

AN E-BRIEFINGS ARTICLE SERIES

The Board's Role following the Wave of Industry Consolidation

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The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

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Introduction

Hospitals and health systems are facing major changes caused by a variety of economic and legislative forces. These changes include the rapid consolidation of the non-profit healthcare sector, a significant shift toward physician employment and related physician alignment strategies, diversification of healthcare system initiatives, and regulatory and payer emphasis on quality of care. All of this is combining to create board agendas of previously unanticipated complexity and challenge.

Boards are being pushed toward a more active role in corporate affairs and there are increasing expectations on the quality of board-level oversight as new business and compliance risk challenges emerge. Board members now face tough decisions that require specialized competencies and unique expertise. As board member responsibilities continue to increase at all levels, organizations are going to need to reassess their director evaluation process and revisit the value and appropriateness of compensating directors.

The post-consolidation wave of healthcare will prompt many boards to review the effectiveness of their organization's corporate structure. The new healthcare environment calls for streamlining to ensure the organization's processes are as efficient as possible, which often includes eliminating duplicative services and board levels and reducing the number of affiliated corporations. There is also a growing consensus on the priority that governance must place on quality oversight. Healthcare changes will have a significant impact on how board members address quality of care concerns.

The following articles touch on these issues and examine the board's role following the wave of industry consolidation. Each article in this series provides forward-thinking opportunities and challenges confronting the healthcare organization of the future.

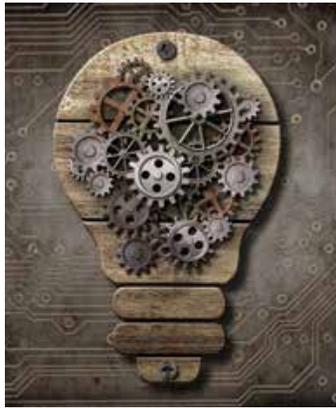
The Move Toward an Activist Board

By Michael W. Peregrine, McDermott Will & Emery, LLP

E-Briefings, Volume 10, No. 1, January 2013

A combination of developments may be pushing healthcare boards toward a more active role in corporate affairs. These include the fundamental change in the healthcare financing system, the rapid consolidation of the non-profit healthcare sector, dramatically increased physician integration, service line diversification beyond traditional care delivery models, and the recruitment of new board members with specialized competencies and unique expertise. These are seminal matters that can prompt a heightened level of board attentiveness.

Add to all of this an increased willingness of regulators (and the media) to raise the “where was the board?” question in times of corporate controversy—prompting subtle new concerns with the appropriate standard of fiduciary conduct and, indirectly, with individual liability exposure. The cumulative effect of these developments is, increasingly, a board that is less passive, less reflexively deferential, and more motivated to become actively engaged in corporate affairs.



This goes beyond enhanced boardroom attentiveness, toward a more pronounced assertiveness with respect to the broader corporate agenda: a tighter leash on senior leadership, a “hands-on” approach to strategic challenges, more direct involvement in care and risk management, a sharpened boardroom culture of constructive skepticism, and a willingness to intervene to resolve ethical lapses, compliance exposure, and reputational harm.

This is not necessarily a bad thing, if managed properly. Indeed, a major emphasis of the post-Sarbanes-Oxley “corporate responsibility” environment has been to ensure an enhanced role for governance in the oversight of corporate affairs and of management’s conduct. The regulatory emphasis on compliance is built on a “tone-at-the-top”-based foundation. Governance best practices are the focus of renewed boardroom attention. Rare is the non-profit health system board that has not embraced these core principles. The days of the “imperial CEO” have mostly passed.

This trend appears consistent with the increased oversight requirements of a more diverse business portfolio. The quality of board diligence must improve if it is to keep pace with the governance demands of the more operationally and financially sophisticated health system. In many respects, the more active, assertive, and aware a board is, the more responsive it is to the governance needs of an evolving healthcare sector.

But this type of board can also be a very bad thing, if not handled properly. Certainly, these new developments help foster an impression that boards must be much “closer to the action” in order to be truly effective—that greater engagement is a reliable prophylactic for personal liability—but it is a perception that is not entirely accurate. The shift toward a more active governance model carries with it the potential for altering, in a negative way, the traditional governance/executive dynamic. When the lines between governance and management are blurred, operational professionalism may suffer and critical checks and balances may weaken.

The warning signs of excessive activism by the board (or by its leadership) may include the following: taking the predominant role in developing the board meeting agenda; increasing the board reporting obligations of corporate officers; becoming directly involved in transaction negotiations; directing major components of the strategic plan; engaging advisors to represent the interests of the board on a regular basis; maintaining direct contact with corporate vendors, constituents, consultants, and strategic partners; serving as primary organizational spokespersons; and assuming an executive role on an interim basis (e.g., upon the departure of the CEO or CFO).

The quality of board diligence must improve if it is to keep pace with the governance demands of the more operationally and financially sophisticated health system.

Rather than reacting to management recommendations on strategic or policy matters, the board is proactively participating in the formation of those recommendations. Rather than exercising oversight of management’s pursuit of individual initiatives, the board is directly involved in the identification and implementation of those initiatives. Rather than utilizing the expertise of advisors recommended in good faith by management, the board retains a parallel set of advisors.

Yet, there is a very fine line between conduct that suggests excessive activism and that which can be fairly characterized as attentive governance. Oftentimes, the risk arises not from individual actions but rather from a pattern of conduct by which the board, acting in good faith, interjects itself more directly and consistently in executive-level tasks. When it does so, it can undermine the effectiveness and credibility of senior management, decrease the quality and effectiveness of the management

function, erode governance checks and balances, and increase board members' exposure to personal liability.

There's no question that expectations of healthcare governance will increase with the dramatic consolidation of the sector. The pronounced concentration of control in larger community, regional, and national systems and the shift toward greater operational diversity will by necessity increase expectations of boardroom conduct. The board that is sensitive to this and similar trends will naturally feel a gravitational pull toward more active, hands-on leadership.

Identifying the appropriate level of board engagement in a changing and consolidating healthcare sector requires the conscious and committed discernment of both the board and management. They have to talk it through. Acting with the support of qualified facilitation and on the legal advice of the general counsel, these organizational leaders should carefully reevaluate their respective roles in the context of industry realities, organizational mission, and governance law. Such an evaluation process should include a review of the following:

- **Traditional roles:** The starting point of any evaluation is to revisit the traditional role descriptions of the board and the senior leadership team, and the fundamental distinction between governance and management. Basic to this is the statutory concept that the business of the non-profit corporation is managed under the direction of the board. However, directors aren't well positioned to manage the corporation directly and comprehensively. For that reason, they are authorized to delegate day-to-day management responsibilities to qualified executive management. The board must then exercise oversight of executive leadership. Implicit in this delegation is the board's ability to rely on the advice of its leadership team.

Law and best practice specify particular duties for the board in its oversight role. These include the following core principles: 1) selection, compensation, and evaluation of the CEO and related succession planning; 2) overseeing the strategic planning process; 3) comprehension and approval of annual budgets; 4) confirming accuracy/clarity of financial statements; 5) ensuring consistency of operations with non-profit mission and tax-exempt status; 6) advising executive leadership on important issues confronting the corporation; 7) rendering informed decisions on major corporate actions; 8) ensuring operation of an effective corporate compliance and ethics plan; 9) nominating qualified candidates for board and committee positions and ensuring comprehensive director education and self-evaluation protocols; and 10) authorizing the exercise of reserved powers over corporate affiliates as may be established in governing documents or statute. Note that none of these responsibilities directly involve the board in day-to-day management.

- **New pressures:** There must be a shared sense of the challenges confronting the board, and executive management, respectively. Only from that basis can there be a true sense of appreciation and understanding of the perspectives that each brings to their roles. For example, senior management should be sensitive to board concerns arising from the responsibilities of

oversight, the exercise of business judgment, specific community health needs, keeping pace with the rapid rate of change in the healthcare sector, and the risk (however attenuated) of personal liability exposure. On the other hand, governance must be sensitive to the pressures on management to operate a very sophisticated business enterprise in a highly regulated industry that is in the throes of a monumental change in the manner in which the organization is paid for its services.

Certain challenges have the potential to create particular board/management conflict; e.g., strategic planning (including major corporate transactions), physician integration strategies, executive-level performance and compensation, compliance plan effectiveness, and risk management strategies and investment management practices. Perceived new fiduciary and compliance pressures could (and maybe should) prompt the board to exercise levels of diligence and inquiry to which management may object, as an encroachment on their authority.

- **Reporting requirements:** There should be a general agreement of the nature and frequency of reporting relationships between senior leadership and the board. Fundamental to such an agreement is an understanding of what is required by law, best practice, and professional ethics. Also important is an understanding that, with respect to certain key positions (e.g., the chief financial officer, chief compliance officer, and general counsel), the law expects a dual reporting relationship—to both the CEO and the board. At the same time though, there should be an understanding of how to structure governance reporting requests so that they are not burdensome to management, a distraction from core responsibilities, or do not work to circumvent the basic authority of the CEO.
- **Information and approvals:** There should also be agreement on the quality of information the board receives from management, and the frequency with which it is received. Again, this requires a delicate balance between that which is reasonably necessary to support informed board oversight and action, and that which is excessive and more consistent with a management-level role. Along the same lines, there should be agreement on matters that the CEO may pursue without board involvement, matters that the CEO can pursue with notification to the board, and matters that the CEO can pursue only with board approval.

A thoughtful, substantive dialogue between the board and the executive leadership team offers the opportunity to clarify the proper roles of governance and management in the context of a rapidly evolving non-profit healthcare sector and the operational and fiduciary demands of a sophisticated healthcare system. The guess here is that these circumstances will lead to greater board engagement on all aspects of the corporate agenda, as a new standard of conduct. But greater engagement must be coupled with guidelines designed to protect against unwarranted intrusion into the executive suite. If the "property line" between governance and management requires a new "survey," great care should be given to the location of the "boundary stakes."

Toward More Engaged Oversight

By Michael W. Peregrine, McDermott Will & Emery, LLP

E-Briefings, Volume 10, No. 2, March 2013

A combination of developments is pushing healthcare boards toward more engaged oversight of corporate affairs. These include financial uncertainty arising from health reform implementation; economic pressures resulting from reduced payments from payers; increasing emphasis on the quality of care; competitive challenges from aggressive providers and physician groups; renewed government enforcement initiatives and related compliance costs; and the need to recruit and retain qualified executive leadership. These and many other business and compliance risks are the byproduct of a rapidly consolidating provider sector in a post-healthcare reform environment. They're fundamental risks that are daunting, and they combine to "ratchet up" expectations on the quality of board-level oversight.



When we speak of "oversight," we're referring to one of the two vitally important components of the director's core duty of care—the expectation that directors will act in good faith, with the care that an ordinarily prudent person would exercise in similar circumstances, and in a manner that the director reasonably believes is in the best interests of the organization.¹ In this context, "oversight" is the general activity of the board in monitoring the day-to-day business operations of the organization (i.e., the exercise of reasonable care to ensure that corporate executives carry out their delegated management responsibilities and comply with the law). It is, in essence, the board's obligation to keep a (collective) finger on the pulse of what's going on, and with the knowledge gained, serve as a more informed resource for—and provide more informed checks and balances with respect to—the executive management team.

Historically, courts have been supportive of the board's oversight role, requiring a demonstration of "bad faith"² as a precondition to sustaining a breach of fiduciary duty allegation. Based on principles of business judgment, courts have been deferential to a board's determination of how detailed its risk monitoring system should be. Indeed, the bar has been set so high that in at least one instance a court held that liability for business risk oversight "is possibly the most difficult theory in corporation law upon which a plaintiff might hope to win a judgment."³ Seems like pretty bulletproof protection, right? Maybe not so much.

It is the board's obligation to keep a (collective) finger on the pulse of what's going on, and with the knowledge gained, serve as a more informed resource for the executive management team.

In the non-profit sector, charity regulators are taking an increasingly harder look at the level of engagement exercised by the board of directors. They're doing this in part to ensure that charitable assets aren't subjected to abuse (e.g., excessive compensation, private inurement) and in part to ensure the directors are up to the task—that they exercise the amount of diligence in connection with their business and compliance risk oversight that the circumstances require. That's what is so significant about the current non-profit healthcare environment, with the combination of larger, consolidated business systems, dramatic changes to the financing model, and increasing operational and regulatory challenges. In that context, it is understandable that charity regulators have concerns about whether the board is fully engaged in oversight, whether expectations of conduct should be increased, and whether we're looking at a new competency profile for the board. To the regulators, the non-profit board is the last line of defense when it comes to protecting charitable assets. There are no shareholders; there is no "market function" that serves to police the efficiency of the non-profit board. It's the increasingly ubiquitous headline in the local papers, "Where was the board?"

For those reasons, it's time for a little introspection at the board level. The boards should ask itself whether or not it has a framework in place from which it can adequately exercise oversight of these emerging new business and compliance risk challenges. *Do our oversight systems work? Do we have the right blend of expertise?*

¹ The other component being the application of duty of care principles to a specific decision or board action.

² E.g., failing to act in the face of a known duty; a conscious disregard for the director's duties.

³ *In re Citigroup Shareholder Derivative Action*, 984 A.2d 106 (Del. CH. 2009).

Must we work harder, faster, and longer? The board that is serious about its oversight obligations will look at the following:

1. **Information flow.** The board's ability to effectively perform its oversight responsibilities depends in large part on whether the *right information* is received from management in an *understandable format* in a *timely* manner. The board—and its risk/compliance committee—has an expectation that management will provide the information it needs to address organizational risks. When that information reporting system breaks down, bad things can and will happen. In the non-profit health system, the problem usually isn't one of deficient governance, but more often one of deficient reporting. To paraphrase the old John Houseman commercials, good reporting systems “don't just walk up, bite you in the bottom, and say ‘we're here.’” The board has to make it happen. In other words, the engaged board will work with management to clarify its expectations about how business and compliance risk information can be conveyed in a useful and timely manner. Be explicit. If there is something that is keeping management up at night, the board and its key committees need to hear it now.
2. **Committee roles.** Effective oversight engagement also requires a clear mandate for the committee responsible for risk and compliance. Are risk oversight responsibilities fully articulated in the charter of the proper committee? Is the committee's board reporting relationship clear, and is it set at a frequency that is appropriate for the size and risk profile of the organization? Does the general counsel serve as staff to this committee? Does the board's governance structure create overlap in responsibility for these matters (e.g., between the executive, audit, and compliance committees)? Is there a risk that oversight responsibilities might “fall between the cracks” between committees with competing charters? Is there proper coordination between key committees, and of the roles and reporting relationships of the general counsel, the compliance officer, and the internal auditor to these committees?
3. **Director roles.** Effective oversight engagement requires a critical analysis of the necessary time commitment expected from business risk and compliance committee members. In light of the increasing operational and risk challenges facing the health system, it's fair to assume that committee service will require additional time and commitment from its members. Meetings will be longer and more frequent. Homework assignments will be more substantial. In this regard, the workload expected of the audit committee members offers a good example. Risk and compliance committee members will also be expected to be more aware of the health system's lines of business, and more familiar with the individual risk managers and the provisions of the organization's risk and compliance plans. They will also be expected to receive specialized continuing education, tailored for their roles. Yes, these committee members will be expected to work harder, faster, and longer.
4. **Director competencies.** More sensitive issues relate to the size and composition of the business risk and compliance

committees. There is perhaps no better way to demonstrate oversight engagement than to populate these committees with enough members to satisfy charter responsibilities, and with members who have the background and expertise necessary to monitor business risk and compliance. Having the right number of committee members, with the right qualifications (and with a regular meeting schedule), sends a clear board statement of good faith. Like the audit committee, the membership of the business risk and compliance committees should be composed entirely of independent directors.

5. **Director conduct.** It is not all a matter of process. Effective oversight engagement also involves educating risk and compliance committee members on the expected standard of conduct. *Once we have the information, what are we supposed to do with it? What's the difference between a green flag, a yellow flag, and a red flag, in terms of our response?* The general rule of thumb is that once presented with information that causes (or should cause) concerns to be aroused (yes, a pretty subjective standard), the committee member is then obligated to make further inquiry until such time as his or her concerns are satisfactorily addressed—and favorably resolved. The trigger is often material information that, on its own or in conjunction with other information known to the committee, “flags” to the committee that action needs to be taken—that there is indeed “smoke” that must be extinguished before it bursts into flame. Absent that, there is no obligation to anticipate the future problems of the organization.

The rapidly consolidating provider sector in a post-healthcare reform environment is setting new standards for board oversight of business and compliance risk. From a governance perspective, it's likely to require thoughtful, substantive dialogue between the board and the executive leadership team on the status of board oversight engagement, the effectiveness of oversight controls, and ways in which these controls can be enhanced to better position the board to respond to emerging business and compliance risk challenges.



Toward a Streamlined Corporate Structure

By Michael W. Peregrine, McDermott Will & Emery, LLP

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Does your corporate diagram contain more lines than a city road map? Do you have more corporate subsidiaries than IBM? Do you need an Olympic-sized pool of director candidates to fill all the boards in your system? If the answer to these questions is “yes,” it may be time to streamline the corporate structure of your health system.

One of the fundamental obligations of the governing board is to periodically review the effectiveness of the organization’s corporate structure. In this regard, the expectation is that the board will evaluate whether the organizational means by which the system carries out the overall mission is efficient from economic, operational, and governance perspectives—and if not, that the board will make appropriate changes. In other words, the board should not automatically consider the corporate structure to be sacrosanct, especially if it is ill-suited to respond to the organizational challenges of the post-Affordable Care Act competitive environment.

The traditional parent/subsidiary corporate governance structure, so popular in the non-profit health sector for so long, may be reaching the end of its useful life. This is in part due to the fact that many of the reasons prompting such a structure (e.g., concerns with veil-piercing, rate review, confiscatory regulation, certificate of need jurisdiction) are no longer as prominent a set of concerns to the health system as they once were. This is also due to the significant administrative, governance, regulatory compliance, and personnel costs and inefficiencies directly attributed to managing a large, multi-entity corporate system.

The rapid consolidation of the non-profit health sector and the increasing size of health systems is similarly raising questions about the continued feasibility of locating individual hospitals in separate corporations. There also are increasing concerns about whether the cost and efficiency associated with the maintenance of large, multi-corporate systems can be reconciled with the benefits associated with such structures. This is coupled with a greater need for more streamlined decision-making processes and unified compliance procedures. Complex parent–affiliate structures increase the risk of confusion and “governance gaps” between the roles and authorities of parent and affiliate boards. There also is significant competition for qualified volunteer directors, and risks associated with overloading existing board members with multiple committee responsibilities.

So, there is great sense in placing corporate streamlining on the board agenda. Even if the ultimate analysis produces a status quo result, the exercise will likely have been worth the effort because it will make board members much more familiar with the reasons supporting the current structure. That’s a valuable result in and of itself—knowing the history behind the organizational chart better positions the board to make structural decisions in the future.

But there is also the possibility that the evaluation process will result in meaningful change, such as a reduction in the number of affiliated corporations; the elimination of duplicative programs, services, and board levels; savings in terms of both administrative cost and in board-level/meeting activity; and a greater appreciation for the roles and functions of individual corporations (e.g., why they were formed, what purpose they serve, whether they can accommodate additional activities). These are realistic goals of a board-level corporate streamlining process.

A corporate streamlining initiative typically involves at least a seven-part process:

- **Part one:** An identification at the senior leadership level of the most significant structure-related problems that require resolution (how would leadership measure “project success” in reference to these identified problems?).
- **Part two:** A “history lesson”; i.e., a review of the rationale behind the creation of the current corporate structure and its component parts (how did things get to where they are today as a whole, and why were certain individual organizations created?).
- **Part three:** A review of the system’s governance structure, with special focus on the relationship of the parent corporation to the subsidiaries, the decision-making authority of boards and management at each level, the utility of certain committees, and the application of administrative services across the system.
- **Part four:** The identification of specific issues, organizational documents, laws, statutes, judicial decisions/administrative rulings, title restrictions, contractual/venture barriers, tax requirements, accounting provisions, political considerations, etc. that must be taken into consideration by leadership in evaluating streamlining options.
- **Part five:** An analysis of whether certain affiliates are needed to achieve the mission goals and objectives of the system (i.e., have individual affiliates achieved—or are they achieving—the purposes for which they were created?). This may involve some difficult evaluation and decision making at the leadership level.
- **Part six:** The evaluation of specific streamlining opportunities, pursued in large part by comparing the opportunities to be achieved by eliminating (either directly or through combination with another affiliate) individual corporations, against the potential legal/tax/accounting and political barriers with doing so.
- **Part seven:** The process by necessary approvals for individual streamlining initiatives are received—either at the local board level, with courts or regulators, with venture partners or financial institutions, and/or with political bodies.

The streamlining process should be realistic in terms of achievable goals—it's not always possible to “turn back the clock” and consolidate a family of affiliated corporations and venture investments into one, large, focused corporate enterprise (but that's not necessarily a bad idea!). Yet, leadership should anticipate the kinds of head-banging limitations that sometimes pop up to frustrate the grandest of streamlining visions (e.g., bond covenants that restrict the consolidation of some entities, favorable accounting treatment or tax status jeopardized by a merger or consolidation of an affiliate, a real estate restriction triggered by liquidating a company, judicial approval required to change the purpose of a particular non-profit, a semi-independent affiliate board that is unwilling to approve streamlining plans, and worse). They're to be expected, so it's best to just plan for them.

Another particular downside of a corporate structure streamlining process is that the lawyers and the accountants need to be involved. This is unavoidable as the core of the board's analysis necessarily—and directly—involves an analysis of applicable state corporate law, exempt organization tax law, and governance principles, and, oftentimes, issues relating to real estate title, bond restrictions, terms of key joint venture investments,

the limitations of existing corporate governing documents, and restrictions imposed by judicial decisions and administrative proceedings, among other issues. These are all matters in which regulators like the state attorney general and the Internal Revenue Service and other third parties such as bond counsel may have a particular interest.

But, if leadership can “hang tough” through the frustrations, time, and expense of the process, the end result is almost always worth it. There are potentially significant cost savings, not only actual cash savings but also those associated with limiting the time, expense, and “wear and tear” of management and board members—that can accrue to an organization simply by reducing the number of corporate affiliates in the system. Streamlining can also result in leadership achieving a greater understanding of not only the role and purpose of the corporate structure, but also the role played by individual affiliates, and the legal, tax, accounting, and financial restrictions that relate to individual affiliates and the system as a whole. These benefits may result in more efficient and informed management and governance, and in greater organizational flexibility and freedom of movement in addressing further competitive opportunities.

Toward an Effective Director Evaluation Process

By Michael W. Peregrine, McDermott Will & Emery, LLP

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A regular, robust, and self-implemented director evaluation process will be a critical component of effective governance, as hospitals and health systems evolve to larger and more sophisticated corporate structures. The concept of director self-evaluation is not a new concept in healthcare, and has been accepted by many prominent systems. Yet, the typical process is the governance equivalent of “soft-toss,” when the organization may be better served by “hardball.” Indeed, the significantly increased fiduciary responsibilities associated with larger systems require a more thoughtful, penetrating evaluative process that incorporates consequences for material underperformance.

It should be noted that director self-evaluation has long been a governance “best practice.” The Panel on the Nonprofit Sector recommends that board members should evaluate their performance as a group and as individuals no less frequently than every three years, and should have clear procedures for removing board members who are unable to fulfill their responsibilities.⁴

This core principle is intended by the Panel to apply to all types of non-profit corporations. Note that it specifically contemplates a removal mechanism. But there is no one-size-fits-all approach; what may work for the local social service agency is unlikely to work for a large health system, many of which have hundreds of millions of dollars—or even billions of dollars—of assets under ownership. And the financial costs and liability risks associated with preserving ineffective board members in office is so very high with respect to health systems.

The traditional resistance to vigorous director evaluation is based on three primary concerns: 1) it will upset the culture of the boardroom, 2) it will increase the difficulty in attracting qualified volunteer director candidates, and 3) there are often practical barriers to removing those who “grade out” poorly. These are understandable in each instance.

Still, none of these concerns are sustainable in the context of the governance of highly regulated, organizationally complex non-profit health systems. The primary cultural focus of the board must be on establishing expectations of competency, loyalty, and compliance. In that context, boardroom collegiality is more of an aspirational goal—a byproduct of effectiveness. Thoughtful governance practices commensurate with the size and sophistication of the organization are more likely to attract competent, qualified director candidates than deter their recruitment.

Indeed, quality directors are more likely to leave a board that tolerates underperforming members, rather than stay because of a climate of non-confrontation. A broad understanding of the risks associated with maintaining underperforming directors in office will often remove many of the practical barriers associated with removal.

For these reasons, the board (or the appropriate committee) is well advised to review its approach to the director evaluation process and to consider those changes that may be necessary in order to ensure that the evaluation process is supportive of the board’s long-term governance goals; i.e., to help ensure that the composition, qualifications, competence, and effectiveness of the board is commensurate with the mission and operations of the organization. Such a review could involve the steps described below.

The board is well advised to review its approach to the director evaluation process and to consider those changes that may be necessary in order to ensure that the evaluation process is supportive of the board’s long-term governance goals.

Step One: Expectations and Goals

Before a comprehensive evaluation process can be identified, it will be important for the board to agree on the goals and expectations for the process. For non-profit hospitals and health systems, a primary goal is usually to establish and supplement evidence of the board’s good faith with respect to governance practices (good faith being, of course, a critical element of effective and responsive governance). Courts have historically recognized that the conscientious pursuit of recognized governance best practices is reflective of good faith—and as noted above, director self-evaluation protocols are recognized as “best practice” in the non-profit sector. A related goal is to supplement the director nomination process, by identifying elements of effective and ineffective governance practices by individual directors. A third goal may be to enhance director training and information through the information gathered in the evaluation process. A fourth goal may be to position the organization for a more favorable credit rating, when the credit analysis takes into consideration the quality of corporate governance. A fourth goal is sometimes to respond to the requirements of statute, regulation, accreditation, settlement, or governance reformation agreement with a third party.

⁴ *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*, Panel on the Nonprofit Sector, 2007; The Governance Institute recommends conducting a formal board self-assessment on an annual basis, and individual board member assessments within time for the board member to make appropriate improvements prior to reappointment to another term (frequency based on term limits).

Step Two: The Self-Evaluation Process

The question here is not whether an individual director self-evaluation process can be an effective governance tool. It can be, especially when teamed with other measures discussed in step three, below. Rather, the question is whether the existing structure and focus of the self-evaluation process still “works” given emerging board dynamics, policy goals, and regulatory expectations. The traditional hospital self-evaluation form necessarily focuses on the individual’s perception of his or her performance in comparison to broad, generous descriptions of expected conduct. It is designed to “touch the bases” of core conduct (e.g., mission comprehension, fiduciary duties, CEO evaluation, strategic awareness, financial model) in an inoffensive and non-threatening manner. Am I committed to the mission of the organization? Is my meeting attendance record satisfactory? Do I read the board materials sufficiently in advance so that I am prepared for the meeting? Do I pay attention during meetings and ask questions? Do I appreciate my basic fiduciary duties? Am I comfortable with the way leadership responsibilities are allocated between the board and executive leadership? Do I have a respectful relationship with the CEO and other members of senior management? Do I generally understand the healthcare sector and its financing mechanism? Am I aware of and support the strategic plan? Those kinds of questions are perhaps well suited to a community hospital board circa 1980, but decidedly unsuited in the context of the more complex healthcare provider/system in the post-healthcare reform environment.



The answers to the traditional self-evaluation questions simply will not provide any clue as to whether board members believe that they understand, and are operating consistent with, the standard of fiduciary conduct applicable to the current environment. Especially if it is a check-the-box type of form that allows a tiny space for a handwritten supplement. The board’s governance committee should review the current self-evaluation form in a manner that emphasizes the currency of the question and the completeness of the response, as opposed to the ease and speed with which the questions can be answered. This may mean adding an “edge” to specific questions—focusing on prompting responses that will generate meaningful data for governance committee evaluation—such as adding questions relating to the level of individual director commitment; a true understanding of

the role of the board as providing a set of “checks and balances” over management; a comfortable appreciation for the changes created by the Affordable Care Act; an appreciation of the strategic risks, and opportunities, of the system; an accurate description of the boardroom culture; a willingness to challenge the CEO when necessary and to push back against management assumptions and proposals; and a recognition of when a relationship might constitute a conflict, and the willingness to make disclosure—and an acknowledgement of the areas in which the director sees room for personal improvement.

“Kicking the tires” of the self-evaluation process every two years or so is thus almost a governance prerequisite in the context of seismic health industry change.

Step Three: The External Evaluation

Perhaps the more serious discussion is whether the hospital or health system should incorporate an external component to its evaluation; i.e., engaging an external consultant once every several (e.g., three) years to conduct a more penetrating evaluation of the board and its practices, intended to raise sensitive and important issues that individual directors may be unwilling to raise directly in the context of self-evaluation. The “template” that some larger health systems are beginning to implement is based on the use of an independent, highly qualified facilitator whose goal is to draw out from confidential interviews with individual board members perspectives that might not arise from the self-evaluative process. These might include comments and views on such important topics as:

- The quality and timeliness of management’s information flow to the board
- The extent to which management decision making is within the board’s risk profile comfort zone
- The extent to which board decision making and oversight are consistent with expected standards
- Concerns with respect to the attentiveness and commitment of individual board members
- Concerns with respect to the ability of individual board members to comprehend and respond to key issues
- Whether the board lacks particular areas of expertise
- Concerns with respect to possible self-interest and conflicts within the board
- Whether the board is adequately focusing on strategic considerations
- The relationship between senior management and the board
- Whether governance control is concentrated in a few, rather than the whole

A qualified facilitator will be well positioned not only to summarize the results of those interviews, but also to make related observations and recommendations. Typically, that facilitator will not be a practicing lawyer and will not be qualified to comment on the legal implications of the interview results. For that reason, the facilitator should work in conjunction with the corporate counsel to make sure that appropriate legal input and comments are included in the final report. This is particularly the case where the facilitator’s engagement covers operational items such as board

size and structure, board policies, committee charters, minute taking, and agenda preparation—all of which are primarily legal matters. Indeed, where the work product protection afforded by the attorney client privilege may be important it may be valuable for the corporate counsel to directly engage the facilitator.

Step Four: Responsive Measures

This is where the “rubber meets the road” in terms of the net result of the evaluation process cycle—the extent to which the board effects meaningful responses to the observations gleaned from both self-evaluation and external evaluation processes. For in many respects, the results of a properly conducted evaluation cycle is like a “live grenade,” it possesses great destructive power if not swiftly and accurately disposed of.

Traditionally, the end of the evaluation cycle has several recognized stages along an escalating chain:

1. Dissemination to the board of a confidential report summarizing the results of the evaluation and, where it was conducted by an external advisor, the recommendations of that advisor.
2. The identification of specific board education measures intended to correct broad-based questions or concerns with respect to the board’s understanding of operational or strategic matters or of fiduciary standards.
3. The pursuit of structural/procedural changes to the manner in which the board is organized and operates (e.g., size, scope, duties, use of committees; receipt of information from management) intended to correct identified deficiencies.
4. Revisions to the director nomination matrix intended to identify specific qualifications and characteristics that should be more prominently represented on the board.
5. The process of either not renominating, or actually removing, those directors whom the process has clearly identified as non-performing.

The larger the non-profit health system, and the greater the assets under its control and management, the more comprehensive a response regulators will expect once the evaluation cycle has been completed. Board leadership will not have the luxury of sharing evaluation results only within the governance

or executive committees; if the full board is empowered to exercise fiduciary responsibilities, then the full board must have the benefit of those results. Neither will the board have the luxury of deferring painful or politically difficult challenges with respect to board restructuring (changing the size and composition of the board and of key committees).

If something or somebody is not working out in terms of effective corporate governance, regulators will expect board leadership to take prompt and effective action, even if it means removing a board member before his or her term has ended. In the current healthcare environment, there is far too much at stake in terms of effective governance to allow sentiment or a desire to avoid confrontation serve as a barrier to decisions that an evaluation process makes painstakingly clear. The liability profile of the board would be significantly expanded if in the context of financial or operational crisis, or regulatory challenge, it was determined that the board failed to implement specific recommendations identified in the evaluation cycle. Governance charters and philosophy statements should be revised to more directly speak to a culture of boardroom accountability, in which sustained substandard fiduciary conduct will not be tolerated. The adoption of such policy revisions, and other steps arising out of the evaluation reports, lend a self-executing mechanism to the evaluation process. There arises a clear expectation of substantive board-level action in response to the recommendations of the evaluation cycle.

Summary

The rapid consolidation of the non-profit healthcare sector from independent, stand-alone hospitals to the proliferation of regional, statewide, and national systems changes dramatically the circumstances through which board conduct will be evaluated. System governance will be expected to operate at a standard of conduct that is commensurate with the size and scope of its operations and the value of the assets under its control and ownership. In that context, traditional perspectives on director evaluation may be insufficient to respond to legitimate concerns re: director and board effectiveness. For that reason, healthcare boards are well-advised to revisit the manner and intensity with which they pursue director evaluation processes.

Toward a More Effective Board Support Process

By Michael W. Peregrine, McDermott Will & Emery, LLP

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Health system general counsel and governance support personnel (GSP) can combine to provide enhanced assistance to the board of directors in the exercise of their fiduciary duties. The combination of operational, regulatory, and competitive forces is creating board agendas of previously unanticipated complexity and challenge. The expectations of, and demands upon, health system directors are evolving dramatically with the rapid pace of industry evolution and consolidation. A premium will be placed on management's ability to develop an accessible and practical platform from which board members can more efficiently act in compliance with their fiduciary responsibilities. The general counsel, acting in coordination with the GSP, can "team up" to implement a series of non-disruptive actions that can increase information flow efficiency, enhance documentation, and reduce individual liability exposure. This is especially important given the increasing reliance on digital technology in the governance process.

The underlying premise is that both the general counsel and GSP have substantial, if differing, roles to play in how the board receives information, processes that information through oversight and decision making, and documents the actions that the board ultimately takes. To the extent that the general counsel and GSP can more effectively team up in pursuit of these shared roles, it will become materially easier for the organization to demonstrate that, on any particular issue, the board acted in a manner consistent with applicable fiduciary duties.

Neither the general counsel nor GSP can, of course, ensure that board members will always act in a manner consistent with the standard of conduct. But, by jointly focusing on the facilitation and documentation of such conduct, they can significantly increase the likelihood that the appropriate standard is achieved. Conduct to be emphasized includes loyalty to charitable mission, constructive skepticism, attentive oversight, informed business judgment, good faith, disinterest, legal compliance, and adherence to corporate/board policies.

The "model" board support platform for today's health system would be built on at least eight separate "planks":

1. **Effective board education.** Targeted, frequent board education contributes significantly to the exercise of the requisite good faith, oversight, and business judgment, and is typically recognized as "best practice." The general counsel and GSP can team up to support satisfaction of this best practice by developing an organized schedule of educational sessions that are designed to address the developing issues of interest to board and committee members. The sessions can be either in-person or Web-based, with supporting reading materials. Education is at the core of informed decision making and the board's agenda should reflect a commitment to organized,

periodic education programs through a variety of presentation modes.

2. **Proper information flow.** A key method for empowering the board to satisfy its fiduciary obligations is to ensure the delivery of relevant information on a timely basis and in a format and context that is useful to the board. The specific type (e.g., electronic or written), format, timing, and source of information will depend upon the composition, mix, and sophistication of the board and of the nature and scope of the system's business and operations. The general counsel and GSP can work together to actively engage the board in a dialogue as to what manner of information delivery works best for their needs and oversight/decision-making obligations. They can work jointly to organize the material in a reader-friendly manner that will better guide board members to the most important and time-sensitive issues. This dialogue can also help confirm the sources from which information is authorized to be sent to the board (e.g., senior executives, other members of the management team, and external advisors). Such dialogue frequently serves as the catalyst for moving from the traditional written "board book" approach to a digital technology method of providing information to the board.
3. **Instructive board agenda.** The meeting agenda is often one of the most underutilized board communication and documentation tools. A properly prepared agenda will reflect input not only from the chair and CEO, but also from the general counsel and GSP. This "team" can help the agenda achieve important governance support benefits, for example, preparing the board for the issues to be addressed at the meeting, facilitating advance information requests from directors, assisting in the identification and disclosure of potential conflicts of interest, identifying documents provided in advance of the meeting, combining with the meeting minutes to serve as a historical reference of matters discussed (and documents provided) at the board meeting, and serving as supportive evidence of the board's advance preparation and diligence. The GSP and general counsel can work together to help ensure the most effective use of the meeting agenda.
4. **Effective minute-taking practice.** We could spend several hours on this topic, but the main point here is that the general counsel and GSP can collaborate to ensure a proper, efficient, and accurate minute-taking practice that memorializes (hopefully) good faith board conduct. Areas of general counsel/GSP collaboration include the style of minutes (e.g., length and context, taping minutes, and the use of board member notes), increased ability to document the genuine exercise of desired conduct and satisfaction of elements of

safe harbors and best practices, appropriately addressing sensitive agenda items that are presented in the context of privileged discussion or executive session, appropriately documenting the key items from any consent agenda process, and protecting against excessive editing of the draft minutes by multiple parties.

5. **Preservation of legal privileges.** Substantial documentation benefits can be obtained from a coordinated general counsel/GSP effort to ensure that processes are in place to preserve the attorney–client and related legal privileges when intended to apply to board presentations and distribution of supporting documents. The GSP can rely on the general counsel’s familiarity with the relevant privileges to ensure that, where appropriate, communications are recognized as privileged, the control group is properly maintained, protections are in place to prevent inadvertent waiver, and privileged material is stored in a discrete manner. The GSP should not need to “guess” in connection with privilege issues but should have the ability to regularly consult with the general counsel to help ensure preservation of the privilege.
6. **Board records retention.** The GSP and general counsel should work together to design a records retention protocol for board documents. The goal would be to ensure storage in safe, secure, and redundant files—both paper and electronic. The goal is to allow for ready access by officers and directors for their own needs and to facilitate prompt response to record requests made by regulatory/judicial authorities, as well as in the context of third-party due diligence. Examples of governance documents that should be subject to special retention protocols include (but are not limited to) organizational documents; board, committee, and executive session agenda minutes; privileged information; resolutions; committee charters; conflict disclosures (and their resolution); conflict management plans; waivers of notice and of quorum; and correspondence and agreements to which the board itself (or a committee) is a party. The general counsel and GSP should coordinate efforts to ensure that all board and committee document retention practices are consistent with applicable law and corporate policy.
7. **Meeting “shortcuts.”** The general counsel plays a vital role in guiding the GSP, chair, and CEO in effectively applying the various corporate governance “shortcuts” available under

non-profit corporate law and best practices. These “shortcuts” include the use of consent agendas, action by “informed written consent,” meetings held by telephone or video conference, and proxies and voting agreements (where applicable). The GSP should reach out to the general counsel to ensure that the intended use of the “shortcut” is consistent with relevant law, that appropriate notices and advance distribution of materials are made, and that the board’s satisfaction of the statutory requirements for the shortcut are appropriately reflected in minutes.

8. **Digital technology issues.** Again, this is another broad and involved topic. In sum, the GSP and general counsel should work very closely together across a broad array of matters relating to the board’s use of digital technology in the governance process. This is especially the case with respect to popular items like board portals and dedicated iPads for board members. Key areas for collaboration include the intended primary use of the technology (e.g., posting meeting materials, in-between meeting communications, distributing minutes, and storing board policies), and possible secondary usage (e.g., self-evaluation and board evaluation processes, conflict disclosures, and surveys and questionnaires). Other digital-related topics for general counsel/GSP collaboration include director training, ensuring dedicated IT support, whether printing is allowed, the use of such technology under state corporate law (e.g., for voting), user limitation/vendor access, role-based access use, and, of course, security and authentication.

There is great benefit to be achieved for the health system governance process in the consistent collaboration between the general counsel and GSP. Teaming regularly, they can implement a series of low-cost and non-disruptive measures that will improve the board information and communication process and enhance the value of related digital governance practices. Working together, these two critical health system leaders can create an enhanced platform for effective board conduct, which in turn can be appropriately documented. Such collaboration can produce meaningful benefits in terms of increasing the efficiency of board processes and reducing the individual liability profile of board members.

Director Compensation: A Fresh Look

By Michael W. Peregrine, McDermott Will & Emery, LLP, and Timothy J. Cotter, Sullivan, Cotter and Associates, Inc.

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The rapid and comprehensive evolution of the healthcare industry provides a compelling reason to revisit the value and appropriateness of compensating directors of non-profit hospitals and health systems.

What's Changed

The operational, economic, and regulatory forces unleashed by the Affordable Care Act are working to drastically reshape the contours by which healthcare is provided in a non-profit corporate model. The rapid pace of provider mergers/acquisitions is fostering both the growth of large national and regional non-profit health systems, and the related decline of the independent community/local hospital and health center. There is a dramatic shift towards physician integration and population health strategies, and away from those that are patient tower-specific. Creative business arrangements are being pursued with a broad array of venture partners. Substantial emphasis from both regulators and payers is being placed on quality of care. Information technology is playing a profound role in both the delivery of care and the communication of health information. The typical non-profit health system is a larger and more sophisticated business enterprise, with substantially more assets under ownership and control than ever before.

This change is seismic, foundational, and all encompassing. It reaches every corner of the non-profit healthcare sector, and it is resulting in board agendas of unprecedented complexity and challenge. The expectations for, and responsibilities of, the non-profit healthcare director will increase to a degree consistent with the extent of change. Attentive non-profit health systems are evaluating whether their existing governance structures will be sufficient to support long-term sustainability given the evolutionary nature of change.

Why Reevaluate

It is within this context that health systems previously reluctant to compensate their directors may choose to reevaluate that position. There are at least four reasons supporting the wisdom of such a reevaluation.

It's a different job now: Given the magnitude of industry change, the portfolio of the health system director is likely to become substantially more involved. More will be expected from health system boards in terms of commitment to the responsibilities of governance, from all constituencies—regulators, medical staff members, consumers, donors, bondholders—and the media. This increased commitment will be reflected in a number of ways: heightened attentiveness to the board's agenda, greater preparation for particular issues coming before the board, sharper degree of oversight over corporate affairs, and an enhanced willingness

to exercise constructive skepticism for management initiatives. To a significant degree, directors will be working longer, harder, and faster. It's not that the applicable fiduciary standard of care will have changed. Rather, it is the prism through which regulators and the courts will apply that standard of care will have changed—the industry circumstances will have changed materially. In that context—where the director's job is becoming a significantly more substantial commitment—compensation may be increasingly appropriate. The “job description” has certainly changed.

More will be expected from health system boards in terms of commitment to the responsibilities of governance, from all constituencies—regulators, medical staff members, consumers, donors, bondholders—and the media. To a significant degree, directors will be working longer, harder, and faster.

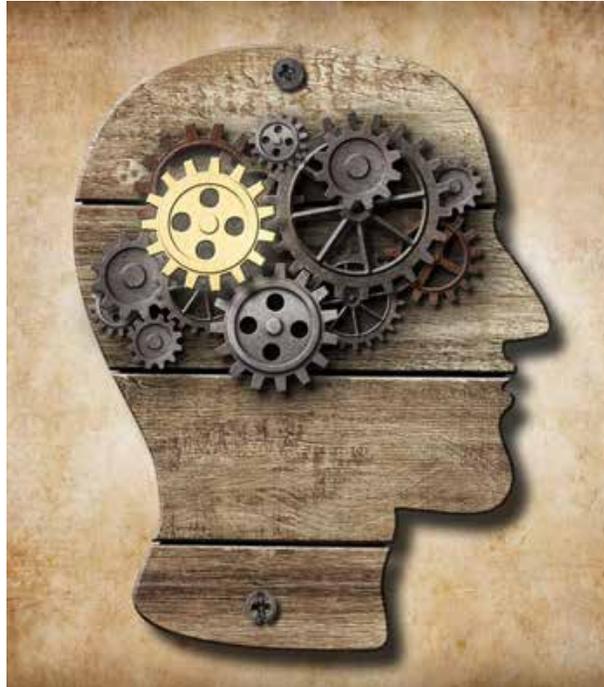
It's a seller's market: An important governance feature of this changed environment is the movement towards competency-based boards (i.e., a board that includes members with subject matter expertise in the emerging areas of the system's investment, commitment, and models of patient care). The premise of this shift is that effective oversight and informed decision making will be supported by including within board membership individuals with atypical skills and backgrounds reflective of the health system's increasingly diversified business portfolio. Areas of expertise most likely to be in demand include quality of care, information technology, insurance and assumption of risk, corporate consolidation, and retail operations.

This is not to suggest that traditional sources of board membership cannot continue to generate highly competent and qualified candidates; rather, it is to suggest that the nominating process can no longer rely on traditional sources alone. The particular challenge is that candidates with unique or atypical expertise are likely to be very popular with boards. For example, some larger non-profit health systems have begun to apply the “fly in director” concept (i.e., going outside the service area to identify the most qualified candidates, and then bringing them to the board). This practice is further enhanced through state laws that allow greater flexibility in terms of meeting through various forms of technology. The problem is that these specially qualified directors are increasingly in great demand by health systems; there is substantial competition for their services from both the non-profit and

for-profit sectors. In such a situation, one (but certainly not the only) factor in the decision to accept a board position is whether the position is compensated.

Liability profile: Compensation may also serve to reduce any lingering concern board members may have with respect to their individual exposure to breach of fiduciary duty liability. There is absolutely no evidence of any major regulatory movement towards holding non-profit healthcare directors personally responsible for violations of the standard of care. There continues to be, however, incidents in which state charity officials have taken high-profile positions against non-profit board members (e.g., the South Carolina attorney general's recent opinion in connection with Tuomey Health Care System). In addition, it is increasingly clear that most state laws that serve to provide non-profit directors with immunity from personal liability arise primarily in the tort context and do not apply to allegations of gross negligence. Finally, there is anecdotal evidence of some D&O carriers increasing their exceptions to coverage. The payment of reasonable compensation may serve to offset the otherwise legitimate concerns a director may have with respect to his/her individual liability profile and the ability of the corporation to provide insurance and indemnification against such risks.

Public policy: In the past, many non-profit health system boards have refrained from implementing director compensation systems out of concern that it would appear inconsistent with charitable, tax-exempt status to provide compensation to board members, no matter how reasonable or modest such compensation may be. In this regard, it should be noted that many state non-profit corporation laws specifically authorize the payment of reasonable compensation to directors for their services as such. Some state laws are silent on the issue, and other state laws (not a majority) don't allow compensation. But there has been no legislative groundswell in recent years to prohibit the practice—despite the expectations of some observers. Indeed, the American Bar Association's Model Nonprofit Corporation Act specifically authorizes the practice of paying reasonable compensation to directors for their services. So, it is a leap of logic to conclude that director compensation arrangements in the non-profit sector are presumptively contrary to public policy. Indeed, it would appear consistent with public policy to support practices (e.g., director compensation) that are intended to facilitate the ability of large healthcare companies to continue to operate within the construct of a non-profit corporate model.



Frame of Reference

Designing a director compensation program for the evolving non-profit healthcare system is no easy task. The published data available on board compensation practices in not-for-profit health systems and hospitals is extremely limited. The most recent survey conducted by The Governance Institute regarding board compensation is the 2013 Biennial Survey of Hospitals and Healthcare Systems.⁵ It reported that 12 percent of the respondents (hospitals and systems) compensate the board chair and 16 percent compensate all or some other board members. Approximately 63 percent of respondents reported board chair compensation is less

than \$5,000 per year and 74 percent reported that board member compensation is less than \$5,000.

This year, there was a significant drop in the percentage of health systems that compensate board members (18 percent vs. 25 percent in 2011, although this is still higher than the 2009 level of 14 percent). Approximately 18 percent of health system respondents compensate the board chair (down from 21 percent in 2011).

The likelihood is that it will be several years before any increase in non-profit director compensation plans prompted by Affordable Care Act-based changes will be reflected in the empirical data. This may require boards, and their ultimate approval body, to rely more heavily on their own business judgment, and on the advice of their independent compensation consultant.

Traditional Decision Factors

It should be emphasized that while the rationale for board compensation may have been broadened by the evolutionary nature of the healthcare sector, the process by which compensation decisions are to be structured, reviewed, approved, and implemented remains fundamentally the same:

- **Application of state law:** This is an analysis of state non-profit corporation law and whether director compensation is authorized or prohibited by state law—or whether the law is silent (which may prompt a discussion with the attorney general's office). This may also involve a review of the implications of a compensation plan on state liability shield protections and on existing director insurance and indemnification benefits. It also involves the confirmation of the reasonableness of the compensation plan, and the associated state and federal tax implications for the individual director and for the health system.

5 Kathryn C. Peisert, *Governing the Value Journey: A Profile of Structure, Culture, and Practices of Boards in Transition* (2013 Biennial Survey of Hospitals and Healthcare Systems), The Governance Institute, November 2013.

- **Approval process:** This is the identification of a process by which the issue of director compensation, the manner in which it might be structured, and the ultimate approval of a compensation plan is fully reviewed and evaluated—with final authority in an approval body with no conflicts of interest or other “stake” in the compensation proposal. Oftentimes, this is a highly critical component of a director compensation plan (at least from the perspective of charity regulators).
- **Structuring the proposal:** The independent compensation consultant may provide a substantial benefit by offering advice on compensation structures that are designed to balance organizational mission with the specific governance needs and challenges imposed on the system by the reconfigured health-care system. There should be no expectation that traditional methods of providing compensation will automatically be effective in the current environment. For example:
 - » Combination of an annual retainer and per-meeting fees for both full board and committee meetings
 - » Additional compensation for board chair and committee chair responsibilities, as these typically involve significantly larger time commitments

- » Reimbursement of travel expenses
- » Liability coverage for board activities

The process of program development must assess if pressing and long-term governance needs can be addressed through those traditional components, or whether more creative means should be considered.

Conclusion

Non-profit health systems are currently struggling with the important question of whether their current governance structure will work effectively given the dynamic forces reshaping the healthcare industry. Many such systems may ultimately choose to make changes to those structures that are designed to enhance the board’s ability to provide effective oversight and informed decision making under new and more complex circumstances. An important part of the board’s deliberations in that regard may focus on the benefits of a targeted program of director compensation.

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

By Michael W. Peregrine and Sandra M. DiVarco, McDermott Will & Emery, LLP,
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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.

Conclusion

The evolving healthcare environment and the recent provider consolidation activity are creating a great number of changes in the industry. As healthcare organizations become more operationally and financially sophisticated the board's role in governance must also evolve.

Boards will need to be more involved in corporate affairs, meaning they will become more hands on when it comes to strategic challenges, be more involved in care and risk management, have a closer eye on senior leadership, and be increasingly willing to intervene when it comes to compliance exposure or reputational harm. As boards become more involved, they need to be cautious that they have the appropriate level of engagement and are not stepping over into management's territory. The rapidly consolidating provider sector is setting new standards for board oversight of business and compliance risk. Charity regulators are taking a harder look at the level of engagement exercised by the board, so it should ask itself whether or not it has a framework in place to adequately provide oversight of these emerging business and compliance risk challenges.

The way board members address quality of care concerns is also being impacted. The board should ensure it is positioned to effectively exercise its quality of care oversight duties in this new era by having an integrated, coordinated process that focuses on the six dimensions of quality oversight. With so much change taking place in the industry, this is also a good time to review the effectiveness of the organization's corporate structure and consider if it is well suited to respond to the challenges of the post-ACA environment. This will require evaluating how the organization carries out the overall mission and if it is efficient from economic, operational, and governance perspectives. If it is not, it's time for the board to make the appropriate changes.

It's safe to say that the role of the healthcare board member is growing and becoming much more challenging. With these challenges comes a need to make sure the board has the right composition, with the expertise and dedication needed to make tough decisions. This may mean revisiting the value and appropriateness of compensating directors and reviewing the board's approach to the director evaluation process to ensure it is

supportive of long-term governance goals. The general counsel and governance support staff will play a big role as the expectations of directors evolve. By working together, they can provide enhanced assistance to the board in the exercise of their fiduciary duties by implementing a framework that will increase information flow efficiency, enhance documentation, and reduce individual liability exposure.

Discussion Questions for Board Members and Senior Leaders

1. In what ways is the board taking a more active role in corporate affairs? Is this the appropriate level of board engagement in today's healthcare environment, and are there clear lines between the board's role vs. management's role?
2. Do we have the proper framework in place to adequately exercise oversight of the emerging new business and compliance risk challenges? What changes may need to be made to better position the organization to respond to these challenges?
3. What does our current corporate structure look like? Are we appropriately positioned to respond to the challenges of the post-healthcare reform environment? In what ways could the corporate structure be streamlined to be more efficient?
4. What changes should we make to our director evaluation process to ensure that it is supportive of the board's long-term governance goals?
5. How can the general counsel and board support staff work together to create an enhanced platform for effective board conduct?
6. Does our director compensation program work for our organization or does it need to be reconsidered given the increasing roles and responsibilities of board members? What benefit would we see from providing directors compensation/higher compensation?
7. What is the board's role in quality oversight at our organization? Is the board's oversight role clear and how is it working with the medical staff and executive leadership to exercise its oversight duties?

