Strategic Quality Oversight by the Hospital/Health System Board of Directors

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In today's healthcare climate, quality drives success. A hospital or health system board of directors that lacks an overriding commitment to quality and a high level of quality literacy cannot expect to have its system survive and flourish in the healthcare marketplace.

Quality is at the heart of:

- The hospital's finances, in light of the federal reimbursement system under the Affordable Care Act (ACA)
- Much of the False Claims Act (FCA) litigation being initiated against hospitals on a regular basis by the government and private *qui tam* relators
- Medical staff credentialing, and related antitrust and state law liability exposures
- The provision of patient care services, and related corporate liability exposures, accreditation, and federal and state licensure exposure
- Staff morale and workplace safety and satisfaction
- The hospital's ability to form accountable care organizations (ACOs), population health management systems, and other forms of clinically integrated networks (CINs) that will expand the organization's reach through partnerships with physicians and other providers

With all of these factors driving the quality agenda, a hospital/health system board should be making quality a strategic focus of its fiduciary oversight activities. This requires substantially more than the creation of a quality committee with specialized expertise to evaluate and oversee the quality of services provided. It requires integrating into the board decision-making process, at every key juncture, questions as to how the decision will positively impact quality, what steps are being taken to maximize the positive quality impact, and how the positive quality impact will be measured and evaluated as part of assessing the overall success of the hospital or health system's strategic plan.

The ACA's Quality Drivers

The federal ACA legislation is premised on the notion that, over the long run, the key to bringing our nation's spiraling healthcare costs sustainably under control is by radical improvement in the quality and safety of the nation's care delivery system, so as to eliminate errors, redundancy, and unneeded services that drive up the cost of care.

The ACA has created a multi-pronged approach to quality and safety. First, it uses the "power of the federal purse" to mandate quality and safety improvement tied to eligibility for Medicare and other federal healthcare program reimbursement. The Value-Based Purchasing (VBP) Program conditions full Medicare reimbursement for hospitals on the achievement of specified quality metrics designed to drive quality improvement in the nation's hospitals.[1] By 2017, CMS will be withholding 2 percent of all Medicare payments to hospitals annually, and hospitals will be required to establish their entitlement to participate in the withhold pool by meeting CMS's metrics for appropriate treatment of heart failure, myocardial infarction, pneumonia, and surgical infection.[2] Hospitals and health systems will be measured both in terms of absolute achievement and in the extent of their improvement over prior years, and only the top performers will be eligible to recoup any portion of the withheld payments.[3] Although the at-risk dollars are relatively small under the current design, it is not unreasonable to foresee future Congressional action to increase the amount of the withhold once the program is underway.

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The ACA also extends the reach of the "never events" programs that were created in prior federal legislation. "Never events" are defined as those hospital-acquired conditions that are 1) high cost or high volume, 2) result in a higher DRG payment to the hospital, and 3) *could reasonably have been prevented through the application of evidence-based guidelines*.[4] Under the ACA, as of 2015, the 25 percent of hospitals and health systems across the nation that have the highest number of "never events" will be levied a 1 percent penalty in their Medicare reimbursement.[5] Medicare payments are also reduced for hospitals and health systems with higher-than-expected readmission rates.[6] And states are now

1 42 U.S.C. § 1395ww(o); see Elisabeth Belmont et al., "A New Quality Compass: Hospital Boards' Increased Role under the Affordable Care Act," *Health Affairs,* Vol. 30, No. 7, July 2011, p. 1,283; see www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html.

2 *Ibid.*

3 *Ibid.*

4 CMS, *Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals Fact Sheet,* October 2012 (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/downloads/HACFactSheet.pdf); Belmont, 2011, pp. 1,282–83.

5 42 U.S.C. § 1395ww(p); see Belmont, 2011, pp. 1,282–83.

6 *Ibid.*

required to adopt their own "never events" policies as a condition of continuing to receive federal Medicaid dollars.[7]

In addition to the ACA's somewhat "punitive" quality-based reimbursement provisions, the ACA provides financial incentives for *voluntary* engagement in innovative approaches to improving care. The most widely known is the Medicare Shared Savings Program (MSSP). This program encourages hospitals and other providers to collaborate in the formation of ACOs, which assume responsibility for the overall health of defined patient populations. If successful in providing high-quality care and reducing cost, ACO provider members can participate in financial incentives provided through the program.[8] As of May 2014, the MSSP had enrolled 338 ACOs covering 4.9 million beneficiaries in 47 states (plus the District of Columbia and Puerto Rico)[9] with 13,858 individual provider participants[10]—an indication of significant growth of the MSSP in the few short years since its inception.

Finally, the ACA has created three new "agencies" devoted to driving quality improvements through a variety of means. The independent, not-for-profit Patient-Centered Outcomes Research Institute (PCORI) uses scientific and clinical research methodologies to develop evidence-based treatment options based on a set of national priorities for improved effectiveness and outcomes.[11] Those national priorities are:

- Assessment of prevention, diagnosis, and treatment options
- Improving healthcare systems
- Communication and dissemination research
- Addressing disparities
- Accelerating patient-centered outcomes research and methodological research[12]

PCORI offers substantial funding opportunities for hospital and health systems and providers that wish to become involved in these outcomes research opportunities.

The new Center for Quality Improvement and Patient Safety (CQuIPS) within the Agency for Healthcare Research and Quality (AHRQ) works to improve the quality and safety of healthcare through, among other things, collaborating with stakeholders across the healthcare industry to implement evidence-based practices, accelerating and amplifying improvements on quality and safety for patients.[13]

The new Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) is charged with testing independent payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care.[14] CMMI's wide-ranging initiatives include:

- The Comprehensive Primary Care (CPC) initiative—a multi-payer initiative fostering collaboration between public and private healthcare payers to strengthen primary care.[15]
- The Medicare Intravenous Immune Globulin (IVIG) Demonstration—a study to evaluate the benefits of providing payment and items for services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIDD).[16]
- The Bundled Payments for Care Improvement Model (BPCI Model) initiatives—a series of initiatives designed to test payment models that include financial and performance accountability over multiple providers involved in "episodes of care," such as acute hospital stays.[17]

Hospital and health system boards need to understand both the potentially negative economic consequences and the enormous positive opportunities embodied by these ACA quality initiatives to guide their strategic planning.

Qui Tam FCA Drivers of Quality

In addition to the ACA's many quality drivers, the federal government, assisted by private *qui tam* relators, is increasingly seeking to hold health system providers accountable for substandard care through the mechanism of the federal False Claims Act (FCA).[18] The FCA is a Civil War-era statute[19] that employs draconian financial penalties to combat defense contractor fraud. Its civil provisions impose treble damages and civil fines of up to $11,000 *per claim* against government contractors who "knowingly" submit false or fraudulent claims for payment to the federal government.[20] The FCA encourages private whistleblowers, known as *qui tam* relators, to prosecute actions in the name of the federal government, by enabling them to share in any financial recovery obtained by the government,[21] be awarded reasonable attorneys' fees,[22] and be protected from retaliation by their healthcare employer.[23]

The FCA has been used increasingly in recent years to combat perceived egregious failures of care in hospitals, nursing homes, and other healthcare settings.[24] *Under-treatment* is pursued under a "worthless services" theory, while *over-treatment* is pursued under the doctrine of "medical necessity." The worthless services theory posits that some services are of such substandard quality as to be essentially "worthless," and that billing the federal government for "worthless services" is tantamount to a "false claim."[25] Fortunately, the federal appeals courts have not thoroughly embraced this new legal doctrine, and instead have set some important limits on the cases in which the "worthless services" doctrine will be recognized.

7 CMS, *Medicaid Program: Payment Adjustments for Provider-Preventable Conditions Including Healthcare-Acquired Conditions: Final Rule,* 76 Fed. Reg. 32816, June 6, 2011; 42 C.F.R. § 447.26.
8 Belmont, 2011, pp. 1,283–84.
9 CMS, *Medicare Shared Savings Program ACO Fast Facts* (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACO-Fast-Facts.html).
10 CMS, *ACOs in Your State* (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-your-State.html).
11 See www.pcori.org/.
12 PCORI, *National Priorities and Research Agenda,* May 21, 2012, p. 8 (available at www.pcori.org/research-we-support/priorities-agenda/).
13 See www.ahrq.gov/cpi/centers/cquips/index.html.
14 See http://innovation.cms.gov.
15 See http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative.
16 See http://innovation.cms.gov/initiatives/ivig/.
17 See http://innovation.cms.gov/initiatives/BPCI-Model-2/index.html.
18 31 U.S.C. § 3729–3733.
19 Department of Justice, *The False Claims Act: A Primer* (available at www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf).
20 The term "knowingly" means with actual knowledge, deliberate ignorance, or in reckless disregard as to the truth or falsity of the claim, 31 U.S.C. § 3729(b)(1)(A).
21 31 U.S.C. § 3730(d).
22 *Ibid.*
23 31 U.S.C. § 3730(h).
24 *United States ex rel. Mikes v. Straus,* 274 F.3d 687 (2001); *U.S. ex. rel. Lee v. SmithKline Beecham, Inc.,* 245 F.3d 1048, 1053 (9th Cir. 2011); *Chesbrough v. VPA, P.C.,* 655 F.3d 461 (6th Cir. 2011); but see *U.S. ex rel. Absher v. Momence Meadows Nursing Center, Inc.,* 2014 U.S. App. LEXIS 16063 (7th Cir., August 20, 2014).
25 *United States ex rel. Mikes v. Straus,* 274 F.3d 687 (2001); *Chesbrough v. VPA, P.C.,* 655 F.3d 461 (6th Cir. 2011).

In the *Mikes v. Straus* case, arising out of allegedly deficient spirometry studies, the Second Circuit Court of Appeals cautioned that not every violation of an applicable quality regulation gives rise to a false claim, and that, in general, quality of care issues are better monitored by state and local agencies and medical boards.[26] In the *Chesbrough v. VPA* case, arising out of poor quality radiology studies, the Sixth Circuit held that only studies that were so deficient as to be *non-diagnostic* could provide a basis for an FCA claim; those studies that were merely designated as "suboptimal," "of poor quality," or not meeting the "standard of care" could not.[27] Likewise, in the very recent decision in *Absher v. Momence Meadows Nursing Center, Inc.*, a nursing home case in which egregious deficiencies of care were pled and proven, the Seventh Circuit declared that, for purposes of establishing FCA liability, services that are "'*worth less*' are not '*worthless*.'"[28]

The FCA cases based on medical necessity posit that the knowing submission of claims for services that are not medically necessary constitutes a "false claim," for which treble damages and civil fines may be levied. The traditional fee-for-service system has embedded financial incentives that can lead unscrupulous physicians to provide care that patients do not need. The government has aggressively pursued cardiologists, in particular, for allegedly unnecessary care, including:

- **$54 million settlement for Redding Medical Center, California.** In 2004, Tenet Healthcare Corporation entered into a $54 million civil settlement with the federal government arising out of claims against the Tenet-owned Redding Medical Center, based on the medical center's failure 1) to identify aberrant utilization patterns by certain physicians on its medical staff and 2) to prevent these physicians from performing medically unnecessary invasive cardiac procedures, including open heart surgery. Four physicians involved in the case settled for $32.5 million, two physicians agreed never to perform cardiology procedures or surgeries on Medicare patients, and the director of cardiology was excluded from Medicare.[29]
- **$22 million settlement for St. Joseph Medical Center, Maryland.** In 2010, the hospital paid $22 million to settle allegations that cardiac surgeons placed medically unnecessary cardiac stents in more than 500 patients. This case also resulted in multiple malpractice cases against the physician; the physician lost his medical license and was also subject to claims of falsification of records.[30]

In the pending case of *U.S. ex rel. Azmat,*[31] the government has intervened in a *qui tam* FCA case alleging, among other things, that a hospital, ignoring the complaints of its nursing staff, knowingly permitted an incompetent physician to perform endovascular procedures that he was not qualified for and to provide medically unnecessary services to unsuspecting patients. Among other things, the complaint alleges that the hospital failed to follow its own peer review processes to investigate and intervene despite multiple clear indications of quality concerns.[32]

Thus, despite cautionary notes by the federal appeals courts noted above, both the "worthless services" doctrine and the "medical necessity" doctrine are regularly invoked by private whistleblowers and the federal government in suits under the FCA, and have the ability to generate substantial financial settlements. Hospital and health system boards need to be cognizant of the potentially draconian remedies that are available under this federal statutory scheme in the event that serious quality issues are not proactively addressed.

Federal and State Corporate Liability and Antitrust Credentialing Exposures

Hospitals and health systems are structurally unique in the sense that the care and services that they provide are delivered, managed, and supervised by physicians who are not directly answerable to the hospital executive team through a traditional management reporting structure.[33] As highly trained professionals, physicians possess the right and obligation to exercise "independent medical judgment" on behalf of their patients, and institutional efforts to control medical judgment are often subject to legal challenge under the "corporate practice of medicine doctrine" that exists under state statutory and common law.[34]

This has led to a bifurcated leadership structure in hospitals and health systems, in which the non-physician care and services are provided and overseen through the traditional management chain of command, whereas the physician services are provided and overseen through a "self-governing medical staff," which reports

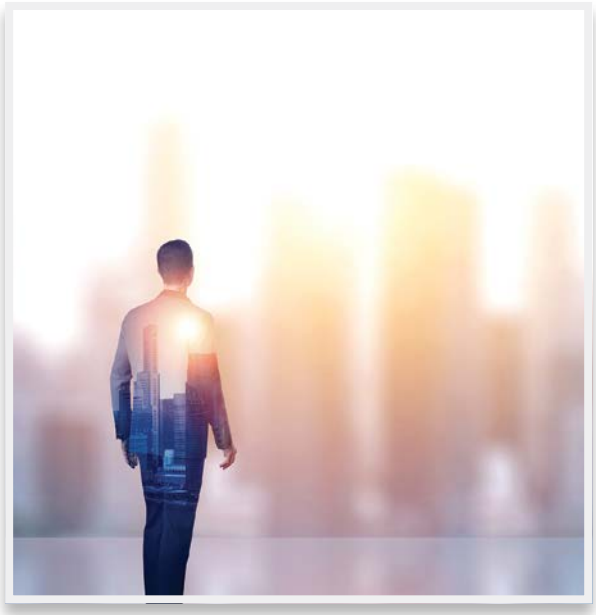
26 *United States ex rel. Mikes v. Straus,* 274 F.3d 699–700.
27 *Chesbrough v. VPA, P.C.,* 655 F.3d, 467.
28 *U.S. ex rel. Absher v. Momence Meadows Nursing Center, Inc.,* 2014 U.S. App. LEXIS, *23 (emphasis supplied).
29 Press Release, "Redding Cardiologists Agree to Pay Millions in Settlement," McGregor W. Scott, U.S. Attorney, ED CA, November 15, 2005 (available at http://mathiasconsulting.com/cases/2005/11/CA/redding); see R. Nagele and K. Bohl, *Effective Peer Review as Your Best Defense to Fraud and Abuse—A Look at the Role of Peer Review in Some of the Key False Claims Cases and Lessons Learned,* AHLA In-House Counsel Program and Annual Meeting Course Materials, New York, NY, June 2014.
30 Press Release, "St. Joseph Medical Center in Maryland to Pay U.S. $22 Million to Resolve False Claims Act Allegations," November 9, 2010 (available at www.justice.gov/opa/pr/2010/November/10-civ-1271.html).
31 *United States ex rel. Lana Rogers v. Najam Azmat and Satilla Health Services,* No. CV507-092, 2011 U.S. Dist. LEXIS 156819 (S.D. Ga. May 17, 2011).
32 *Ibid.*
33 See Brian Peters and Robin Nagele, *Promoting Quality Care & Patient Safety: The Case for Abandoning the Joint Commission's "Self-Governing" Medical Staff Paradigm,* 14 MSU Journal of Medicine and Law 313, 2010.
34 See Robin Nagele and Andrea Kirshenbaum, *Quality Metrics, Contractors, and the "Right to Control": Extending "Employee" Rights to the Independent Medical Staff,* PBI's Health Law Institute Course Materials, Philadelphia, PA, March 14, 2014.

directly to the board of directors.[35] This bifurcated leadership places the board of directors in the critically important and unique position of providing direct oversight of the quality decisions made initially by the "self-governing medical staff." This includes the ultimate authority to approve or disapprove of decisions to grant initial or renewed medical staff membership and clinical privileges to the physicians on staff, and the ultimate authority to suspend or revoke those privileges based on issues of competence or professionalism.

> When hospital management or the board fail to heed staff complaints, they miss important opportunities to empower staff members at every level throughout the hospital to speak up and take action that can result in direct quality improvements on many fronts simultaneously.

There are significant liability exposures that flow to the institution, and to individual members of the board of directors, arising out of this credentialing and privileging authority—whether arising from the *failure to act* or the *failure to act reasonably*. The *failure to act* on quality issues that a board either knows or should know about can lead to damage awards for corporate negligence or negligent credentialing (i.e., failing to fulfill its non-delegable duty to select and retain only *competent* physicians).[36] The corporate negligence doctrine led the Redding Medical Center, in the case described above, to pay a total of $395 million to settle the claims of hundreds of individual patients who alleged harm as a result of the hospital's failure to ensure the competency and provide proper quality oversight with respect to a cardiologist and cardiovascular surgeon who allegedly subjected those patients to unnecessary cardiac procedures—up to and including open heart surgery.[37]

The *failure to act reasonably* can generate liability when a board acts hastily, or under



the influence of biased or self-interested medical staff leaders, in suspending or revoking a physician's hospital privileges without having engaged in a thorough and objectively fair process. Revocation of physician privileges frequently leads to costly litigation under the federal antitrust laws, discrimination laws, or state laws of contract, defamation, and tortious interference.[38] Partial immunity from damage awards arising from staff privileging lawsuits is available to hospitals, executives, and directors under the federal Health Care Quality Improvement Act (HCQIA),[39] but only in the event of full compliance with procedural requirements set forth in that act. Those requirements are that the contested act be taken 1) in the furtherance of quality healthcare, 2) after a reasonable investigation, 3) after appropriate "due process" hearing procedures, and 4) that the final decision by the board was reasonable when viewed in light of the full record created during the investigation and hearing phase.

Therefore, hospital and health system boards must be equally attentive to the need to *act* and the need to *act reasonably*, in providing ongoing, proactive oversight of the quality and competence of the organization's medical staff.

Licensure and Accreditation Exposures for Substandard Quality

The failure to address quality and safety issues can also create licensing and accreditation exposures for hospitals and health systems, which can lead, under a worst case scenario, to loss of the hospital's accreditation, loss of its state license, and/or exclusion from participation in the Medicare and Medicaid programs—any one of which can effectively shut the hospital down.

Most hospitals in the country are accredited by one of five national accrediting agencies—The Joint Commission (TJC), Det Norske Veritas (DNV), the Accreditation Association for Hospitals/Health Systems (AAHHS), the Center for Improvement in Healthcare Quality (CIHQ), or the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA). Although hospitals do not require accreditation to operate, there are considerable advantages to accreditation, in terms of public perception, commercial payer requirements, and ease of participation in the Medicare and other federal healthcare programs.[40] Therefore, loss of accreditation can have considerable negative consequences for a hospital.

State licensure *is* required for hospitals to operate, and therefore the consequences of a negative state licensure survey or inspection, if the identified quality issues are not promptly and comprehensively remedied, can be that the hospital is shuttered. Moreover, since in most states the state surveyors also act on behalf of CMS with delegated authority, a negative state survey can also put a hospital on a "de-certification track" for exclusion from participation in the Medicare and other federal

35 Peters and Nagele, 2010.
36 *Ibid,* p. 364.
37 *Ibid,* citing Tenet Healthcare Corp., Annual Report (Form 10-K), March 9, 2006, p. 56.

38 *Ibid,* pp. 365–68.
39 Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*

40 CMS has conferred "deeming authority" in the five accrediting agencies identified above, meaning that if hospitals maintain their accreditation in good standing they will be "deemed" by CMS to meet the CMS Conditions of Participation without undergoing a separate survey process conducted by CMS (see www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Accreditation.html).

healthcare programs.[41] Either one of these events—loss of state licensure or exclusion from the Medicare program—can serve as the hospital's "death knell."

Thus, significant quality concerns that are not proactively addressed until identified by an external surveyor can generate major negative consequences for a hospital's ability to continue operating.

Staff Morale and Workplace Safety

A hospital or health system's failure to place quality at the center of its mission also risks generating low staff morale that can, itself, exacerbate safety issues and thus create even more risk for patients and staff. As The Joint Commission articulated in its 2008 Sentinel Event Alert, "safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the healthcare team."[42]

Healthcare workers who perceive that they are not respected and that their complaints of incompetence or lack of professionalism are not taken seriously can become whistleblowers, or in some cases, may file sexual harassment, discrimination, or hostile work environment lawsuits. Moreover, when hospital management or the board fail to heed staff complaints, they miss important opportunities to empower staff members at every level throughout the hospital to speak up and take action that can result in direct quality improvements on many fronts simultaneously.

Clinical Integration and Population Health Readiness

Finally, hospital and health system boards need to put quality at the top of the agenda to position themselves effectively to partner with other providers in their regions to form clinically integrated networks and to manage population health. The industry is moving in the direction of ever-larger and more coordinated groups of providers managing the health of ever-larger populations of patients—trying to achieve synergies, efficiencies, and data-driven "evidence-based best practices" that are deemed to be effective only on a large scale.

Hospitals and health systems should be preparing themselves for the rigors and challenges of managing care in a highly coordinated manner on a large scale so as to achieve measurably improved outcomes. Those entities that can demonstrate success in improving population health and achieving better outcomes using cutting-edge technologies and superior health information systems will be in demand as these large clinically integrated networks are being formed. Those health systems and providers that have not mastered the new quality-driven approaches and methods will be left behind.

How Can the Board Drive Quality for the Hospital/Health System?

There are many methods and tools available to hospital and health system boards of directors to proactively pursue and implement a quality agenda. The starting place, however, is to position the commitment to quality centrally in the hospital/health system's mission statement, its strategic planning, and its CEO's annual goals and objectives. The mission statement provides the beacon that guides all decision making at the board level. The strategic planning process sets the hospital/health system's agenda and milestones over a prescribed term—such as the next five, 10, or 15 years. The CEO's annual goals and objectives reduce the strategic plan to achievable action items by which the CEO is held accountable on an annual basis and by which his or her long-term success is measured.

When quality takes a prominent place in the mission and the strategic plan then it necessarily becomes integrated into all aspects of the decision-making process at the board level. When it is baked into the CEO's goals and objectives, then it fuels the CEO's management and oversight of his or her own executive team, and from there to every other level of management and staff operations. Simply put, quality should not simply be regarded as a routine board agenda item that is reviewed in isolation from other board business—it should be at the center of all board decision making.

Once the board recognizes that quality is driving its decision making, then board members will be asking for tools to measure quality, to evaluate quality indicators, and to integrate quality factors meaningfully into their broader decision-making process. We propose a number of specific steps that can be taken.

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Quality Dashboards and Metrics

Quality dashboards have become a popular and effective way for boards to gain a regular "snapshot" of how well the hospital is doing relative to the achievement of national benchmarks and specific metrics such as the VPB quality measures, Physician Quality Reporting System (PQRS) measures, and TJC National Patient Safety Goals. The regular review of metrics should be not the "end" but only the "beginning" of effective quality oversight at the board level. Ideally, the board's expectation will be that the hospital is performing at the very top of the scale on all metrics, and if not, the board will be probing whether the failure to perform at the level of excellence is indicative of larger quality issues that need to be addressed. If "average" or even "above average" are tolerated on a routine basis, such that they serve to end rather than start the inquiry, then that may be an indication that the leadership team has not genuinely placed quality at the center of its mission.

Board-Level Quality Committee

In addition to the strategic oversight of quality, the board has day-to-day responsibility under federal and state law for the review and action on medical staff activities relating to quality, safety, and peer review. In order to fulfill this accountability, it may be appropriate for the board to create a quality committee responsible for receiving and acting on reports from the medical staff (and management) of their respective quality oversight, credentialing, peer review and corrective action activities, and

41 CMS explains that: "The State Agency, by a survey conducted by qualified health professionals, determines whether and how each [of the Medicare Conditions of Participation for Hospitals] is met. While an institution may fail to comply with one or more of the subsidiary standards during any given survey, *it cannot participate in Medicare unless it meets each and every Condition [of Participation].*" See www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/index.html (emphasis supplied).

42 The Joint Commission, Sentinel Event Alert (SEA) No. 40, *Behaviors That Undermine a Culture of Safety,* July 9, 2008.

for the board's review and approval of all medical staff (and management) policies and procedures pertaining to quality, patient safety, and peer review.[43]

Oversight of the medical staff peer review, quality, and safety activities requires some level of expertise. Therefore, it is helpful to ensure that the individuals appointed to this committee have background in one or more of the following areas: medical or clinical expertise, legal expertise, and for lay members, common sense and good judgment. Boards often have members of the hospital/health system's medical leadership—employed and/or independent—serve on the committee or as a management resource to the committee. It is helpful when the board quality committee has a relatively stable membership, so as to preserve the knowledge and experience that is built up over a period of years.

Since the quality committee is, unlike many other board committees, a "hands-on" working committee, boards should consider providing appropriate education to new (and existing) members of the quality committee on such topics as: 1) the hospital's bifurcated leadership structure of medical staff and management, 2) the requirements of the medical staff bylaws and applicable policies and procedures, 3) the basic substantive and procedural elements of the hospital's peer review and corrective action process, 4) how to meaningfully analyze quality dashboards and other metrics, and 5) what additional tools may be available to the quality committee (such as the use of external consultants) when the committee feels that it lacks a sufficient level of knowledge or expertise to decide a particular matter coming before it.

Quality Policy

Boards may want to consider adopting, either as a freestanding document or as a section of its corporate bylaws, a quality policy that sets forth the structure and processes by which board oversight of quality takes place. This quality policy could have the following key elements:

- The board's aspirational goals for the proactive pursuit of exceptional quality in all of its endeavors (if not already articulated in its mission statement)
- Composition, standards, and specific functions of the board quality committee
- Process for review and follow-up (including the substantive triggers and mechanisms for such follow-up) with regard to the quality dashboard and metrics reviewed by the board on a regular basis
- Process for review and follow-up on specific quality-related problems that confront the hospital/health system (e.g., through negative results on accreditation or licensure surveys, serious safety events, physician disputes or litigation, whistleblower allegations pertaining to substandard quality, and so forth)
- The specific means by which the pursuit of exceptional quality is factored into the board's routine and non-routine decision making
- Interface with other board committees, such as the finance committee, governance committee, and/or strategic planning committee
- Delineation of any periodic or ongoing educational requirements and resources pertaining to quality

Quality Audit Process

Boards should consider regular auditing of the effectiveness of their quality oversight processes, which can provide valuable information both as to what is working well and where the processes may be falling short. In particular, the quality committee's oversight activities can be evaluated with respect to whether it has demonstrated a track record of consistent and effective resolution of the quality, safety, and peer review issues coming before it for resolution on a regular basis. To the extent the audit reveals an inconsistent record of quality oversight, the deficiencies can be addressed through enhanced education, tighter processes, or personnel changes on the committee.

Conclusion

In today's challenging healthcare environment, quality must be squarely placed at the center of a hospital/health system board's agenda. The monitoring and oversight of *current* quality and safety in hospitals in real-time will help insulate boards from the liability exposures that arise from FCA litigation, loss of licensure or accreditation, corporate negligence, and antitrust actions. The *forward-looking* commitment to quality in boards' mission statements, strategic planning, and ongoing decision making will position hospitals/health systems to meet the challenges of the changing reimbursement landscape, and to participate effectively in the clinical integration and population health movements that are taking hold in the post-ACA healthcare world. Boards can no longer afford to view quality as simply a discrete agenda item, viewed in isolation from the other matters coming before the board. Only when quality is at the heart of all other executive and board decision making can an organization be regarded as truly quality driven.

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43 For a sample quality committee charter, see The Governance Institute's governance support templates or email kwagner@GovernanceInstitute.com.