in 2014 will translate into right-sizing staffing, especially in non-clinical areas. When mergers and affiliations occur, staffing adjustments are inevitable in order to reduce duplication and realize economies of scale. We anticipate more unionization efforts, labor strife, and workforce actions as financial pressures and uncertainty increase. At the same time, hospitals must seek to improve employee engagement and satisfaction, and maintain high levels of morale and commitment to excellence. Is the cliché, "culture eats strategy for lunch" true? If

so, it will be essential to have a clear vision and articulated approach to culture enhancement, to reinforce the ideal and monitor how it is applied every day to decisions and behaviors at all levels of the organization. Effective culture management requires constant and consistent messaging to all stakeholders, especially in times of significant organizational transition and change.

In the boardroom:

- Continue to monitor right-sizing efforts to maintain adequate staffing levels to ensure high-quality care and positive financial outcomes.
- Do you regularly survey associates to monitor levels of engagement and satisfaction?
- Do you invest as much time in "culture planning" as for "strategic planning?"

10. Portfolio Assessment: "Shrink to Grow"

Some hospitals and health systems have businesses and services that are underperforming. Why? Was it a bad business? Did the marketplace change? Does it not fit with the core business and therefore lacked synergy? Was there poor management? 2014 is the right time to perform an objective and disciplined analysis of underperforming assets and services based on strong quantitative analysis. High-priority areas to examine include imaging centers, skilled nursing facilities, health plans, outreach labs, freestanding ED, medical office buildings, business services centers, and other areas that do not provide a positive contribution margin to the organization. If these businesses and services are not core to the mission and operations of the organization, look at alternatives (including divestiture or repurposing of facilities) and compare options with the opportunity to reinvest proceeds in other essential core areas, which might include IT, ACO, outreach or ambulatory facilities, physician recruitment, and other priorities. Sometimes it is necessary to shrink in order to grow.

In the boardroom:

- Consider an assessment of each underperforming business or service to bring focus to the root causes and identify key drivers to improve performance. Can this situation be turned around? What are the best alternative actions?
- If it is decided to dispose of the asset, conduct a valuation of the business.
- Spend the time to collect information and analyze why metrics are not being met. Both quantitative and qualitative information must be assembled to provide an objective assessment of the situation. Assess the industry as well as the marketplace.
- Be willing to make prudent business decisions about your portfolio.

Conclusion

Times of change create times of opportunity. As a board member, physician leader, or senior management member, vision, creativity, and prudent risk-taking are the underpinnings of great strategy. Embrace the opportunity and responsibility for leadership amidst change so that your organization will thrive in the evolving environment. This will be a very exciting new year!

The Governance Institute thanks Steven T. Valentine, M.P.A., president, and Guy M. Masters, M.P.A., senior vice president, of The Camden Group, a national healthcare consulting firm, for contributing this article. Both are strategic and business advisors to hospitals, health systems, medical groups, ACOs, and integrated delivery systems nationwide. They are frequent speakers at industry conferences, board retreats, and other strategy advisory meetings. They can be reached at (310) 320-3990, or at SValentine@TheCamdenGroup.com and GMasters@TheCamdenGroup.com.

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The Board's Quality of Care Responsibilities: Six Dimensions of Oversight

By Michael W. Peregrine and Sandra M. DiVarco, McDermott Will & Emery, LLP, and Anne M. Murphy, Rush University Medical Center

This is the seventh article in a series examining the role of the board following the wave of industry consolidation.

The evolving healthcare environment is having a significant impact on how health system board members address quality of care concerns. The board's quality oversight role is being impacted by larger organizational structures; complex and diverse contractual arrangements with physicians; multiple delivery of care models; acute risk management concerns; reputational, rating, and patient satisfaction matters; and the intense focus of government and private payers. Additional pressures are arising from the organized medical staff and executive leadership, each of which have their own perspectives on the proper role of the board with respect to quality of care. These factors combine to compel the board to reconfirm for internal constituencies its "claim" to an oversight role.

Pursuit of this goal invites a collaborative process among the board, management, and medical staff leadership. For while there is substantial clarity on the need for greater emphasis on quality of care, there is much less clarity on the board's role in the process by which the board, medical staff, and management should work together on quality matters. There is an increasing body of recognized peer practices, but there is no coalescence around specific "best practices." Thus, the board must take the initiative in determining what it is required to do with respect to quality of care oversight, why it's expected to exercise that oversight, and the process it should use to get where it needs to be.

The board can effectively achieve its quality of care oversight responsibilities through an integrated, coordinated risk management process that focuses on the six specific dimensions in which quality of care issues implicate board responsibilities. These dimensions include licensure and accreditation, payer reimbursement, Affordable Care Act (ACA) themes, regulatory compliance and enforcement, organizational reputation, and financial risk. The expectation is that such an integrated approach will work to confirm the appropriate role of the board for not only individual board members themselves, but also for members of executive leadership and the medical staff. It's so very important that all of these constituencies understand why and how the board must be involved in quality oversight.

Background: Core Fiduciary Responsibility

It is useful to remember that the board's quality of care obligation is grounded in the oversight function of the basic fiduciary duty of care (i.e., the obligation to exercise oversight of hospital and health system operations and to ensure an effective compliance/risk management program). This duty is "additive" to the traditional duty of hospital board members to monitor the granting, restricting, and revoking of medical staff privileges. The quality oversight duty also arises from the fundamental duty of board members to support the mission of the organization, which typically speaks in terms of the promotion of quality healthcare services. As health systems grow in size through consolidation and the expansion of integrated relationships with physicians, the "filter" through which these duties are evaluated by regulatory officials, insurers, plaintiff's counsel, and other interested parties becomes sharper.

This fundamental duty is the platform from which the six practical dimensions of quality of care oversight are best evaluated.

The First Dimension

The board's quality of care duties are affected by its traditional oversight of the health system's **licensure and accreditation** arrangements. For example, Joint Commission governance standards specifically reference the governing board's responsibility for the safety and quality of care, treatment, and services of the institution. The particular governance standards contain several references to quality of care throughout Joint Commission guidelines, with a strong emphasis on the obligations of board leadership to establish a culture of safety and quality.

It is not unusual for hospitals to experience surveys that link findings in clinical and non-clinical areas to failures in governing body oversight, even where the issues are not clearly governance-related. Plans of correction for such findings often involve correcting the actual finding and demonstrating the existence of a corrective plan that would be overseen by the governing body.

And there's a lot riding on this. Joint Commission standards compliance and accreditation results in "deemed" status as a facility compliance with CMS Conditions of Participation (see discussion below). Further, CMS and most state departments of public health (or similar licensing agency) survey and certification activities incorporate specific, targeted, and nuanced features that incorporate or reflect governance obligations. Hospitals with particular programs or service lines may also be subject to additional accreditation or certification (e.g., research, stroke clinics) requirements. Other entities (e.g., MCOs, health plans) may be accredited or certified by organizations like the National Committee for Quality Assurance (NCQA).

The Second Dimension

The board's quality of care duties are also affected by its traditional oversight of the health system's participation in governmental and private insurance **payment programs**. For example, key CMS Conditions of Participation assign to the hospital governing board the responsibility for the quality of care provided to patients, including but not limited to medical staff appointment. CMS has also historically been involved with quality of care disclosure protocols, beginning with voluntary disclosure and moving towards ACA-based mandatory disclosure. Along the same lines, NCQA standards affect health plans, and commercial payers may also have specific quality-based standards.

The Third Dimension

The board's quality of care duties are also affected by its obligation to monitor the organization's compliance with the **Affordable Care Act** and to work with management to implement ACA-based responses. As many board members recognize, the ACA contains a series of important quality of care-based themes, including greater transparency of quality matters, an emphasis on alignment of financial incentives with quality outcomes, a new focus on concepts relating to improved care management and population health management, and increased financial support for the development of new quality measures and further research on outcomes effectiveness.

A good example of how the ACA implicates quality of care matters is the new approach to hospital readmissions. Under the ACA, patients with certain conditions who are readmitted for additional care within 30 days of discharge cause a penalty to the discharging hospital of up to 1 percent of all Medicare payments, where the rates of readmission are determined to be excessive. The list of readmission conditions is substantial (e.g., acute MI, heart failure, pneumonia, chronic obstructive pulmonary disease, and total hip/knee replacements) and is likely to expand further.

In this regard, it is worth the board noting that over 10 separate sections of the ACA address quality of care issues in one way or another. It is also worth noting that these ACA provisions evolved from prior federal efforts to regulate quality of care; e.g., the early pay-for-performance initiative/demonstration programs, the early (2007) development of financial penalties for failure to report quality-related data ("Hospital Consumer Assessment of Healthcare Providers and Systems"), CMS efforts to restrict payments for hospital acquired conditions, and CMS' "Hospital Compare" Web site, launched in 2005 to increase the transparency and public availability of hospital quality data.

The Fourth Dimension

The board's quality of care duties are also affected by its obligations to provide **oversight of the organization's corporate compliance programs** and system of legal controls. Regulatory concerns with quality of care issues arose long before the enactment of the ACA, and have historically focused on the legal implications of reimbursement for substandard (or no) care provided to beneficiaries of federal healthcare programs. Quality of care-based enforcement actions reflect a coordinated effort of state and federal regulatory agencies under false claims and fraud and abuse-based laws. Sanctions for violations of these laws may range from civil money penalties to exclusion from participation in federal healthcare programs, and (in the extreme) to criminal penalties.

These enforcement initiatives are based on theories of civil and criminal fraud law and rely on the submission of a claim for reimbursement by the government for either a) medically unnecessary services, in which the patient is unnecessarily exposed to the risks of the medical procedure and the government incurs unnecessary costs, or b) the failure of care, the provision of care that is so deficient that it amounts to virtually no care at all. These initiatives have been manifested in a variety of ways; e.g., civil and criminal enforcement actions and judicial proceedings, dedicated provisions of corporate integrity agreements, permissive exclusion authority over hospital officers, strict liability provisions (e.g., the "responsible corporate officer doctrine"), media reports on excess utilization, and compliance

guidance materials jointly published by the Office of Inspector General, Department of Health and Human Services, and the American Health Lawyers Association.

The Fifth Dimension

The board's quality of care duties are also affected by its obligation to protect the **reputation of the organization** (as an important asset). Directly, this relates to the overall reputation of the health system in the marketplace, as perceived by the media and by consumers. In that regard, an obvious manifestation of this dimension is the board's responsibility to work with the general counsel and medical staff leadership in monitoring the organization's medical malpractice risk profile, and responding to trends, indicators, and warning signs arising from identified risk. Other important manifestations of this particular dimension include the institution's profile in public reporting vehicles such as the CMS/Medicare Hospital Compare Web site, CMS survey results (findings, not responses) available online, and state online resources (e.g., the Illinois Hospital Report Card and Consumer Guide to Health Care Web site).

The Sixth Dimension

The board's quality of care duties are also affected by its obligation to serve as attentive **stewards of the organizational fisc** (i.e., to monitor its financial affairs and to take necessary and prudent steps to minimize financial risk). The intersection of financial affairs and financial risk, on the one hand, and quality of care, on the other hand, is located at the confluence of government/payer reimbursement, medical malpractice exposure, False Claims Act exposure, and the impact of quality of care matters on the organization's credit rating. Indeed, the prominent non-profit healthcare rating agency Moody's Investors Service has noted that it takes board oversight of quality-related matters into consideration in the credit rating evaluation process. These are all vitally important oversight topics in their own right, and each has the potential to be affected by the organization's quality of care issues. The ability to evaluate quality matters as consistent with overall duties of financial stewardship is a vital component of the necessary level of oversight.

These six "dimensions" help answer the basic question, "Why should the board be involved?" Not only do they serve to reinforce the understanding of board members as to how quality of care impacts the organization as a whole, they also help demonstrate to other internal constituencies (e.g., the executive leadership team and medical staff leadership) that the board has legitimate and very understandable reasons that prompt its focus on quality of care. That demonstration may help the board, management, and medical staff work in a more cohesive manner on quality issues, where each constituency understands and respects their respective portfolios on the subject. With such a consensus in place, the board can work with the medical staff and executive leadership on the other basic components of effective quality oversight.

These basic components represent the building blocks of an effective board-level quality of care oversight protocol. Once established, they help to facilitate the board's ability to exercise its responsibilities for quality of care in an efficient and organized manner.

Other Basic Components

The first such component is the appointment of a board committee, with delegated powers, to exercise primary quality of care oversight on behalf of the full board, with a clear periodic reporting obligation to the board. If it is more convenient to incorporate this responsibility within the duties of an existing committee, that can certainly be accommodated by charter amendment—with the caveat that the committee has sufficient time to dedicate to quality oversight. A related matter is to populate the committee membership with individuals who by background or experience may be well suited for quality of care oversight responsibilities. This does not mean that the committee members must have medical experience or background. It does mean that the members should have a level of experience and perspective that positions them to exercise effective oversight, assuming proper staff support.

The second such component is to establish a quality of care information reporting system that provides the board and its quality committee with relevant information in a timely manner and in the proper context to allow effective oversight. The identification of such a reporting system is usually the byproduct of collaborative discussions between the board, committee leadership, the medical staff, and executive leadership. The most important focus of the reporting system is to provide information that will be useful to board and committee members given their base of experience and understanding. The reporting system would be supported by regular assistance of dedicated staff to the committee (e.g., the chief medical officer and other medical staff representatives, the chief risk officer, and a representative of the general

counsel's office. Such staff can be counted on to provide the expert support and guidance the board/committee needs in order to properly evaluate the material they receive. This would include, of course, appropriate "dashboard" materials and other documents intended to brief board/committee members on trends and developments. It would also include an understanding that staff will report to the board or committee all incidents and developments that have the potential for material significance.

The third process component is to foster the development of an organizational culture that places high value on quality and quality improvement. Obviously, delegating quality oversight to a dedicated board committee, as discussed above, is a major component of such a culture. A related measure would be to include within the board as a whole individuals who embrace quality improvement goals and objectives. An additional measure would be to establish some level of expectation, based on available data, of the time commitment that the board and quality committee members should reasonably be expected to devote to quality oversight matters. Also recommended is a board/committee-led effort to ensure the coordination of all areas of management and medical staff that touch on the six dimensions identified above in a comprehensive approach to quality of care issues. It is the board's responsibility to ensure that there is no "silo effect" when it comes to coordinating quality and safety efforts within the organization.

Conclusion

There is growing consensus on the priority that governance must place on quality of care oversight. This priority is enhanced by the organizational growth, expansion, and diversity that is a fundamental byproduct of both the recent provider consolidation activity and the evolving healthcare environment. However, there is no established "best practice" for the governing board to pursue in terms of ensuring the proper fiduciary response to quality of care oversight. A recommended approach is one that is grounded on a) clarifying for all constituents the board's quality of care "portfolio"—the six dimensions of operations that combine to require governance-level oversight—and b) a collaborative effort of the board, the medical staff, and executive leadership to establish basic structural, reporting, and information delivery systems intended to better position the board to exercise its quality of care oversight duties.

The Governance Institute thanks Michael W. Peregrine, Esq., partner, and Sandra M. DiVarco, partner, McDermott Will & Emery, LLP, and Anne M. Murphy, senior vice president, legal affairs and general counsel, Rush University Medical Center, for contributing this article. They can be reached at mperegrine@mwe.com, sdivarco@mwe.com, and Anne_Murphy@rush.edu.

New Publications and Resources

Transitioning to Effective System Governance
(Elements of Governance®, December 2013)

Governance Notes (Governance Support, December 2013)

Part Two: Genesys Health System Tackles Pioneer ACO Challenge
(Case Study, December 2013)

Part One: Genesys Board Transitions to a New Level to Prepare for Healthcare Change
(Case Study, December 2013)

BoardRoom Press, Volume 24, No. 6 (*BoardRoom Press*, December 2013)

To see more Governance Institute resources and publications, visit our Web site.

The Governance Institute Conferences

Join Us for Our Upcoming Leadership Conferences

Our February Leadership Conference is **February 9–12**, at **The Breakers** in **Palm Beach, Florida.** Leading healthcare experts will present current trends in healthcare and give their predictions for the future. This conference will offer healthcare leaders the opportunity to gain new perspective on the current healthcare landscape and walk away with fresh insight on ways to better prepare for the governance challenges and industry changes ahead.

Presenters at this conference include:

- **Nathan S. Kaufman:** Redefining the Role of the General Contractor in Healthcare
- **Michael W. Peregrine, Esq.:** Leading Governance Pitfalls: What the Law Sees
- **Kenneth Kaufman:** Healthcare Inflection 2.0
- **Ryan Donohue:** The Outsiders: Creating & Demonstrating Value to the Healthcare Customer

Our March Leadership Conference is **March 9–12**, at **JW Marriott Tucson Starr Pass Resort & Spa** in **Tucson, Arizona**. Healthcare leaders from around the world will gather to hear about industry trends and gain knowledge they can use to better govern their organizations. Healthcare experts will present information on various topics including population health, avoiding costly mistakes, providing customer-centric care, and dealing with serious illness and end-of-life care.

Presenters at this conference include:

- **David B. Nash, M.D., M.B.A., FACP:** Population Health: The Key to Quality
- **Marian C. Jennings, M.B.A.:** "Everybody's Doing It" Is Not Enough: Strategy for the Long Haul
- **Marc Halley, M.B.A.:** Avoiding Costly Mistakes
- **Guy Masters:** Leading Changes in Clinical Integration

Special Governance Quality & Safety Training Program

Before the March Leadership Conference, we will be holding a **Governance Quality & Safety Training Program** in partnership with the Jefferson School of Population Health at Thomas Jefferson University. The interactive program will focus on both the strategic and tactical issues involved in creating a cutting-edge quality and safety governance program. Training will include practical examples of the board's role and the role of the quality committee in quality and patient safety efforts, and incorporate the perspectives of all affected stakeholders in the healthcare system.

Click here to view the complete programs and register for these and other 2014 conferences.

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