



The Governance Institute's 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.

News, Articles, and Updates

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

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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

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 to 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.

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