Hospital Boards and Post-Acute Care Partnerships: Ensuring Robust Relationships

By Mark Dubow, Veralon

Whether an acute care organization is located in a market just starting the transition to fee-for-value (FFV) or in one that is well along in that transition, partnering relationships with post-acute care (PAC) entities—skilled nursing facilities (SNFs), home health agencies, long-term acute care hospitals, and acute rehabilitation providers—are vital. These relationships support the FFV emphasis on maximizing quality, reducing costs, and minimizing readmission penalties. Careful selection of PAC participant(s) and creation of a partnership structure is critical, and yet those steps are relatively easy compared with ensuring that the partnership is robust and will support the short-term success and long-term viability of both the acute care and PAC entities. The board of an acute care organization plays an important role in contributing to that success.

In a robust partnership, benefits accrue to both the acute care and PAC provider on three dimensions: strategic (differentiation and competitive position), financial (economic performance), and operational (efficiency and effectiveness of care coordination and management). This article highlights key operational elements that contribute to making a partnership robust. We focus on partnerships with SNFs, since a high proportion of acute care patients have historically been discharged to SNF care (22 percent of all patients and 42 percent of Medicare FFV patients in 20131), and SNF care has had the highest impact on the escalation of PAC spending.

Many of the principles addressed here will also apply to other portions of the PAC continuum.

Hospital and health system boards must understand the key operational components of robust partnerships and hold management accountable for their effective implementation. Particular attention should be paid to:
1. The formation of a preferred provider network of SNFs
2. The factors that contribute significantly to enhancing clinical quality and care coordination

Preferred Provider Networks

The emerging trend is for acute care providers to establish a PAC strategy and form a narrow preferred provider network, rather than building or acquiring organizations on the PAC continuum. The SNF portion of those networks typically includes one or more facilities, each of which meets criteria such as:
1. Location near patients served by the acute care facility
2. Available capacity
3. Willingness to adopt the acute care organization’s care protocols and approach to care management
4. Strong performance on benchmarking metrics:
   a) Quality
   b) Risk-adjusted cost per patient
   c) Risk-adjusted length of stay
   d) Patient satisfaction

Ideally, when acute care organizations discharge patients who need SNF care, they should use

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preferred SNF network members meeting those criteria. After all, the hospital or health system has thoroughly vetted these post-acute care providers, selecting those that achieved the best outcomes, are easy for patients to access, and are providing ongoing education of PAC clinicians in medical management in SNFs. Discharging patients to these SNFs will optimize care management and achieve the best clinical outcomes while lowering the cost of care.

Discharge planners, case managers, and medical staff members typically struggle with the concept of “directing” patients to specific facilities, stating that they are legally bound to offer patients and their families a comprehensive list of all providers and let them make the final selection. After studying this issue, a number of hospitals and health systems in the Midwest and western U.S. have determined that they can legitimately use “soft steering” to help patients and their families to make an informed choice, using a four-step process:

1. Share a list of all SNF providers in the market with patients and their families, placing those that are members of the preferred provider network at the top.
2. Describe SNF characteristics that contribute to better care and higher patient/family satisfaction (e.g., a track record of high quality, well-coordinated transitions, proactive medication management, ongoing clinical training, etc.).
3. Indicate that the SNFs at the top of the list have been vetted by the acute care organization and are known to have those characteristics. Share data on outcomes, readmission rates, and satisfaction scores demonstrating that those at the top of the list perform well in comparison to others on the list.
4. Conclude by saying, “It’s your choice.”

Given the information, patients/families tend to choose those providers that are in the preferred network.

Soft steering is accepted by the Medicare Payment Advisory Committee (MedPAC) and by legal counsel for many providers once they are educated on the topic.

Preferred Provider Relationships: The Board’s Role

Since soft steering of patients to preferred SNFs is beneficial, boards should be conversant with this topic and ask management to study it if the organization has not yet adopted this approach. If management experiences “push back,” the board, after obtaining support from legal counsel, should actively stand by management in endorsing the approach. Both steps will contribute to making the partnership between the acute care facility and SNF more robust.

Enhancing Clinical Quality and Care Coordination through the Partnership

SNF management tends to perceive that a relationship with a hospital or health system is made robust when the two parties take a collaborative approach to patient care delivery. They want to see the acute care provider enhancing care delivery at the SNF by contributing value in one or more of the following ways:

1. Providing the SNF clinical team with access to specialty physicians, nurses, and other clinicians for care of patients at the SNF, with particular emphasis on clinical support related to infectious diseases, wound care, pressure sores, respiratory therapy, pulmonology, and infection control. SNFs favor a multi-pronged approach to clinical support that includes:
   a) Consultative arrangements for training SNF clinical staff in the care of patients with these conditions
   b) Skype/video consultations between the SNF clinical team and hospital staff
   c) On-site consultation and support at the SNF by hospital clinical staff—more frequent during the initial months of the relationship, less as time progresses

2. Having clinical team members participate in “grand rounds” at the SNF
3. Giving the SNF clinical team access to physiatrists and physical therapists
4. Establishing a health information exchange (HIE) as a “bridge” between the SNF electronic health record (EHR) and the hospital EHR, so that patient clinical data can be shared more easily
5. Offering the SNF access to hospital-developed, evidence-based protocols that extend from acute to post-acute care; guidance on the best types of equipment and supplies to purchase; and the ability to use group purchasing discounts
6. Providing the SNF with a medical director candidate who has training and expertise in geriatric care and familiarity with state SNF regulations
7. Offering an avenue for the SNF to gain patient volume, access to managed care contracts, and improved payer mix, as well as access to patients with conditions that result in improved resource utilization group (RUG) types and reimbursement
8. Enhancing the patient transition from the acute to the post-acute setting through:
   a) Medication reconciliation and management
   b) Effective transfer of patient clinical information
   c) Assistance in integrating selected SNF quality indicators with those of the acute care organization

9. Supporting enhancement of SNF performance on patient and life safety codes
10. Offering business process personnel to assist the SNF in enhancing operational efficiency and patient flow

Enhancing Clinical Care and Coordination: The Board’s Role

In hospitals/systems that are developing SNF partnerships, the board should ensure that the acute care management team understands the types of clinical and operational improvements that SNF leaders seek, and request that management create a plan for addressing those. Where SNF partnerships are already established, the board should monitor the performance of the management team to ensure SNF partners obtain the value they seek.

Conclusion

Board members can play a significant role in helping their healthcare organizations achieve and maintain a robust partnership with PAC entities, by familiarizing themselves with the development of a preferred provider network for PAC, and with the specific type of value that SNFs and other PAC organizations are looking to achieve from the partnership. The board may want to consider seeking outside assistance if management is not comfortable with these concepts or needs expert assistance to put them in place.

The Governance Institute thanks Mark Dubow, Director at Veralon, for contributing this article. Mark leads the delivery of Veralon’s advisory services in the Pacific region. For more information, he can be contacted at (424) 299-8850 or mdubow@veralon.com. The author would like to extend his acknowledgement and appreciation to Kathleen A. Hill-O’Neil, RN, M.S.N., CRNP, NHA, Gerontological Nurse Practitioner, Family Practice Center of Newtown, and Consultant, United States Department of Justice and United States Department of Health and Human Services, and Kathleen Griffin, Ph.D., President and CEO, Care Management Innovations, LLC, for their contributions to this article.

Best Practices for Internal Investigations

By Benjamin J. Christenson and Alyssa D. Shaughnessy, McGuireWoods LLP

Corporate boards face increasing responsibilities as the regulatory environment tightens up and new legislative developments encourage reporting by whistleblowers. As such, organizations must continuously monitor their compliance with federal and state law. It is therefore crucial for boards to understand internal investigations and the board’s role in them. This article discusses some of the issues the board and other individuals, such as senior management and in-house counsel, must confront when faced with a potential internal investigation.

When to Conduct an Internal Investigation

An internal investigation is conducted to determine what conduct occurred, its scope, and the individuals responsible, as well as the steps needed to mitigate and end the conduct. Internal investigations may be triggered by the government or internally when a whistleblower raises an issue or one is detected during a routine review.

Internal investigations provide organizations with significant protections, including: the ability to preserve the confidentiality of findings and conclusions to the greatest degree, reducing the likelihood of unpleasant surprises, and giving an organization sufficient understanding of the facts to enable voluntary disclosure.

Benefits

Conducting a thorough, prompt, fair, and accurate internal investigation can benefit organizations in a number of ways. If problematic conduct is discovered at an early stage, it may provide the organization with an opportunity to cure a problem before government involvement. If the government is already involved, it may provide the company with necessary facts to cooperate, reducing the likelihood of criminal prosecution or substantial civil monetary penalties. In both instances, it provides an organization with the opportunity to cast the circumstances in the most favorable light.
Risks
Risks inherent with conducting an internal investigation stem from increased exposure. During the investigation, the organization may uncover conduct it must disclose that it may not have otherwise discovered. It may also run the risk of identifying the grounds for civil claims by third parties. In many cases, however, a company choosing to remain willfully ignorant of potential problems will not prevent their discovery by the government or whistleblowers, and it will reflect poorly on the company and senior decision makers and potentially incur further liability.

Considerations Prior to Launch
Scope
Determining the scope of an internal investigation is a critical decision to be made prior to launching the investigation. Depending on the nature of the misconduct at issue, an internal investigation can consume tremendous resources at great cost to the company. Deciding on the appropriate scope will save the organization time, expense, and prevent unnecessary exposure.

Generally, the scope should be defined after considering the ultimate destination of the final report. If the investigation is the result of a whistleblower allegation or another internal trigger and the ultimate destination is a report to the board, senior management, or an internal audit committee, the level of detail and depth of the report is generally less than if the ultimate destination is an outside governmental agency. In general, an investigation intended for government disclosure should be as thorough as possible, because self-reporting to the government is likely to trigger a government investigation.

In investigations triggered by government inquiry, it may be possible to negotiate to reduce the scope of government demands from initially overbroad requests.

Hold Notices
Hold notices, typically in the form of a short advisement or memorandum written to be readily understood by recipients, should be sent out at the onset of an internal investigation to all employees who might conceivably have relevant information. Such notices advise these individuals not to destroy any documents, emails, or other correspondence relating to the facts at issue. They are particularly important if the company has been subpoenaed by the government or in other litigation.

Employees should be required to formally acknowledge that they have received, read, and understood the notice and an individual should track those acknowledgements and follow up when necessary.

Liability for Failure to Investigate
Organizations can incur civil liability or criminal exposure if they do not investigate an allegation of credible evidence of wrongdoing. Ignoring allegations may be seen as evidence of an intent to willfully conceal or cover up material facts, which could support an allegation of obstruction of justice.

Who Conducts the Internal Investigation
Companies must initially determine who will conduct an internal investigation.

Outside Counsel
Although sometimes the option with the highest upfront cost, outside counsel, independent of the company and the conduct in question, are frequently the best choice to conduct an internal investigation, particularly when the investigation has been triggered by government action. Outside counsel provides specialized expertise including particular knowledge of and familiarity with the substantive legal issues and business procedures at the core of an investigation. In the case of an investigation by the government—even if the organization believes the government is pursuing only a civil resolution—the outside legal team should include a government investigations or white-collar lawyer who will be particularly attuned to the criminal statutes in play and is likely best-positioned to make judgment calls about the necessary scope, potential liability, and exposure of the organization. Outside counsel also provides an additional layer of protection through attorney–client privilege and work product protection that is not always afforded to in-house counsel.

In-House Counsel
An organization’s in-house counsel generally should not conduct internal investigations for several reasons. First, courts are sometimes reluctant to conclude that attorney–client privilege and work product protection covers part or all of the investigation, determining instead that inside counsel’s role is providing non-privileged business advice. In-house counsel may also not have the necessary subject-matter expertise, the resources of
outside counsel, or the time required to devote to research, document review, and other tasks necessary for a thorough investigation. Finally, in-house counsel may also face questions concerning independence and objectivity.

In-house counsel, however, may be appropriate to conduct an internal investigation when she/he has the required subject-matter expertise and when her/his work could not be compromised by relationships with implicated employees.

Oversight by the Board of Directors

Investigations may be overseen by the board. It is important that board members briefed on the investigation do not include any individuals implicated in the conduct under investigation, as independence is a key factor in determining the adequacy and reasonableness of an investigation. A committee of independent board members without any company executives may be an ideal supervisor for an investigation. In addition to serving as the liaison between the outside legal team and the company executives who need to understand the investigation, this committee will often be tasked with making the difficult decisions about voluntary disclosure.

Information Collection and Retention

Document collection, retention, and review is a necessary component of all internal investigations. Beyond formal announcements and policy documents, relevant documents can include email, chat programs, and text messages. Information may be located on an organization’s servers, but information may also include personal text messages, email accounts, and other documents maintained on individuals’ personal devices.

Gathering and evaluating documents can be a very significant and costly undertaking. Typically, individuals who may have documents are initially identified and then interviewed about their role as document custodians. Depending on the scope of the investigation, electronic discovery consultants may be hired to assist with the collection to avert the risk of losing or damaging information in the collection process.

Interviewing Witnesses

Conducting Interviews

As a critical part of its investigation, counsel will interview all employees believed to have relevant information. Such employees, or witnesses, will fall into one of three categories: 1) implicated employees, whose acts or omissions are believed to expose the company to civil or criminal liability and who may also have personal exposure for their civil or criminal conduct; 2) implementing employees, whose acts or omissions may expose the company to civil or criminal liability, but are unlikely to have personal exposure because they were merely acting on the directions of superiors and were not aware that their conduct was in violation of a law; and 3) mere witness employees, who do not expose the company to liability, have no personal exposure, and have only observed or heard of the conduct being investigated.

When to Conduct Interviews

Generally, interviews will be most productive at a later stage in the investigation, when the interviewer has already reviewed documents and identified those most relevant to the conduct at issue. Having read those documents, and having them available to question the witness will ensure that interviews are both focused and that any confusion or dissembling on the part of the witness does not last long.

Who Should Conduct Interviews

Typically at least two individuals should be present for each interview, with one primarily conducting the interview and the other taking notes and acting as a “prover” should there later be disputes or a need for testimony about what was said. If these two interviewers are outside counsel, in-house counsel or other company employees may participate in interviews. In many circumstances, however, the best practice may be for the company representative to not be present in the interview so that the witness feels less inhibited, but to emphasize before the interview that the witness should speak freely and fully to outside counsel.

Upjohn Warning

The Supreme Court in *Upjohn Co. v. United States* confirmed that both the attorney–client privilege and the attorney work product doctrine apply to confidential communications in the context of an internal investigation of corporate misconduct. To avoid any confusion, at the onset of the witness interview counsel should explain that the organization—not the individual—holds the privilege and thus may choose to disclose the content of the interview with company executives, board members, and third parties. Counsel is also expected to advise the witness of an existing or potential conflict of interest between the organization, its board of directors, and the employee, to state clearly that
counsel does not represent the employee, and to advise the employee that he/she may want to seek independent counsel. Counsel will likely also explain that the witness is obligated to keep the substance of the interview confidential from all other persons.

**Reporting Conclusions**

There are several considerations in deciding to whom outside counsel or others investigating an issue should report. It may not always be best to report widely to company management, as certain management employees may be implicated in improper behavior, or the requirement to report to management may cause the investigation to appear less credible and independent. In larger corporations, it may be best to report only to a special committee of independent board members or a senior in-house counsel or compliance executive.

The form of the report will vary depending on the audience, but in certain cases an oral report or at least an initial oral report may be the most desirable option. Written reports from counsel will likely be protected from compelled disclosure, but they may also be disclosed by recipients either intentionally or inadvertently.

**Making Changes**

Through an internal investigation, an organization may identify corrective actions it should undertake. These may include difficult negotiations with government agencies, significant changes in corporate governance, and actions against high-level employees.

**Considerations for Voluntary Disclosure**

**Cooperation**

A critical decision in a government investigation is whether to cooperate with the regulator or prosecutor. Cooperation generally includes providing information that the prosecutor has not asked for, such as presentation of the most important facts of the matter, which likely includes incriminating information. Cooperation does not result in immunity, but almost always carries some benefits. If the organization’s conduct was unlawful and egregious, the benefit may be a small concession in a plea agreement; but if the conduct was unlawful and minor, cooperation may result in a sanction rather than an indictment.

**Self-Disclosure**

In certain cases, an organization will have an affirmative duty to disclose the results of an investigation, but in others, the organization may elect to voluntarily self-disclose. If the decision is made to self-disclose, the organization will likely issue a report including some or all of the following:

- How the incident or practice was identified
- The origin of the information that led to its discovery
- The organization’s efforts to investigate and document the incident or practice
- The chronology of the investigative steps (such as the list of individuals interviewed; dates and subject matter of the interviews; a description of files, documents, and records reviewed, etc.)
- Any actions to stop the conduct
- Any related healthcare business affected by the conduct
- Efforts to prevent recurrence of the incident or practice
- Disciplinary actions taken
- Appropriate notices made in connection with the disclosed matter

**Concluding Thoughts**

Although every investigation presents unique aspects, there are certain actions that a board can take to ensure that all situations meriting investigation are handled appropriately. First, ensure that the investigation is supervised and run at an appropriate level by individuals who are not implicated in the conduct in question. Often, the best choice is a committee of independent board members. Second, regardless of scope, every investigation ought to be handled carefully by counsel with expertise and be sufficiently thorough to maximize the company’s understanding of the situation while minimizing exposure. Do not hesitate to contact your in-house counsel or engage outside white-collar defense counsel if you have identified an issue or believe your company may be at risk. Third, ensure the organization carefully considers the potential courses of conduct once an investigation is concluded, including whether and how best to disclose conduct to the government.

The Governance Institute thanks Benjamin J. Christenson and Alyssa D. Shaughnessy, Associates with McGuireWoods LLP, for contributing this article. They can be reached at bchristenson@mcguirewoods.com and ashaughnessy@mcguirewoods.com.
The Health System of the Future: Millennial Impact, New Revenue Streams, and Trends in Value-Based Care

By Josh Luke, Ph.D., FACHE, University of Southern California, Sol Price School of Public Policy, and Nelson Hardiman Law & Compliagent

As healthcare moves further into the value-based business model, stand-alone hospitals will be increasingly challenged to be profitable. The strategic imperative to join a larger network (whether through merger, partnership, or affiliation) and focus on value-based care initiatives is growing, largely due to the fact that hospitals are the largest expense in the delivery model.

As a long-time hospital CEO, let me be the first to share that myself and my Generation X colleagues might just be passed over for the next wave of health system leadership roles, as millennials are chosen as the new leaders. In fact, physicians’ willingness to transform healthcare is largely generational—older generations are not as nimble, while younger physicians emerging from medical school are eager to be employed and work in a team.

I am proud to be Gen X, but as Gen Xers began assuming more C-suite positions within the healthcare delivery system in recent years, the likelihood of those leaders being exposed to and thus poisoned by the fee-for-service era increased significantly. Fee-for-service was about one simple strategy: put heads in beds to drive hospital and health system revenues—and it worked. In fact, it worked so well, that the bank accounts of insurers bled dry—the most notable being the federal government’s Medicare program.

In this new era, millennials will become leaders in hospitals as long-time seasoned executives (of the baby boomer generation) retire or are driven out because they are unable to adapt to the new model. The transition to value-based care in hospitals has been slow at best, as these long-time leaders saw little incentive to begin the transformation process until recently, when financial penalties were developed for not providing patient-focused, cost-effective care. Five years after Obamacare passed, midway through 2015, the slow crawl to transformation finally began in most hospitals and health systems (with the exception of a handful of visionary hospitals nationwide that had started the transformation shortly after the law passed in 2010).

Providers will now need to begin looking for new ways to generate revenue or increase margins. It’s often the millennials who are first to identify these opportunities as they are tech-savvy and not impeded by fee-for-service influences.

Too many healthcare executives assume that hospitals and health systems are not allowed to partner and share revenue with post-acute providers. The healthcare lawyers of the past were quick to cite Stark and anti-kickback regulations when these discussions arose. Then Cleveland Clinic, Kaiser, St. Joseph Health, and Cedars-Sinai, among others, made aggressive pushes into post-acute care and in most cases took an ownership stake in the new entity. Whether it’s owning acute rehab or skilled nursing facilities outright, white-labeling a non-medical home care product line, or simply purchasing franchises of non-medical home care as St. Joseph Health did, these are all signs that reputable health systems understand that the success of the delivery model of the future depends largely on identifying new revenue streams. And these opportunities may lie outside the traditional healthcare delivery model, as non-medical home care historically has been viewed.

But what about the Gen X leader who put in the time to climb the corporate ladder? In large part it will be up to the individual to demonstrate that they grasp and understand that a head in a bed is no longer the business model. In fact, it’s quite the opposite. When fully evolved, the new model will reward empty beds at all levels of care and emphasize technology-based solutions, home-based care solutions, self-management, and healthy lifestyles.

This is all made possible through communication and technology—two things that millennials grew up with in their hands. In October 2016, I had the privilege of presenting to residents and interns at Oklahoma State University Medical Center in Tulsa. Of the 100 doctors-in-training in the room, it appeared that almost across the board they were millennials. These soon-to-be doctors now entering the workforce grew up in the iPhone and iPad era. Yet when you look at physician leadership at leading hospitals and health systems around the country, it’s almost always the aging physician who has gained clout within the organization based on experience and success that is calling the shots. But in many cases these physicians resist change and technology adaptation.

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The question now remains, will Gen X leaders be willing to learn the new model and cast aside the habits, traits, and skills they learned from fee-for-service mentors? Only time will tell. Millennials grew up in an era of self-commitment to healthy lifestyles, in-hand technology, and a mindset of healthcare being delivered in the home, which has given them a firmer grasp and clearer path to visualizing patient-centered care. The biggest question for millennial health system leaders then becomes, can you prove that this delivery model can be profitable for the health system?

Companies like Santa Monica, California-based HomeHero, one of the fastest-growing non-medical home care providers in the country, was founded by two millennials whose entire platform is to use technology to benefit the patient, improve quality, and provide relevant data on each patients' home-based care and self-management efforts to the health system managing the care. When Kyle Hill and Mike Townsend created the company, they had little idea that leading national health systems would not only create formal partnerships with them, but that one would even become an investor. In the last year, HomeHero and competitors have signed exclusive white-label partnerships with hospitals and skilled nursing facilities that now have a new revenue stream as a result, as well as an enhanced care continuum with improved communication and quality—it's the Triple Aim of healthcare!

The latest trends and discussions I am hearing from hospitals and health systems calling for insight are: transforming case managers to a home-first mentality, development of “SNF avoidance” strategies, avoiding the low utilization payment adjustment (LUPA) bulk payment after five home health visits, implementing programs adhering to the waiver program for the Comprehensive Care for Joint Replacement mandated bundles (including using non-medical home care, assisted living, Abbott's nutritional programs, or simply sending an iPad home with the patient to improve self-management and communication), and aggressive discharging to alternative locations from the emergency department.

Ultimately, if you are looking to shorten the curve on transforming to a value-based model, start looking at some of these tactics and including millennial leaders in the conversation. If you don't, you may miss out on the opportunity to ensure your organization succeeds in these challenging times.

*The Governance Institute thanks Josh Luke, Ph.D., FACHE, Adjunct Faculty, University of Southern California, Sol Price School of Public Policy, and Chief Strategy Officer and Senior Health Policy Consultant, Nelson Hardiman Law & Compliance, for contributing this article. He can be reached at lukej@usc.edu.*
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The Ritz-Carlton, Naples
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Leadership Conference
Boca Raton Resort & Club
Boca Raton, Florida
February 5–8, 2017

Leadership Conference
Fairmont Scottsdale Princess
Scottsdale, Arizona
April 23–26, 2017

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The Role of Palliative Care in Achieving Value Strategies
November 30, 2016
2:00–3:00 p.m. Eastern Time/11:00 a.m.–12:00 p.m. Pacific Time

Healthcare reform; innovations in the organization of healthcare; and the focus on the triple aim of better health, better healthcare, and lower costs are driving hospitals and health systems to adopt new strategies for achieving value. A key target population for these new strategies is patients with serious illness. This Webinar will discuss the challenges in providing care for seriously ill patients and highlight innovative programs and partnerships to improve value for this vulnerable and important patient population.

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System Governance Structure: A Resource for System Boards (online toolbook, November 2016)

Governance Notes (Governance Support Newsletter, October 2016)

System Governance Structure: A Resource for Subsidiary Boards (online toolbook, October 2016)

Board Education and Development (Intentional Governance Guide, October 2016)

Emerging Director/Officer Liability Risk (article, October 2016)

The Board as Think Tank: Moving Beyond Legacy Roles in a Time of Transformation (article, October 2016)

Leadership, Governance, and Changing the Business Model at Carilion Clinic (case study, September 2016)

BoardRoom Press, Volume 27, No. 5 (BoardRoom Press, October 2016)

The New Payer: Why Consumers Will Save Healthcare—Or Destroy It (Webinar, September 2016)

The Role of the Board Chairperson, Third Edition (Elements of Governance, September 2016)

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