

Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Editorial

Governance is "Risky Business"

By David B. Nash, MD, MBA
Editor-In-Chief

Last summer marked the 6-year anniversary of our partnership with Eli Lilly and Company to bring you our collaborative newsletter, *Prescriptions for Excellence in Health Care (PEHC)*. This issue is the first in a series devoted to an extremely important but often overlooked and underappreciated element in the process of transforming US health care – the critical role of hospital boards in ensuring the quality of care.

Before 2000, quality and safety were largely missing from hospital board agendas, if they were discussed at all. With the nation's slow but steady push toward transparency and accountability in health care, things are beginning to change for the better at the governing board level. However, we still have a long way to go to understand how the definition of quality has changed in this new era of accountable, integrated care (ie, identifying the short- and long-term implications for board responsibility, determining how best to design and deliver appropriate training for board members).

If you are at all skeptical about the importance of the topic, consider this. Currently, the boards of over 5000 community hospitals in this country

are populated largely by businesspeople (eg, the local car dealer), philanthropists, religious leaders, and local politicians. All of them make a huge time commitment, most serve without pay, and – whether they fully realize it or not – all are at personal risk for fulfilling the fiduciary responsibilities of their organizations.

With the advent of pay for performance, hospitals are now at financial risk if they fail to meet specific quality metrics around “never” events (eg, wrong site surgery, readmission for heart failure within 30 days of discharge). Good governance dictates that clinicians cannot be held solely responsible for a hospital's quality and safety record. Counterintuitive as it may seem, the nonclinical members of the governing board bear responsibility for the hospital's clinical outcomes. That being said, we

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determined that the timing was right for an in-depth discussion.

We set the stage for the series with a high-level overview of governance, *“The Future of Board Governance: The Board as a Mosaic of Talent,”* an engaging account of where we’ve been and where we’re going from a “30,000-foot” perspective.

The second article, *“The Board’s Role in Quality and Patient Safety,”* offers a comprehensive summary that explains the rationale for board involvement, discusses the evolving definition of quality, and hones in on the various levers, tactics, and tasks for ensuring success. Next, we drill down

a little further into some essential elements for good governance in an aptly titled article, *“The Journey to Better Governance: Board Education, Competencies, and Self-Assessment.”*

With the Affordable Care Act firmly in place and the Accountable Care Organization (ACO) model gaining traction, the final article, *“Pioneering at the Trust Frontier: The Expanded Role of Governance in ACOs,”* takes a look at the complexities of multiorganization boards and the additional oversight challenges they pose.

To date, there are no “how-to” textbooks or programs that cover this topic. However, an organization called

The Governance Institute (www.governanceinstitute.com) has developed a variety of resources and tools to help equip boards for success. Among their offerings are regular regional leadership conferences. The complete schedule of programs is available on their Web site at <http://www.governanceinstitute.com/Conferences/ConferenceCalendar/tabid/79/Default.aspx>. On February 10, 2013, I will be coleading a preconference education session at the Governance Institute’s Winter Meeting in Palm Beach, Florida, and encourage interested readers to attend.

As always, I look forward to hearing from our readers. I can be reached at: david.nash@jefferson.edu.

The Future of Board Governance: The Board as a Mosaic of Talent

By James Kristie

Over the past 3 decades, the public company board of directors has evolved from a board composed of friends, family, and social and business acquaintances of the chief executive officer (CEO) to a board now dominated by independent members who have no unduly close ties to the top management of the company. It is a board that has gone from being what is derogatorily referred to as an “old boys’ club” to a board that is being remolded to be a “mosaic of talent”: each member selected for a specific background or skill set that he or she can bring to complement the overall mix of expertise sitting around the board table.

This review provides a basis for projecting how the future of board governance, specifically in terms of board composition, will continue to unfold. To the extent that there is a “spillover effect” of corporate practices

being adopted into the not-for-profit sector — a trend recognized by Jefferson School of Population Health Dean David B. Nash in his coauthored (with Sean Patrick Murphy and Anne D. Mullaney) article, “Governance: Current Trends in Board Education, Competencies, and Qualifications”¹ — the forces that caused a rethinking and remaking of public company board membership are worthy of close attention by leaders of private and not-for-profit health care institutions. To see how this evolution has played out, here are a few key milestones of change.

The 1970s

The Securities and Exchange Commission began a bully-pulpit campaign for a more independent board. An ideal board, in its view, would be one composed entirely of independent directors, with the

chairman and CEO roles separated. Other developments at work:

- Nominating committees were being formed as a separate and distinct formal board committee. General Motors (GM) had one of the first when it established its committee in 1972.
- Women began to enter the boardroom in growing numbers. Pfizer, for example, added the first woman to the board in 1976.
- The stock exchanges began to take the concept of an independent board more seriously. In fact, the New York Stock Exchange threatened to delist Johnson & Johnson in 1978 unless it added the first independent directors to its board.

The 1980s

Building on this initial momentum for a less management-dominated and insider-populated board, these 3 developments advanced that evolution:

1. *Corporate takeovers:* With many companies still operating as conglomerates of unrelated businesses, their stock prices often sold at far below breakup calculations. Raiders such as T. Boone Pickens and Carl Icahn took notice and began preying on such “mispriced” companies. Shareholders started paying attention to how boards handled the transactional deal making.
2. *Activist courts:* Precedent-setting decisions, frequently an outcome of bungled Merger and Acquisition behavior by boards, were issued by the influential Delaware Chancery and Supreme Courts, pointing to the need for directors to be much more diligent about their fiduciary duties.
3. *Rise of the institutional investor:* With the big bull market that started in 1982 and the huge inflows of funds into new retirement vehicles such as individual retirement accounts, institutional investors began owning larger percentages of company stock. Proxy voting became a tool for shareholders to more aggressively assert their ownership rights when unhappy with management and the board.

The 1990s

As we entered the 1990s, shareholders were more vocal and had more muscle to push back on boards, as did boards on management. What happened then?

- *When corporate performance faltered, boards were less willing to sit idly by:*

A bevy of CEOs began to get the boot. In 1 year alone (1993) the CEOs of IBM, American Express, Westinghouse Electric, and Kodak all were fired by “suddenly emboldened” boards.

- *Boards formally codified their roles and responsibilities:* This move was inspired by the board of GM, which in 1994 issued a set of 28 governance principles that laid out for all the world to see how the GM board would conduct itself—from determining the board meeting agenda to how it would select new board members.
- *Rise of the lead director:* A new position began appearing in boardrooms—a single member designated to be the leader of the independent directors on boards that lacked a separation of the chair and CEO.

The 2000s

Two historic pieces of legislation further solidified the professionalism of boards:

- Despite having a highly credentialed board, the Houston-based energy company Enron collapsed almost overnight into bankruptcy in 2001, and the next year Congress unleashed Sarbanes-Oxley. The law mandated that a board have a “financial expert” among its members, an important precedent highlighting the need for a specific skill set on the board.
- The Great Recession provoked the Dodd-Frank Act, signed into law in 2010. One provision, again pertinent to this analysis, is that boards now must codify their policy on board diversity and enumerate the qualifications of their board members.

What the Future Holds

Looking to the future after this 30-year sequence of initiatives for boards to become more independent, the big issue is, “How can boards get smarter about the organizations they govern?” In recruiting a new director, the prevailing marching order no longer is to “get the best person available.” That was how it was done when I entered the field 30 years ago. Today, boards follow a different script: “What’s missing on our board . . . and let’s find the right person to fill that gap.”

So what recruiting trends can we expect to see that will make boards more knowledgeable and skilled overseers of their organizations? Here are 5 prime trends:

1. *Fewer CEOs, more senior executives:* For decades, getting a “sitting CEO” has been the gold standard for a new board member. But CEOs, fearing the liability and time commitment required, are cutting back dramatically on the number of outside corporate boards they will take on. Plus, their own company boards are restricting them from outside board service. Up-and-coming senior officers are prime candidates. This is seen as a career-enhancing step for them, so the expectation is that they will be more diligent in taking their oversight role seriously.
2. *Greater gender diversity:* Women represent about 16% of the membership of Fortune 500 boards, a number that has not moved much in a decade. With board quotas catching on in Europe, there is a “gathering storm” of women’s organizations here in the United States pushing for greater participation of women on boards.

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Fueling the movement is a growing body of literature that links higher performance of companies with greater representation of women on their boards.²

3. *Age diversity*: With 62 as the average age of a corporate director, attention is being focused on the “graying” of corporate boards as a governance weakness.³ Expect to see a younger cohort advance into the boardroom to reflect the information age and the rapidity of technological change.

4. *The “social” director*: In 2011, Starbucks Corp. added to its board a 29-year-old CEO of a social media company. That action riveted attention in the governance world. One top recruiting firm confided that as of April 2012 it had 40 open searches under way for directors with social media expertise.

5. *Other in-demand skill sets*: Desired directors will include: senior human resource officers to help boards with talent management and compensation oversight issues; health care executives to help boards with health care delivery and cost management issues; and executives with legal backgrounds, such as retired general counsels, to help boards meet their expanding compliance responsibilities.

The Mosaic of Talent

This set of broad brushstrokes shows how corporate boards have professionalized their membership over the past 30 years, moving decisively from a “who’s available?” to a “who do we need?” imperative in recruiting new members. Corporate America has gone from a look-alike, think-alike board to a board as a mosaic of

individuals with diverse but additive expertise, strengths, personalities, and backgrounds as well as ages and sexes. Some of these forces have already, or may yet, exert themselves in the remaking of health care institution boards for an era of profound changes to their missions and businesses.

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The Board’s Role in Quality and Patient Safety

By Evan M. Benjamin, MD, FACP

Governing boards have come a long way in comprehending and accepting their roles in and responsibilities for quality and patient safety. In addition to grasping and navigating the organization’s financial health, boards now realize that it is necessary to comprehend the quality of health care delivered by their organizations.

Over the past decade, progress made in the science of improvement, and increased national attention on improving population health, have created the imperative for boards to not only comprehend quality and safety but also to focus attention on the important

work of improving value for their patients. Governing boards must have in-depth knowledge of the challenges of providing reliable care, the role of systems in health care settings, the existing waste and redundancy in health care systems that may lead to significant geographic variation in health care costs, and the significant amount of harm that still is produced within the health care environment today.

A Bit of History

To better appreciate the needs of governing bodies, it is important to understand the history of governing boards of health care organizations.

In 1965, a landmark legal decision in the case of *Darling vs. Charleston Community Memorial Hospital* placed the ultimate responsibility for the quality of patient care with the governing board of the hospital. In this case, an Illinois star athlete’s broken leg was set improperly by a physician at the hospital, and the landmark decision clearly placed the role of oversight regarding the quality of care on the board of the hospital.

There was a veritable era of weeding out poor quality from 1965 to 1990; peer review systems were established and quality “assurance” programs

were created to begin identifying poor performing physicians in hospital settings. Additionally, in 1984 Donabedian articulated 7 pillars of quality that health care providers must incorporate into their delivery systems: efficacy, efficiency, optimality, acceptability, legitimacy, equity, and cost. Although his paper was a breakthrough in thinking about improvement of health care quality, surprisingly few providers took on the challenge of developing a systematic approach to health care quality improvement.

In 1999, the Institute of Medicine (IOM) published *To Error is Human*, which heightened awareness about human factors that influence health care delivery and articulated the rate of errors that occur in a health care delivery system. In 2001, the IOM issued a follow-up report, *Crossing the Quality Chasm*, which outlined the aims of medicine and affirmed that all health care should be safe, timely, effective, efficient, equitable, and patient-centered. Three years later, the National Quality Forum issued a "call to responsibility" for health care boards to understand and accept their roles in providing oversight of the quality and safety of health care.

Provider organization governing boards must thoroughly comprehend this history to fulfill their fiduciary responsibility.

Transparency and Accountability

Because fiduciary responsibility has expanded to include not only the financial health of the provider organization but also oversight of the quality of care it provides, boards must address the business case for improving quality. The substantial financial costs of poor quality include complications (eg, adverse drug events, hospital-acquired infections) that may occur,

adding significant costs to a patient's episode of care. Governing boards must understand that financial improvements will result when health care providers practice with "standard work" and decreased practice variation. Improved outcomes and better patient experience lead to a more positive bottom line for health care organizations.

Today there is increasing emphasis on transparency and accountability for the entire spectrum of health care delivery components. Health care organizations are expected to share data on the quality and safety of the care they provide and to assure that care is delivered in the most efficient manner. Calls for increased data transparency have led to health care organizations being measured on the quality, safety, and costs of care. Such data are now publicly available - yet another impetus for organizational transparency and accountability.

Numerous national initiatives to promote the transparency of quality, safety, and costs have been implemented:

- In 2005, Medicare launched a pay-for-performance demonstration program that was modified to create a "value-based purchasing" program in 2011. Health care organizations are now being paid for quality of care and patient experience scores. Financial penalties for poor care (eg, hospital complications) soon will be launched by Medicare.
- The Institute for Healthcare Improvement has rallied for and modeled the use of data transparency to leverage and transform quality and patient safety.
- The newest initiative from Medicare is the Partnership for Patients

campaign to reduce both harm and avoidable rehospitalizations.

These initiatives emphasize the urgency of and create the platform for early organizational adoption and integration that ultimately will help attain the desired results - improved quality and patient safety and lower costs. With additional insight, governing boards will begin to anticipate issues and continually incorporate quality, safety, and efficiency outcomes into the organization's infrastructure and strategic goals.

Defining Quality

In order to judge the success of the organizations they serve, boards must understand how quality is defined and measured in the context of health care. Unfortunately, there is no universal agreement on a succinct definition of quality or on appropriate measures to help define health care quality.

Most boards would agree that the purpose of health care is to decrease morbidity from disease processes and to improve the productivity of their community members through caring for the sick as well as preventing other illnesses.

A few definitions of quality are worth exploring.

The IOM defines health care quality as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."* This definition allows many providers to feel comfortable with the care they are providing, yet it lacks specific measures that could lead to actionable steps to improve health care quality.

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Donabedian suggested that we think about health care quality in terms of 3 components: structure, processes, and outcomes. This is a preferable approach, incorporating elements that are more actionable for health care organizations desiring to improve health care quality. *Structure* allows an organization to assure that it has the appropriate facilities and equipment to provide excellent care. Reliable *processes* reflect the organization's ability to provide evidence-based medicine and to achieve the outcomes desired. And finally, *outcomes* are measured in terms of importance to the patient (eg, decreasing morbidity or mortality).

Emerging definitions of health care quality focus on patient-centered definitions of quality. A patient-centered definition allows an organization to look internally at the kind of care it provides. Patient-centered care is care wherein:

- patients have access to care by multiple means;
- care is based on patient needs and values;
- patients are the source of control;
- there is shared knowledge and a free flow of information between providers and patients;
- decision making is evidence based and specific to the patient's situation;
- safety is a fundamental attribute of the organization;
- care anticipates the patients' needs.

Finally, we must broaden our understanding of health care to encompass "value." Boards need to

have basic knowledge of how to define the value of the health care their organizations deliver to the populations they serve. In this era of health care reform, we are called on to appreciate the impact of health care on the population and the costs of care for our communities. With its focus on value, this contemporary definition of quality will certainly take boards in new directions as they consider their fiduciary responsibility and their approaches to organizational modeling and operations.

The Board's Connection

Governing boards have a very significant role in defining and shaping the context in which services are delivered within the organization. The board oversees infrastructure such as facilities, medical staff, and the tools necessary for improvement. The board selects what processes will be in place, what services the organization will deliver, what departments exist, and what kind of procedures will be done. Importantly, the board has oversight over all of the outcomes the health care delivery system achieves; hence, measuring and improving these outcomes are a vital part of the board's responsibility.

The board must recognize and acknowledge its role and responsibility in ensuring quality of care by directing the creation of a culture of patient safety within the organization and supporting the efforts necessary to achieve clinical excellence. By becoming educated about the measures of health care quality and the improvement science that results from analysis of data, the board will improve its oversight of health care quality.

Levers of Governance

To fulfill its responsibilities, the board can use certain levers of governance to help the organization achieve its

goals: (1) Mission, (2) Culture, (3) Performance, (4) Leadership, (5) Strategy, and (6) Resource allocation.

1. Mission. The hospital's mission states the organization's purpose and establishes the direction of its journey. Accountabilities generally fall into 3 categories for the mission: quality of care, access to care, and stewardship. The governing board has the ability to alter the mission to provide oversight of these 3 major categories.

2. Culture. The governing board has the responsibility to assure that the health care organization's culture includes quality among its highest values and provides the ongoing resources and support necessary to fulfill its commitment to health care quality. The board must ensure a culture of improvement and a culture of patient safety throughout the organization.

3. Performance. Boards must ensure that the organization commits to a definition of quality that addresses the needs of its stakeholders and that the definition is operationalized through performance measures that help its leaders evaluate the extent to which the commitment is being fulfilled.

4. Leadership. The board must ensure that health care quality is understood by leadership at both the management and board levels. Finding the proper expertise for management and governance becomes the ultimate responsibility of the board.

5. Strategy. Boards are obligated to ensure that the organization has strategies, goals, and performance

measures in place to foster performance that both enables and supports mission achievement. Because quality and patient safety are so critical to fulfilling the mission, the organization's board has the responsibility to make sure there is a strategic plan to improve health care quality, patient safety, and the overall value of the health care delivered.

- 6. Resource allocation.** Boards often are faced with difficult decisions and trade-offs between cost, quality, competitiveness, and efficiency. Boards must pay special attention to the appropriate allocation of resources that will help to achieve high-quality *and* low-cost care. The board must stay focused on what is important for the delivery of health care and on the mission of the organization.

Tactics for Board Engagement in Quality

Four tactics can help the board become engaged in health care quality: (1) increasing the quality literacy of the board, (2) creating an agenda for quality, (3) quality planning and focus, and (4) sharing patient-centered stories.

- 1. Literacy.** The board must become educated on salient issues regarding quality beyond those related to public reporting. A quality expert should sit on the board to help initiate and lead discussions about what defines health care quality. Board retreats offer opportunities for in-depth dialogue on quality and safety projects. Finally, board members should attend national health care conferences.
- 2. Frame an agenda.** The board chair and the chief executive officer should meet to discuss the status of quality in the organization. At

every meeting, the board should hear how the hospital is progressing in terms of quality, what barriers exist to achieving breakthrough performance, and how the board can support improvement of health care quality. A discussion of quality on the board agenda at every meeting ensures that it will get equal billing with other important agenda items.

- 3. Quality planning.** The board should help create a vision for quality as part of the health care organization's long-term measures and goals, such as target quality measures (eg, mortality, complications) and value-based purchasing measures. The board should review the organization's quality plan for conformity with the overall strategic plan and should review appropriate quality measures on a regular basis.
- 4. Patient-centeredness stories.** Patients' stories should be shared with the board at its meetings to further increase the focus on patient-centeredness. Sharing patient stories ensures that the board stays focused on the processes and the barriers to improving the quality of care. Positive and negative stories highlight the importance of the many quality initiatives going on throughout the organization.

Tasks to Improve Quality

There are 4 specific tasks involved in improving the quality of care:

- 1. Establishing culture.** Boards should ensure that management has an understanding of safety that includes training in systems thinking as well as in improvement science. Organizations that use human factors to help design processes have better results and better care.

Board members can participate in promoting a culture of safety by walking around the organization with management, focusing in on errors, teamwork, and transparency so that everyone sees the goals of creating a culture of safety.

- 2. Establishing performance goals.** Boards must set specific performance goals for the organization. Some boards use the IOM aims (ie, safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) to help decide upon measures for their organizations. Newer measures to evaluate the health care delivery system's impact on improving population health, per capita costs, and patient experience also could be used. The data must be readily available and used on a regular basis to help drive improvement. Accountability for these performance goals must be incorporated into management's responsibilities.
- 3. Promoting leadership collaboration.** Boards must ensure that management and physicians are collaborating to achieve improvements in quality, patient safety, and value. The medical staff must be engaged in health care quality and its leaders must be committed to establishing a culture of improvement and safety for the organization. These medical staff leaders must be able to work in a multidisciplinary fashion with management teams to create "standard work," to decrease practice variation, and to improve health care quality.
- 4. Empowering a Quality Committee** Finally, the board should establish an independent governance committee to oversee quality of

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care. The Quality Committee must be multidisciplinary, involving physicians, nurses, and board members as well as experts in improvement. Oversight of the Quality Committee includes performance improvement, clinical outcomes, patient satisfaction, and patient safety. Literacy in health care quality, patient experience, and measurement are required for members of the Quality Committee. The health care Quality Committee should demand total transparency throughout the organization and use performance data to help drive improvement.

Conclusions

There are new levels of transparency and accountability in health care delivery today. Governing boards have a specific call to responsibility in providing oversight of the quality of care that the organization delivers. There are specific levers of governance that boards can use to help

improve health care quality and there are specific tasks that a board can employ to improve the oversight of health care quality. As health care organizations move forward in the era of health care reform, understanding the value that health care organizations provide with regard to improving population health in a cost-effective manner will become paramount to the role of governing boards.

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The Journey to Better Governance: Board Education, Competencies, and Self-Assessment

By Sean Patrick Murphy, Esq.

It is no secret that governing boards - including hospital and health systems boards - are under enormous pressure to become more accountable and effective. Good governance is a challenge for hospitals and health systems as they continue to transform themselves in response to these pressures. The role of the governing board is oftentimes unclear in this challenging environment. This article will examine 3 recent governance trends that can make a difference in building a better board: notably, (1) the movement toward “formal board education” programs, (2) the concept of director and board competencies, and

(3) the increasing demand for board and director assessment.

Board Education

Today, everyone understands the value and importance of board education, especially in the exceedingly complex health care industry. However, the demand for “accountable governance” has driven many stakeholders and governing boards to go further by pursuing formal board education programs. By 2011, eleven state hospital associations had instituted some form of voluntary, formal board education program for hospital boards and

directors. New Jersey passed legislation requiring that directors and trustees of hospital boards receive 7 hours of formal board education as a legal requirement and condition for serving on a hospital board. Since then, Delaware, Arkansas, and South Carolina state hospital associations have implemented formal board training programs for their hospital trustees and directors.

Why the trend toward formal board education? Some might argue that it provides a baseline for educational competency, demonstrating to stakeholders that the hospital’s directors

and boards have taken the time to complete formal training and education. Others might argue that a voluntary state hospital association initiative could possibly help to ward off potential legislation that would mandate it, as was the case in New Jersey. Finally, as the vast majority of hospital directors and trustees are volunteers who serve without compensation, it can be said that there are many who pursue such programs in the spirit of service.

These programs are not without their critics. Many state associations appear to be opting out of formal certificate/certification programs because they believe that the programs are not sufficiently rigorous or that they provide a false sense of competency and achievement. Clearly, health care governing boards need - and will continue to need - plenty of education, especially in light of the many upcoming changes to the payment delivery system. However, the jury is still out as to whether these state association initiatives will prove to be a definitive vehicle for establishing board educational competency, or whether they will need to do more.

The truth is that the educational needs of governing boards are not likely to be satisfied merely through certificate programs. Health care is complex, and each director and governing board is unique. Although these certificate programs arguably could provide some core training for boards, they need much more.

Board education programs should be aligned with comprehensive board orientation programs. Such programs acquaint new directors not only with health care in general but also with the organization they will be governing, including market dynamics and upcoming changes in the delivery

system (ie, health reform). Further, a recent governance report published by the Alliance for Advancing Nonprofit Healthcare suggested that governing boards conduct individual director educational assessments to target specific needs and opportunities to enhance board knowledge and performance through education.

Competent and Qualified to Govern

Another emerging issue is board competencies (ie, assessing whether governing boards and individual directors are competent and qualified to govern). In 2009, the American Hospital Association (AHA) Center for Healthcare Governance's Blue Ribbon Report ultimately defined competency as the combination of knowledge, skills, personal characteristics, and individual social behaviors needed to effectively perform a job.

A closely related concept is whether a governing board is "qualified" to govern. In February 2010, the Securities Exchange Commission (SEC) issued a new series of regulations on director qualifications for publically traded companies. The SEC regulations require that corporations disclose to shareholders biographical information about directors and nominees so that shareholders may determine whether directors have the requisite qualifications to govern.

Although competency-based governance continues to gain acceptance as an important standard of governance, health care organizations have been slow to react. In fact, a 2011 AHA Center for Healthcare Governance report indicates that the vast majority of health care governing boards are not employing "competency-based" governance standards. Further, and perhaps more troubling, is that those health care organizations that do employ

competency-based tools continue to rank finance and strategic visioning as the "top 2" competencies—with patient safety and quality rating a distant fifth place.

In an age of increasing transparency, hospitals and health systems are well advised to take standards for board competencies and qualifications more seriously. Further, as health care migrates from fee for service to population health, hospitals and health systems would be well advised to gain substantial expertise in quality and safety as this will be the foundation for both payment and performance in our new value-based system of health care.

Board and Director Evaluation and Assessment

A final area of increasing importance is evaluation and assessment, particularly individual director assessment.

Feedback is essential for both personal and professional growth and maturity. This is true for the governing board. A 2010 Governance Institute study revealed that the vast majority of directors and chief executive officers believed that feedback about individual director performance would help improve governance and help build a better board. Yet, a 2011 AHA Center for Healthcare Governance survey indicated that most boards are far off the mark. Fewer than 25% of those surveyed indicated that individual board members conducted self-assessments and that fewer than 3% conducted peer-to-peer assessments.

In this instance, there is wide disparity between what boards and directors think they should do to become better boards and what they actually do. This is not surprising as most hospital and health system directors and boards are volunteers, and those who are compensated receive fairly negligible

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remuneration for the time they spend and the responsibilities they bear. Under these circumstances, some directors might find it disconcerting to have their behavior and performance evaluated by others, including their peers. However, this need not be the case.

Communication is at the heart of evaluation and assessment. The purpose of assessment is to strengthen the board by providing helpful, productive feedback that will not only build a better board but also will enable directors to maximize their capacity and potential to be contributing, effective board members. There are many tools and techniques that boards can employ to accomplish these goals without imputing a harsh, hypercritical evaluation technique. Further, if done properly, each director should be given the opportunity

to comment on the board itself to help build a better, more effective board and to help keep directors involved, interested, and engaged.

Conclusion

We are moving away from an era in which boards and directors were merely “presumptively qualified” by their resumes (ie, their training, education, experience) and moving toward a model of board accountability and effectiveness. Board education, competencies, and qualifications, and board and director assessment are 3 areas that hospitals and health system governing boards can embrace to meet the challenges of changing systems of governance. The opportunity exists to build highly effective and accountable health care governing boards.

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Recommended Reading

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Pioneering at the Trust Frontier: The Expanded Role of Governance in ACOs

By Nathaniel Foote, JD, MBA

Accountable Care Organizations (ACOs) are at the heart of initiatives to reform health care delivery under the Affordable Care Act (ACA). ACOs are designed to move payment structures beyond the perverse incentives of “fee for service.” They build in rewards for delivering more efficient, high-quality care by creating accountability for a specific patient population and sharing in the savings derived from delivering care to that population.

Although some ACOs are fully integrated delivery systems governed by a single board, they were explicitly designed as a construct to bring together multiple corporate entities to function as an integrated system of care. This article focuses on the implications of this multi-entity construct for board governance, and elaborates on the following propositions:

- In bringing together multiple corporate entities to act as part of an integrated system, ACOs create an expanded role for governance.
- The dual demands on ACOs for both cost and quality create a strengthened imperative for effective board oversight of care quality.
- To succeed, ACO boards will need to embrace responsibility for developing and overseeing an aligned, high-commitment, high-trust system of care for patients.

Multi-entity ACOs Expand the Role of Board Governance

ACOs create a formal legal structure that enables “shared governance” so that multiple corporate entities function as a coordinated system that

is accountable for the care delivered to a population of patients and that provides a mechanism to receive and distribute payments for shared savings.

Historically, there have been various legal barriers to coordination across independent provider entities. Implementation of the ACA explicitly sought to address these; for example, providing ACOs with waivers of the application of the Physician Self-Referral Law, the Federal antikickback statute, and applying a “rule of reason” antitrust test (rather than per se illegality) for price setting and market allocation agreements among competing providers who participate in an ACO, including explicit support for risk-sharing arrangements that promote efficiency.

With these barriers removed, the challenge for ACOs is to develop an organizing approach that achieves effective coordination and integration across entities to optimize patient outcomes. To the extent that multiple institutions are involved, each with its own governing board, the required integration of decision making and cross-boundary coordination cannot rely on a single hierarchical line of authority, because the line of accountability within each institution runs from its administrative and clinical leadership to its own board. Instead, achieving effective coordination and integration depends on an expanded governance role for the ACO board. Specifically, the accountability of constituent entity boards to the ACO board serves as the basis for the administrative and clinical leadership of the ACO to provide direction to the enterprise. Figure 1 illustrates how the authority of ACO leadership is derived from that of the ACO board in a multi-entity structure.

Dual ACO Responsibility for Cost and Quality Creates a Strengthened Imperative for Effective Quality Oversight

Although enhancing the effectiveness of board oversight of the quality and safety of patient care has been a major focus in health care for nearly a decade, the imperative for ACO boards is even greater. With powerful incentives to reduce costs, ACOs will be under heightened scrutiny from patients and other observers for any signs that they are sacrificing quality to cut costs. Indeed, the ACA invited such scrutiny by including stringent requirements around transparency of ACO performance on both quality and patient satisfaction dimensions.

In particular, ACOs must overcome the legacy from our earlier experience with health maintenance organizations. As

the Department of Health and Human Services noted in promulgating the final rule implementing ACOs under the ACA, “Many commenters were concerned that the Shared Savings Program has similar characteristics to some forms of managed care where it is possible to achieve savings through inappropriate reductions in patient care.”

It follows that ACO boards must understand that ensuring unimpeachable quality and safety of patient care is central to their institutional mission and viability, and is necessary to ensure patient confidence in the integrity of the ACO’s clinical decision making.

Board Governance Role in Ensuring High-Trust, High-Commitment Systems of Care

In addition to a strong focus on quality, a multi-entity ACO board must play an expanded role in overseeing the effectiveness of the care delivery system, ensuring:

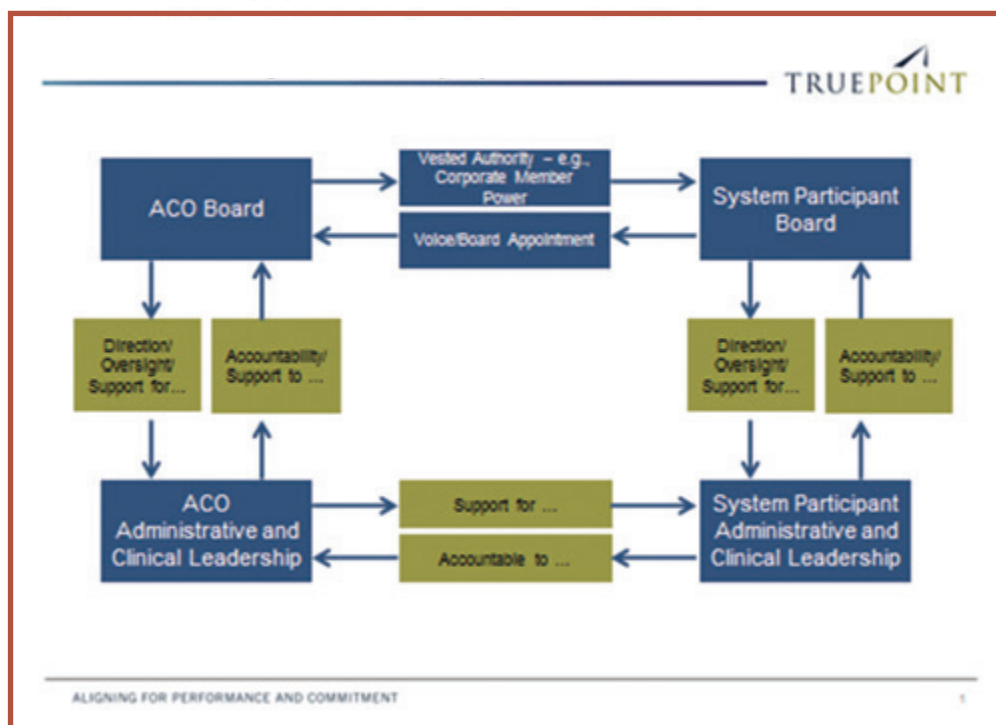
- An effective system design and corresponding funds flows to align incentives around providing high-quality, cost-effective care.
- A shared culture and commitment to a common purpose of effective patient care that enables effective cross-boundary collaboration.

System Design to Align Incentives

The board has ultimate responsibility for the design of the system of care, so as to enable and reinforce appropriate patient referral flows and clinical decision making. Key elements include the effective design of accountability units and their corresponding funds flow to provide incentives to optimize “Triple Aim” outcomes.

Board focus on system design is particularly important because of the fundamental shifts in relative bargaining power that the move to a patient

Figure 1. ACO Board Authority Sets the Context for Effective Executive Leadership in Multi-Entity Systems



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population perspective is likely to set in motion. Patient care likely will become more primary care centered, with funds flow models that increasingly treat the primary care practice as accountable for "Triple Aim" outcomes for its patients and, specifically, total medical expense. Conceptually, primary care will become the purchaser of services from specialty, hospital, and ancillary services. To the extent this occurs, it will put significant pressure on specialists, who become cost centers rather than profit centers, and on shifting care out of higher cost tertiary institutions into more cost-effective community hospitals.

The ACO board may well be confronted by constituent entities that are more focused on protecting legacy positions and assets than on the optimal design for the future, and

will need to be actively involved in negotiating a viable path.

Culture and Commitment to the Purpose of Patient Care

In addition to ensuring aligned accountabilities and financial incentives for effective system functioning, ACO boards also will need to focus attention on promoting a shared culture and mind-set among system participants to enable effective collaboration across entity boundaries.

ACO Boards will need to appreciate that the enterprise is both an economic entity and a social institution in which individual providers' sense of affiliation and commitment is shaped by the extent to which they believe there is a meaningful common purpose and a community of colleagues with whom they identify.

Multi-entity ACOs represent an attempt to gain the benefits of functioning as an integrated system without moving to full asset merger. The paradox for these ACOs is that what they are trying to do is harder than functioning within a single system; therefore, they must work harder on mind-set, trust, and commitment – starting with the ACO board.

Whether multi-entity ACOs represent an approach that is viable over the long run, or simply a transitional stage to greater consolidation of integrated systems, will depend heavily on how effectively ACO boards are able to address the governance challenges highlighted in this article.

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