The Board's Accountability for Complex Healthcare Strategies: Exercising "Due Care" in the Face of Unfamiliar Organizational Strategy and Strategy in Action

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Strategy is the pathway to mission fulfillment; tactics are the action of strategy. The purpose of strategy is the development and application of the full potential of an organization's ability to move it forward towards its vision and mission responsibilities for those served.

Boards, by definition, are accountable for the actions and outcomes of all corporate strategy, with the CEO and other senior leaders serving as instruments of strategy management. Further, boards and senior leadership share the responsibilities of "due care" as strategic goals and objectives are initiated and pursued. Governing boards cannot avoid nor compartmentalize the duty of due care in the development and management of strategy by exclusively utilizing committees of the board (e.g., the strategy committee) or the senior leadership team. The full board owns all related responsibilities and the accountabilities of an organization's strategic planning process, as well as the results and consequences of the execution of a strategy ("strategy in action").

Boards and senior leadership share the responsibilities of "due care" as strategic goals and objectives are initiated and pursued. But the full board owns all related responsibilities and the accountabilities of an organization's strategic planning process, as well as the results and consequences of the execution of a strategy.

Due Care Defined

Fiduciaries of hospitals and health systems that engage in governance are bound by three critical duties:

- The duty of care
- The duty of loyalty
- The duty of obedience

By definition, the duty of care requires all boards (and individual board members) to exercise due care in discharging their duties of governance. "Due care," defined in a practical sense, means that board members individually and collectively bring to bear their experience and judgment in service to the mission of the organization, exercising reasonable and sufficient effort to best ensure that the organization they govern operates prudently as it pursues its mission within all appropriate boundaries of legal and regulatory guidance, sound fiscal and managerial practices, according to the highest standards as amplified within industry practices. This is a high standard often lacking clear "bright-line tests" defining due care, except to the extent that governmental regulation applies. In corporate governance disputes, issues surrounding compliance with these illusive standards of due care are judged based upon alleged violations of these uncertain standards. In other words, a governmental agency or a court will itself define and apply a "standard" to adjudicate the actions of a governing board. The governing definition of due care can come *ex-post facto*; i.e., following the event warranting judicial or regulatory review.

Key Board Takeaways

Board members are ultimately responsible and accountable for the design and execution of strategy. While responsibilities of execution may be delegated to management, state statutes regulating licensed hospitals will see a board as the accountable body regarding plan design, execution, and outcomes. A few things for boards to consider include:

- Directors are charged with the responsibility of "due care" as it relates to the design and execution of strategy. Board members are expected to be qualified and competent to approve and oversee the execution of decisions they make.
- Due care, as it relates to organizational strategy, must address a comprehensive range of potential risk exposures, including the risks that derive from the interaction and interplay of multiple tactics of a strategy (referred to as "integrative risk"). A comprehensive range of integrative risk extends beyond legal, regulatory, and compliance risk to include financial, patient care, reputational and brand risk, work environment, cultural, and the risks of dysfunction of the senior team.
- Required board behaviors, as it relates to due care of strategy, involve ongoing demonstrations of effort in monitoring strategy in action—a concerted and recorded effort of evaluating outcomes of an approved strategy, including the identification and mitigation of observed and potential risks of the strategy.
- Insurances covering directors and officers (D&O insurance policies) should be examined for gaps and coverage limitations relating to an active organizational strategy.

The Complexity of Strategy and Related Integrative Risk

Healthcare system strategies must embrace a complex series of marketplace inevitabilities including:

- A consolidating payer market
- Governmental payer pressures for demonstrable value
- Downward pressures on price, utilization rates, and total costs of care
- A waning interest in independent practice by physicians
- Patients' demands for services, availability, access, and a superior experience
- Intense price competition

- The emergence of niche market (and service) innovators and disruptors
- The need for scope, scale, and related economies to remain relevant and viable

It is apparent that governing boards are required to authorize strategies of increasing complexity and often uncertainties. Resulting tactics put into play present increasing organizational risk and these tactical risks must be considered in at least two dimensions. Initially, the risk of each tactic operating in isolation of all others must be weighed. The second dimension of risk to be carefully reviewed involves the intersection and interaction of all tactics together. This latter dimension, not always fully considered, is referred to as "integrative risk." As the performance of individual tactics are encouraged and often pushed to higher levels of performance, so too is the integrative risk profile of a given organization. The two case examples below better illustrate the need to carefully consider organizational risks.

Case Example #1

Community Health System (CHS) operates a clinically integrated network inclusive of employed physicians and affiliated independent physicians. CHS launches an aggressive "brand value" marketing campaign, emphasizing its ability to coordinate care according to evidence-based best practices.

A new patient joins the system as a result of being positively impressed by the campaign. Not surprisingly, this patient's first visit is with a primary care physician employed by CHS; the visit goes well. A referral is next made to an independent cardiologist affiliated with the network. Another related referral is then made from the second physician to a non-affiliated consultative specialist. Neither of the referral physicians are employed by CHS nor do they operate within CHS's electronic medical record. The primary care physician who first saw the patient is unaware of the referral to the third physician. A key lab result never reaches the primary care physician and the patient's health suffers, accordingly. Additionally, the patient bears a high percentage of cost for services performed by the third physician, as that practice is out-of-network given the patient's insurance coverage.

From the perspective of strategy and tactics approved by governance:

- The first physician is employed by CHS; the organizational tactic was to pursue and "employ more primary care physicians."
- The second physician is an independent affiliate of CHS's clinically integrated network; this tactic was applied to expand the number of affiliated specialists cost-effectively.
- The third physician was not in the strategic plan at all.

Here the tactics were sound, by design, but the tactics in action produced unexpected, and potentially costly and harmful, integrative risk results. So far as the plaintiff's lawyer is concerned, all physicians involved were operating as "agents" of the health system.

"Agents" can bind their "principals" by what they do or fail to do. In the employment context, an employee is unquestionably an agent of his/her principal and a mistake of the agent/employee can impose liability on that principal/employer. For example, if an employed OR nurse makes a mistake, his/her employer/principal is liable under the law for whatever damages flow from the misadventure of the agent/employee.

In this case, the plaintiff's attorney will assert that all of the physicians involved in patient care in this setting are agents of the health system and that it is legally responsible for the actions of these physicians, even if they were not technically employees of the organization. The law may (or may

not, depending on what comes out at trial) conclude that the facts proven allow the jury to conclude that *apparent* agency was created by all of the facts involved in the care of the patient/plaintiff.

A finding of apparent agency will impose legal liability upon our hypothetical health system that often does not carefully consider the risk of this occurrence. One caveat—state law varies here and some states will not yet apply the law of apparent agency to all healthcare activities.

Case Example #2

A principal goal of the strategy for CHS is partnerships with independent physicians. One tactic within the strategic plan calls for joint ownership of an ambulatory surgery center (ASC), shared between physicians and the hospital, which will retain a 51 percent ownership. Ten surgeons are included in the venture, including one employed by CHS. The physicians are paid as "managing partners" of the entity, based partially on the financial performance of the venture.

The partnership exceeds volume and financial performance projections well ahead of the expected timeline. Clinical outcomes are good and patients report "excellent experiences." All seems good. But underneath, there are issues brewing:

- Since the hospital is a 51 percent owner, the health system's auditor concludes that the partnership should be viewed as a "consolidated entity" for accounting purposes meaning that, while the terms of the partnership remain in place, the venture will be reflected and reported by the auditors as a "consolidated entity" of the health system.
- The payer mix of the surgery center is weighted to patients covered by commercial insurance, reflecting a more favorable

payer mix than that of the health system's hospital.
- The physician management company earns bonus payments based upon the financial performance of the ASC.
- The hospital provides a number of support services to the ASC that may not be fully accounted for and billed to the partnership, and the ASC benefits from supply contracts held at the local hospital (a tax-exempt entity), for necessary items including medications.
- Two physicians employed by the health system have ownership interests in the ASC.

While there may be no obvious legal, regulatory, or tax violations apparent in the operation of the partnership, based upon the facts presented, none of these facts or circumstances were disclosed to the board and may or may not be known by the full senior leadership team. At this point, the board's responsibility for strategy (beyond approval of the strategic plan) is guided by a fiduciary's responsibility of "due care." As noted above, boards and their officers are fully responsible for the actions of implementation and the consequences of strategy—known or unknown.

How Can Boards Exercise Due Care in the Management of Integrative Risk?

There are no tried and true recipes for the exercise of due care by a board as it relates to strategic initiatives and plans. Likewise, there are no bright-line legal tests of a board exercising due care in the face of ever more complex legal and regulatory action in the healthcare industry. Experience does demonstrate, however, that best efforts have value and do indeed "count" at least in matters of civil litigation and non-criminal governmental enforcement actions.

How can a governing board and senior leadership teams of healthcare organizations effectively execute a goal of "due care" as it relates to the management of a complex market strategy? A best practice approach can be devised.

One effective approach calls for the senior leadership to present its evaluation of a risk and reward profile for one or all tactics encompassed by the proposed strategic plan (see **Exhibit 1**). In the example in Exhibit 1, each member of the senior leadership team (SLT) establishes their position regarding the value and risk profile of a specific tactic of a strategic plan under development: equity partnerships and contractual arrangements with independent physician specialists (and specialty groups).

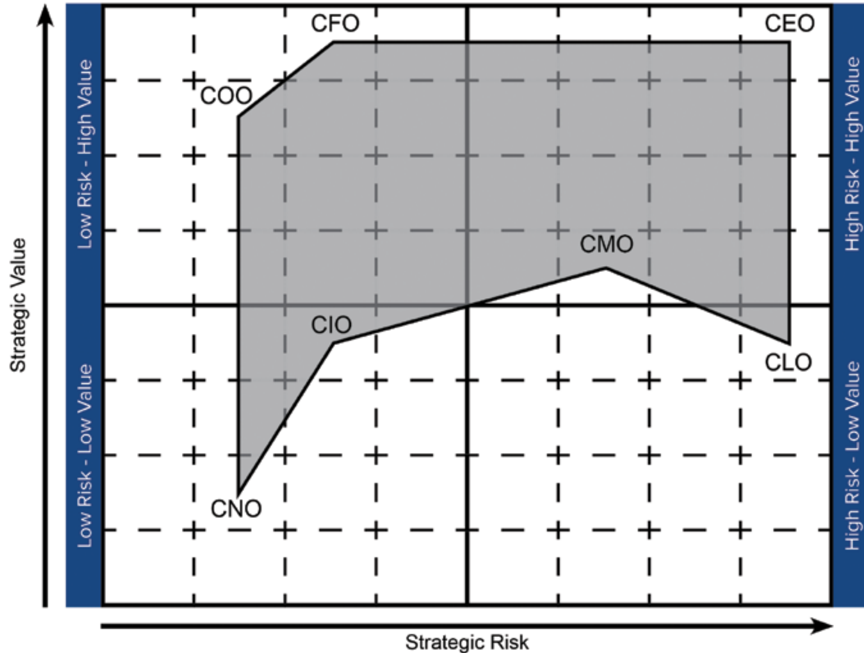
The consensus is that success in the markets served will require new and innovative relationships with independent physicians who practice specialty care in areas of strategic interest to the organization. Consensus among SLT members does not, however, mean that each feels the same about the value-to-risk profile of the tactic. Based upon the concordance profile of the group, it is clear that individual officers' sentiments are "all over the map." Notable are the differences in sentiment between the CEO (who sees the tactic as high value and high risk) and the CFO (who also sees high value, but much less risk). The CNO sees the tactic as low value and low risk. There are no correct answers here. The need is for a frank conversation among members of the SLT. The three important questions are:

1. What causes such apparent "discordance"; why do members of the SLT judge the value/risk profile to be so different?

Exhibit 1: Strat-a-Map

Organization: Community Health System **Date:** December 2015

Tactic: Equity Partnerships and Contractual Arrangements with Independent Physician Specialists (and Specialty Groups).



Response Qualifiers	Tactics to be Judged by SLT
A. Financial: P&L, Cash Flow, Balance Sheet	1. Employed PCPs
B. Brand Value	2. Employed SCPs: Cardiology
C. Market Position Geographic	3. Large Ambulatory Centers 2 x 100,000 sq. ft.
D. Payer Opportunities and Relationships	4. Clinical Service Lines with Geographic Reach
E. Competitor Positioning/ Response	5. Our Own Health Plan
F. Internal Culture	6. Clinically Integrated Network
G. Physician Attractiveness	7. Population Health with Financial Risk
H. Total Allocation of Org. Resources	8. Partnerships with Independent Physicians
I. Internal Competencies ("Know How")	9. Acquisition of Home Health Agency
J. Risks to "My Performance"	10. Tele-Health Development
K. Quality of Patient Care	
L. Key People Response: Those Essential to Success	
M. Other:	

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Exhibit 2: Strategy Performance Scorecard

Strategy Plan Section:	Physician Services Tactics	Plan Status	Risk Status
Reporting Period:	Third Quarter, FY 2017		
Tactic #1:	Expand employed primary care network	Green	Red
Tactic #2:	Expand number of employed specialists; cardiovascular and hospitalists	Green	Green
Tactic #3:	Develop regional clinical service line; cardiovascular and cancer	Red	Green
Tactic #4:	Develop partnership with orthopedic group	Red	Red
Tactic #5:	Engage key independents in clinical network formation	Green	Green
Tactic #6	Ensure timely patient access across pcps	Green	Red
Tactic #7	Interprofessional team development - Primary Care	Red	Red
Tactic #8	Network-in regional CAH's	Green	Green

Note:
The strategy scorecard is designed for use with governing boards. This report provides progress status indicators for tactics in action. Two status indicators are recommended; "Plan Status" and "Risk Status". Green and red colors are used to indicate need for management and board interaction; green for "on-plan" or "no risk briefing required" and red meaning "progress negative to plan" or "risk briefing required".

2. With this apparent discordance, can all members of the SLT support execution of the tactic?
3. What will each individual's outward response be if execution doesn't yield the expected outcomes?

CEOs or chief strategy officers may be reluctant to share results of such an exercise with the full board. Results could be used as "strategy work in process" to be shared with a standing or *ad hoc* strategy committee of the board. Work such as this can be summarized for the board as it considers the approval of the plan. A process such as this provides the SLT the opportunity, regarding the risks of execution, for transparency.

Evaluation of a Strategy in Action

With every board meeting, a report of "strategy in action" should be provided by the leadership team (see **Exhibit 2**). For each tactic of the approved strategic plan, a member of the leadership team should clearly:

- Identify the tactic.
- Note the parties responsible for oversight and management of the tactical plan.
- Report the results expected as well as those achieved.
- Illustrate the categories of potential risk identified, as well as the method of risk management applied.

This report should often include commentary by internal legal counsel or outside experts supporting oversight of risk management related to the strategic plan.

The CEO is accountable for providing the board with a detailed assessment of the current state of the management of the strategic plan. This review should include future actions anticipated to best ensure favorable performance of the plan, with a clear focus on balancing expected returns with all inherent organizational risk.

Prudence dictates that physician leaders of the organization also participate actively in such a strategy performance review, as they are often in a position to see consequences of strategy through a "set of eyes" burnished by education, training, and experience, different from senior leaders who are not clinicians. Boards should encourage these physician leaders to speak as accountable partners when evaluating the organization's strategy in action.

The Tests of the Process of Due Care by a Governing Board

There is reason to believe that courts and regulatory bodies at both the state and federal levels intend to hold governing boards and the officers of not-for-profit healthcare organizations to an increasingly high standard of due care emphasizing organizational behaviors that fall within the ambit of strategy and strategies in action. While it is challenging to reduce the process of managing related risks to a collection of "operating checklists," policy and process do matter in this setting, as a well-defined process indeed represents a governing board's clear commitment to meet that illusive "reasonable person standard."

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Regulatory agencies and the courts will likely be sympathetic to sincere attempts by governing boards and officers to safeguard an organization and those it serves from possible missteps arising out of strategy in action, providing there are not blatant attempts to create benefit by violating the law. In such cases, governing boards may indeed be accorded consideration in their sincere efforts to manage this challenging risk.

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