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

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Transforming the Healthcare Experience: The Five Imperatives for Sustainable Change

By M. Bridget Duffy, M.D., Vocera Communications and ExperiaHealth

In an era that challenges healthcare organizations to do more with fewer resources, patient experience is often considered an add-on. However, hospitals and health systems can no longer solely focus on stripping out waste and reducing costs as a growing body of evidence points to human experience as a key driver for improved patient satisfaction, quality, safety, and outcomes. Now that patients have more information about providers and more freedom to choose, it is more important than ever to ensure consistent and seamless healthcare journeys—from the first impression to the last. The five imperatives of this infrastructure include:

1. Align experience with quality and safety strategies.
2. Build a relationship-based culture.
3. Infuse the voice of patients and families into decision making.
4. Map the gaps in efficiency plus empathy.
5. Put science behind the human experience of care.

1. Align Experience with Quality and Safety Strategies

Faced with the need to improve care quality and reduce costs, many health systems have implemented efficiency methodologies such as Lean and Six Sigma. When used effectively, these practices improve patient flow and address quality checklists and safety risks. However, they fail to address some of the greatest barriers to patient care including fragmented communication, broken relationships, unaddressed emotional needs and concerns, and physical barriers to receiving care. These gaps in the human experience are key drivers of sentinel events,[1] low patient engagement, and poor clinical quality. Studies show patients choose healthcare resources based on personal experience, relationships, and recommendations. Positive patient experience also correlates to quality, safety, and outcomes. Therefore, rather than treating experience improvement as a parallel initiative, progressive organizations align these efforts to reduce initiative fatigue, restore joy to the practice of medicine, and return care teams to purpose. To unify strategies, successful organizations create a single project management hub that builds alignment across experience, process improvement, human resources, and quality and safety initiatives. The establishment of a chief experience officer or similar position allows the organization to exploit synergies and find efficiencies in process improvement, data collection, and methodologies. This centralized structure will help break down silos and enable the creation of unit-level champions, departmental transparency, and proactive development of experience solutions.

2. Build a Relationship-Based Culture

To create an ideal healthcare experience, a focus on building connection and collaboration must be integrated into all aspects of operation—from executive leadership to the frontline. Successful organizations foster a relationship-centered culture in which patients, families, nurses, physicians, and support staff are viewed as valued members of the care team. Organizational culture and communication influence working relationships, staff satisfaction, and quality of care, which have a profound impact on patient safety and trust in a

[1] Ashish K. Jha et al., "Patients' Perception of Hospital Care in the United States," *The New England Journal of Medicine*, October 30, 2008.

healthcare system. While technology cannot replace human-to-human interactions, it can help restore humanity to healthcare by removing barriers, extending relationships, empowering patients, and creating a sense of connection. Mobile solutions are available to untether care team members from nurses' stations and ensure clinical alerts and alarms are going to the right person at the right time no matter where they are located. Technology can help restore dignity and respect to healthcare. For example, no human being should be incontinent in his or her bed because no one is responsive to the call button at the nurses' station. In turn, nurses should not need to leave the patient's bedside during care delivery to search for supplies or other team members. Care teams work in a mission-critical environment that requires technologies to connect them to each other, information, and patients instantly. Proven solutions include wearable communication devices, integrated call lights, secure texting, real-time care rounding, and alarm management systems.

3. Infuse the Voice of Patients and Families into Decision Making

To strengthen a relationship-based culture and develop processes that support the human experience of care, leaders must keep their finger on the pulse of what patients, families, and employees need. Listening to these voices requires more than simply deploying satisfaction surveys, which only scratch the surface and are often conducted too many days after a patient leaves the care of the hospital or clinic. An optimal healthcare experience for patients and families can start with a "Sacred Moment," whereby a clinician asks a patient about his or her fears, concerns, spiritual needs, and/or expectations—instead of jumping directly to administrative paperwork such as whether the patient has insurance or a living will. Twin Rivers Regional Medical Center in Kennett, Missouri, undertook a design effort to improve patients' first impression in which doctors led the creation of "Sacred Moments on Admission"—a chance for clinical staff to connect with patients; address their immediate physical, emotional, and informational needs; and focus on the plan of care and patients' goals. Together with a "No Excuses Team," Sacred Moments led to a 117 percent increase in patient top-box hospital "Overall Rating" scores and significant improvements in financial performance and physician engagement.[2,3]

4. Map the Gaps in Efficiency Plus Empathy

Instead of focusing solely on cost reduction and efficiency, leading organizations concentrate on understanding the human experience of care and mapping the gaps in efficiency plus empathy. Experience mapping enables hospital leaders and frontline staff to identify barriers in care and provide valuable information about what matters most to patients, their communication preferences and their emotional, spiritual, and physical needs. Using this human-centered approach, multi-disciplinary teams can create the next standards of care, or Always Events®, which are practices or processes that should always occur when patients interact with the healthcare system.[4] After identifying gaps in patient understanding and compliance with hospital discharge instructions, Cullman Regional Medical Center hardwired mobile technology into the discharge process that allows nurses and doctors to record instructions at the patient bedside. After a hospital stay, patients, family members, and caregivers can access the personalized teaching at any time using any phone, computer, or mobile device. As a result of this extended communication, the hospital reported a 15 percent decrease in readmission rates, and a 63 percent increase in patient satisfaction for the discharge communication domains. In 2014, the Institute for Healthcare Improvement recognized the practice of recording discharge instructions as an Always Event.

5. Put the Science behind the Human Experience of Care

According to The Joint Commission, 80 percent of serious medical errors are linked to communication failures during transitions of care.[5] In addition, research from the University of Maryland revealed that communication inefficiencies result in $12 billion in excess costs or lost revenue annually.[6] Therefore, it is essential that organizations transform communication and care coordination to improve healthcare delivery. Successful

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[2] Kevin B. O'Reilly, "Redesigning the Patient Experience for Safer Care," *American Medical News*, June 24, 2013 (available at www.amednews.com/article/20130624/profession/130629967/4).

[3] M. Bridget Duffy, Kimberly Petty, and Liz Boehm, "Differentiating on Human Experience: How Healthcare Organizations Drive Lasting Loyalty and Growth," Experience Innovation Network, 2014.

[4] See www.ihi.org/Engage/Initiatives/PatientFamilyCenteredCare/Pages/AlwaysEvents.aspx.

[5] The Joint Commission Center for Transforming Healthcare, Hand-off Communications (available at www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=1).

[6] R. Agarwal, D.Z. Sands, J.D. Schneider, "Quantifying the Economic Impact of Communication Inefficiencies in U.S. Hospitals," *Journal of Healthcare Management*, Vol. 55, No. 4, July/August 2010.

organizations create a consistent, seamless experience of care from pre-admission to discharge, connecting with primary care physicians, skilled nursing facilities, and other healthcare providers. As healthcare organizations implement human-centered care models to reconnect patients and care teams, they will be required to measure their impact on patient safety, satisfaction, and clinical outcomes. Progressive organizations create transparency around data that drives action and further improvement throughout the organization. To accelerate this scientific agenda, research collaboratives in the U.S. and Canada are measuring and sharing proven best practices related to physician communication, patient and family engagement, care team coordination, care transitions, alarm management, staff resiliency, and many other key drivers that create and sustain an ideal healthcare experience. By studying the impact of human-centered practice models in relation to quality, safety, and outcomes, these organizations are positioned to set the next standards of care for the nation.

The Governance Institute thanks M. Bridget Duffy, M.D., Chief Medical Officer of Vocera Communications, Inc., for contributing this article. Vocera Communications is humanizing healthcare through improved communication and is widely recognized for developing smarter ways to connect care teams, patients, and families. Dr. Duffy is also the Cofounder of ExperiaHealth and the Experience Innovation Network, which helps organizations rapidly design and deploy innovations that restore the human connection in healthcare while improving clinical outcomes and patient, staff, and physician loyalty.

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New Frontiers in Hospital Joint Ventures

By Barry Sagraves, Juniper Advisory, and Ken Marlow, Waller

This article is the second in a series examining the uses of joint ventures, the process of developing a joint venture, and expected trends related to these transactions.

In our first article, we examined the history of joint ventures (JVs) and summarized some of the potential benefits to a non-profit hospital or health system considering a JV.[7]

In this article, we will speculate as to the directions this flexible yet complex organization structure may take in the future and solutions it may provide to the healthcare industry. We will also cite some recent examples of joint ventures and other affiliations and assess the circumstances under which success is more likely than not.

Seller and Buyer Joint Ventures

There are many examples of hospital joint ventures. These are often referred to as "seller JVs," where a hospital that otherwise would have been sold retains a minority stake in a new company. These JVs usually involve a non-profit as the minority partner and an investor-owned company as the majority and managing partner. The benefit to the "seller" is that it remains involved in the governance of the JV and has an ongoing financial stake and potential return, as well as receiving a cash payment for value of the assets contributed to the JV.

A more recent phenomenon is the "buyer joint venture," in which two parties team up to acquire a hospital. The most prominent of these has been Duke LifePoint (DLP), the joint venture between Duke Quality Network, a North Carolina non-profit corporation, and LifePoint Hospitals, a publicly traded hospital company. DLP has acquired through acquisitions or joint ventures a total of 11 hospitals since its inception in 2010.

These arrangements are becoming more mainstream, as is demonstrated by Watertown Regional Medical Center's recent decision to create a seller JV as the first for-profit conversion in the state of Wisconsin.

The Next Big Thing

More recently, a number of creative JVs have been announced that are structured to enable hospitals and health systems to manage populations, collaborate more effectively with managed care providers, and better respond to the compliance demands and reward structures placed upon health systems by the ACA. These structures, five of which

[7] Barry Sagraves and Ken Marlow, "The Rise of the Hospital Joint Venture," E-Briefings, The Governance Institute, Vol. 11, No. 5, September 2014.

are described below, could be precursors to fully integrated health systems, which many believe will be the dominant financing and delivery model of the future.

We've witnessed an increase in the number of multi-party JVs, which adds significantly (some might say exponentially) to the complexity of both negotiating and operating the resulting organization.

The transactions listed below range in their complexity from true joint ventures to more of the "vertical" joint ventures that involve payers and large employers:

- **Tenet, Ascension, and Dignity Health**: The three-way JV between Tenet, Ascension, and Dignity Health in the Tucson, Arizona, area is an example of parties with different strengths, expertise, and resources joining forces to become a more efficient and effective provider. Dignity Health will invest $30 million in cash and hold a minority interest in a proposed joint venture with Tenet Healthcare Corporation and Ascension Health. Tenet will hold a 60 percent ownership interest in the venture, which will operate Carondelet Health Network, a subsidiary of Ascension Health. Dignity Health and Ascension will each hold a 20 percent ownership interest. Carondelet Health Network includes three hospitals, two medical groups, and other assets. While creating a JV with three partners is usually significantly more complex than it is with two partners, the logic in this example is that all partners get to spread their risk while also having the opportunity to pursue additional new business opportunities. Such arrangements usually work best when the parties are reasonably comparable in size, sophistication, and financial strength, and when all benefit to a similar degree from the JV.
- **Stratus Health**: Possibly the largest recent multi-party arrangement is Stratus Health, a 14-system (which owns and operates 29 hospitals) JV in Georgia that formed in order to pool resources, coordinate information, and manage population health in the region. The new organization is a not-for-profit limited liability company and was conceived as a way for providers to collaborate while remaining independent. As with most such organizations, two of the Stratus members took the lead in its formation in 2012, and then brought the others along a year later. The leap to a change of ownership or full integration is too large for many organizations to make in one step, particularly those that are doing reasonably well financially. "Testing the waters" in this way while gaining some benefits of scale works for both the smaller hospitals and the larger ones leading the charge—that tend to prefer to get to an ownership stake sooner rather than later.
- **Vivity**: Anthem Blue Cross and seven health systems in Los Angeles and Orange County have created a joint venture to offer a narrow-network product in that region—Anthem Blue Cross Vivity (Vivity). The partners plan to share data and seek economies of scale to offer higher-quality, lower-cost products than their competitors. Profits and losses are to be shared equally among the partners. Vivity will initially target large employers in the Los Angeles market, and the "narrow network" Vivity plan is designed to align the financial risks and rewards of providers and payers through population health management in a manner that will (hopefully) be an appealing alternative to the high-deductible plans many large employers offer their employees. On its face, Vivity appears to be well positioned to facilitate Anthem's and its hospital affiliates' ability to provide an alternative to payers such as Kaiser and providers of healthcare services in the Los Angeles area. There are still many questions to consider as we evaluate partnerships like Vivity. For instance**,** will the hospital systems be both willing and able to share information and expertise with one another while implementing the population health management tools? How will the Federal Trade Commission and state agencies react to hospital systems potentially sharing competitive information outside the admittedly murky framework of clinically integrated organizations?
- **Puget Sound High-Value Network**: This network of eight hospitals (including those of CHI Franciscan Health and Virginia Mason), more than 160 clinics, and almost 3,000 specialty and primary care providers will contract directly with employers in an effort to offer higher-quality, lower-cost benefits to the self-insured market. Marketed specifically to self-insured employers with 50 employees or more, the network offers competitive rates by selecting network providers that are committed to services at reduced unit costs, while still maintaining a focus on quality through the development of ongoing clinical initiatives. Similar to Vivity in its goal of providing a narrow(ish) network model to the market, this is quite distinct in that the network is a direct-contracting model without a health plan. As such, it may be a more applicable model for providers in other markets that do not have a health plan market but do have the data and care-management skills to successfully take on capitation-like risk.
- **Advocate Health Care**: Based in Chicago, this system has developed an innovative model, not

dissimilar to its clinical integration program, for use in aligning with non-owned hospitals. The strategy is to use Advocate's know-how to improve quality, lower costs, and increase efficiency, and potentially allowing affiliated hospitals to be included in Advocate's managed care contracts. Blue Cross Blue Shield of Illinois has recently decided not to extend its contract with Advocate to hospitals that are part of this affiliation, so the contracting advantages of the structure may not be as strong as hoped. Nonetheless, the quality and cost benefits to the affiliate would remain in any case.

We expect to see an increasing number of these "vertical" joint ventures in coming years as trying to balance quality, access, and cost control becomes ever more central to hospitals' success. The "glue" provided by a corporate structure like the joint venture will be important as employers and government programs seek stable partners to minimize their healthcare costs over time.

When to Consider a Joint Venture

Whether a joint venture is the appropriate corporate structure for a given activity is a matter of the facts and circumstances in each particular situation (see **Table 1**). Form should follow function.

Table 1: A Joint Venture May Be the Most Appropriate Structure If…

Circumstance	How to Address
• Your organization lacks the skills or resources to undertake the activity on its own.	• Be sure your partner actually has the skills/resources, and has deployed them in a similar situation in the past.
• Speed to market considerations preclude you from "growing" the service or activity.	• Do a classic buy vs. build assessment; do not underestimate the complexity of either approach.
• The proposed venture is outside your organization's risk tolerance, and so you wish to spread the risks in exchange for sharing the potential rewards.	• Losing half as much as you otherwise would, with the same probability of doing so, is not much of an improvement; you should be convinced that the odds of failure are significantly lower with your partner than without.

Conclusion

JVs have progressed significantly over the past several years, to where they are a viable option to help organizations provide services or enter markets they would otherwise be unable to access. They have progressed from a way to align with physicians, to a means for building hospital systems, and now to a potentially revolutionary approach to population health.

In our final article of the series, we will outline the process through which hospital directors would seek a joint venture partner, the many steps to consider in structuring a joint venture, and the challenges that may arise in doing so.

The Governance Institute thanks Barry Sagraves, Managing Director at Juniper Advisory, and Ken Marlow, Partner at Waller, for contributing this article. They can be reached at bsagraves@juniperadvisory.com and ken.marlow@wallerlaw.com. Juniper Advisory is an independent investment banking firm dedicated to providing its hospital industry clients with M&A and other strategic financial advice. Waller is a law firm specializing in healthcare transactions and regulations.

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Terms of Engagement: Board/Executive Collaboration on Public Health Crises

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

This is the fifth article in a series examining governance tasks that may now require a heightened level of attentiveness.

The current Ebola epidemic challenges healthcare boards to articulate their most appropriate role with respect to the organization's response to a public health emergency. Such circumstances present extraordinary threats to the public, patients, the medical/nursing staff, and employees—and to the hospital or health system's finances and reputation. They present critical issues with respect to the organization's preparedness on multiple levels to respond to extraordinary clinical, operational, legal/regulatory/liability, and media pressures. All of this will be complicated by intense public attention from the media, the public, and federal and state elected officials and regulators. The board will be expected—and will want—to play a significant role in directing the organizational response.

Yet traditional expectations of governance conduct and competency don't fit neatly within the context of Ebola-type events. Public health crises transcend issues presented by significant, "bet the farm" transactional and regulatory matters that infrequently but methodically appear on the boardroom agenda. A public health crisis generates complex issues of clinical care, infectious disease, contagion protocol, and medical research, as opposed to more familiar matters of business, finance, and law. The expertise necessary to respond to the former scenario is less likely to be found in the boardroom than with the latter scenario. In the absence of a formal plan of guidance and engagement, board members may quickly grow frustrated by the inherent limitations on their ability to provide informed oversight. Thus, the board's ability to effectively engage will be dependent in large part on close collaboration with, and acute reliance on, senior executive staff and medical and nursing staff leadership, and a more acute awareness of the related role of government.

The guidance necessary to define governance's proper role in a public health crisis can be developed in large part through education, focused on what experience suggests are the most prominent elements of an effective hospital/health system response to a public health crisis. To be effective, that education will identify matters that are appropriately the focus of direct board oversight and direction, and those for which the board must be particularly reliant on the advice of clinical leadership—and perhaps government mandate.

Fundamental Crisis Response Guidelines

Focus on safety, consistency, and risk reduction. The diverse safety concerns raised by public health crises demand close coordination between all key management and staff levels (e.g., infectious disease, emergency medicine, physician leadership, nursing leadership, emergency management/incident command/security, physical plant, clinical engineering, supply chain, hospital administration, physician practice administration, communications, human resources, risk management, and legal). Leadership will recognize that there will be multiple internal constituencies with a strong interest in safety and risk reduction issues. A central working group structure with clear lines of reporting will be critical; in the academic setting, it will also be important to include university leadership as part of the working team, and to be attentive to issues of student safety.

Importance of policies, procedures, protocols, and processes. It will be essential for leadership to work with public health authorities and incorporate their guidance regarding clinical protocols, coordination of expectations for service delivery, lab testing capabilities, emergency powers such as isolation and quarantine, and the like. In that regard, leadership will want to consider CDC, CMS, state law, and any accrediting body guidance or requirements in development of or when revising policies and procedures. The management team will want to work proactively with medical staff leaders to develop a highly detailed protocol for care, recognizing that this may need to be adapted as additional information regarding the health crisis becomes known.

The leadership team also must recognize that government guidance may evolve as circumstances change, as has been the case, for example, with federal and state standards related to mandatory quarantine for certain travelers and healthcare workers. This potential for change underscores the need for the adaptability of institution plans, as well as internal and external communication that is timely, clear, objective, and reassuring.

Intensive training, retraining, and auditing. Leadership will also want to develop immediate clinical training sessions for healthcare workers. This would commence with the core workers inevitably to be involved, and move outward from that point. It will be important to internally publicize the training protocol to provide workers with a sense of organizational direction, and to allay concerns. Frequent audits and retraining will help to keep staff on point. Also important will be immediate leadership intervention when any lapse in policy, procedure, or process is identified, and to share lessons learned.

Leadership/employee/staff matters. An effective crisis response plan will incorporate leadership levels of interaction, coordination, communication, and concern with employees and medical/nursing staff on multiple levels. It is very important for senior executive and medical staff leadership to assume a coordinating role early in any crisis response effort, and to communicate with employees and staff early and proactively. It is essential that the hospital's response focus on the best available clinical and epidemiological information. While administration and executive leadership must exercise judgment on critical issues, their judgment should be informed by the subject matter experts.

Effective leadership will deal with concerns of staff. In that regard, preparations should be made with respect to possible worker refusal to engage, likely worker anxiety regarding the infectious disease itself, or conditions imposed for engagement (e.g., use of post-exposure quarantines).

Determine what the facility can and cannot handle. Practicality commends a SWOT analysis (evaluating strengths, weaknesses, opportunities, and threats) of both physical and human resources. This could be supplemented by a process of confirming and documenting facility capabilities to help guide patient care and potential transport if a suspected case is identified in the facility or another facility nearby. In the context of the Ebola crisis, relevant questions might include the mechanics of transferring potential or confirmed Ebola patients to a CDC-designated treating hospital nearby.

It is also important to understand that in the unique context of a public health crisis, more than the ordinary degree of inter-facility cooperation and collaboration may occur. This may take the form of intensive information sharing around best practices, supply and equipment availability, staffing availability, and government guidance; collective training; the transfer arrangements discussed above; and inter-institutional treatment teams. The emergency nature of a public health crisis gives broader than usual latitude in this collaboration. It is important, however, that leadership remember that legal, compliance, liability, and cost issues will dictate in favor of involvement by legal counsel, finance, and medical staff leadership in connection with these collaborative initiatives.

Communication is key. Extra effort should be made by leadership to have a health crisis-specific communication plan. This would include clarity on identifying an organizational spokesperson and what is to be shared with the media. It will be imperative to communicate (to *all* constituencies) the realities of the disease, the current state of the institution's readiness, and how the institution intends to proceed. To the extent possible, the communication plan should be coordinated with public health agencies and other healthcare providers.

Remember that existing laws and regulations apply. Leadership must recognize that there is a direct legal component to an effective organizational response to a public health crisis. Most relevant may be compliance with the Emergency Medical Treatment and Labor Act (EMTALA). This federal law requires that participating hospitals and health systems provide a medical screening examination to determine the presence or absence of an emergency medical condition to all individuals who present for care. This obligation is not abrogated by the suspicion of or known diagnosis of Ebola or any other medical condition, and the risk of misdiagnosis of a disease that in many ways mimics others is a prevailing risk. Matters of Informed consent are implicated where patients are recommended to receive experimental medications not yet approved for use by the FDA, or plasma or blood transfusions from individuals who have recovered from Ebola.

Also relevant are state and federal laws regarding confidentiality and privacy, including HIPAA, which remain in full force for covered entities in the context of a public health crisis. Any response preparation process should incorporate refresher education on the need to maintain patient confidentiality—even where the matter is of national or even international interest.

Public health law related to infection control, including monitoring, isolation, and quarantine, may also come into play in a public health crisis. This area of law is relatively unfamiliar to many and, as seen with Ebola, application of the law may shift as circumstances change.

Implications for Governance

The law has no clear template for what may constitute effective oversight in a public health crisis; an effective board response will depend upon

the critical circumstances. While the board may include medical competencies, and members with experience in crisis management, its oversight and related decisions will incorporate an unusually high degree of reliance on experienced clinical and executive leadership. The board should be proactive in obtaining general advice and direction in advance of any public health crisis.

Given that perspective, the board should be advised by the CEO as to the plans, issues, and challenges associated with the particular crisis. The board should be interested in the level of preparedness, the extent of internal cooperation, and the potential reputational, legal, and financial exposure to the institution attendant to the particular crisis and the risks of inadequate preparedness. However, the board also should understand that hospitals will be required to respond as circumstances warrant, and therefore there is an inherent uncertainty and risk to the circumstances that cannot be entirely avoided. The audit committee and other key board committees should guide executive leadership to consider strategies that would involve risk management, insurance coverage, and contractual protections. Whichever committee has responsibility for legal and compliance matters should help ensure that the legal implications associated with crisis response are being adequately addressed.

A pre-prepared "dashboard" of sorts, identifying basic principles of public health crisis response, may also help the board exercise its oversight duties. The dashboard could identify the types of fundamental measures that executive and clinical leadership recognize as critical to the organizational response—thus providing the board with some framework from which it could evaluate the actual organizational response.

In the context of the typical continuum of oversight conduct, proper board response to a public health crisis falls closer to the "follow leadership's direction" than it does to "hands on presence in the C-suite." The ability of the board to exercise close oversight in a public health crisis will be limited by its unfamiliarity with the clinical complexities. That will not prevent the board from developing a preparedness plan, becoming informed through reasonable reliance on the experts, and becoming more directly involved when the circumstances warrant. The successful organizational response to a public health crisis will be dependent upon judicious oversight by a properly informed board.

The Governance Institute thanks Michael W. Peregrine, Esq., Partner, and Sandra M. DiVarco, Esq., 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.

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