Healthcare Governance Amidst Systemic Industry Change:

What the Law Expects

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A Governance Institute White Paper | Winter 2014 | AUTHOR Michael W. Peregrine

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Executive Summary

The healthcare sector is in the midst of seismic, generational change—prompted by a variety of economic, legislative, competitive, and quality-of-care forces. These forces, and the changes they are unleashing, are creating board agendas of unprecedented complexity and challenge.

THEY ARE ALSO PROMPTING INCREASING EXPECTATIONS OF fiduciary conduct of individual board members. It will be incumbent on hospital and health system board members to anticipate and plan for these new governance challenges.

The direct financial implications of the ACA will impact the provider sector over many years in the future. The evolving financing model has combined with other economic and quality factors to fuel an extraordinary period of provider mergers and acquisitions over the last several years. This activity has resulted in a dramatic consolidation of the non-profit healthcare sector, and an evolution away from traditional corporate platforms. Industry change is further evidenced by a renewed shift towards physician employment.

For governance models to remain relevant in response to such dramatic structural change, they may need to adapt accordingly. It is the expectation of the law—as manifested through regulatory agencies and the courts—that boards will examine their existing governance structures and make changes where necessary. The basic question presented is, will the system's governance structure remain effective in the midst of this dynamic change? The greatest focus can be expected in the following key areas: core fiduciary principles and the standard of conduct by which board members will be held, governance structures, board and committee size and composition, governance processes, and the overall level of engagement of individual board members.

Basic Expectations of the Law

Directors' obligations to monitor the effectiveness of corporate governance in a transformed healthcare environment arise within the context of both the oversight and decision-making functions of the duty of care. The manner and extent to which directors address the impact of industry change will depend on a number of factors:

- **First** is the transformative nature of industry change. Courts and regulators are likely to recognize the significance of this change and hold board members to a higher level of attentiveness and care as a result.
- **Second** is the size and sophistication of the individual organization. For example, large health systems are substantial business enterprises with complex business agendas. Thus, the director's duty of care is likely to be interpreted through the prism of a sophisticated business enterprise rather than a typical not-for-profit charity.
- **Third** is the unique business structure of the healthcare sector and the significance attributed to the oversight and decisions made by hospital and health system directors.

These factors support the application of a higher standard of care in terms of the board's obligation to monitor the effectiveness of corporate governance in a transformed healthcare environment. Courts and governance regulators may well interpret the duty of care in these circumstances and are requiring an enhanced level of engagement by the board in connection with this emerging issue—*working smarter, longer, and faster*. A good-faith response would be a board-driven examination of whether current governance processes are sufficiently responsive to the transformed healthcare environment. The specific focus would be on the need to position the board to make informed decisions and provide attentive oversight to an increasingly complex agenda and in the context of a highly regulated, evolving operational environment.

Applying Legal Principles to a Governance Review

It is a well-established governance best practice that the board should periodically review its own size and structure in order to ensure the continuing adequacy of its oversight and decision-making practices, and commitment to the organizational mission. The law's expectation regarding governance self-review becomes more acute in periods of great economic, regulatory, legislative, or societal change. The issue is almost less about specific elements of change, and more about the willingness to consider, in a focused manner, whether change is necessary.

Review Components: Fiduciary Principles, Governance Processes and Structures, and Board Size and Composition

A primary focus of board attention should be on the extent to which transformational change will affect the fiduciary standard of care to which it is subject. Simply put, the question is whether transformational change will require board members to work "smarter, faster, and longer." There should be an expectation of increased board involvement in and commitment to the strategic planning process; risk oversight; quality oversight; a more robust

conflicts of interest approach; and the executive evaluation, transition, and search process.

The board should examine the extent to which the level of transformational change will affect its established governance structures and practices:

- The calendar for scheduled board meetings will need to take into consideration increased agenda items arising from transformation-based developments and challenges.
- Transformation-related issues also warrant an evaluation of the control powers that the health system parent retains over its subsidiary organizations and joint venture investments.
- The transformation's intensity and complexity prompts a second look at the effectiveness of traditional management and board communications and reporting relationships.
- Will the existing committee structure and charters be adequate to address the challenges from the evolving environment?

A critical issue for board consideration is the extent to which the level of transformational change will affect its current approach to board size and composition. Determination of board size must be a very informed decision by the board in normal circumstances—and it requires a particularly deliberate reevaluation in circumstances of seismic industry change. The competencies required to serve in the new model of care environment will in many instances be less traditional, more sophisticated, and more expansive.

The transformed healthcare environment also serves to involve the governing board more closely with the role of the corporate general counsel as she/he confronts new ethical and professional issues. It will also require a close working relationship between the governing board and senior leadership. This should be a relationship that recognizes that, in a period of intense industry change, traditional roles and duties may be pressured and may bend, but should ultimately be preserved.

Discussion Questions for Boards and Senior Leaders

1. What do we need to change in order to work smarter, longer, and faster?
2. How should our board agenda change to account for the economic, legislative, competitive, and quality-of-care forces changing the healthcare sector?
3. Are we fulfilling heightened expectations of our duty of care to the organization? If not, how do we need to conduct business differently in order to fulfill these increased expectations?
4. Is our board size and composition sufficient to serve in the new model of care environment? Does the board composition reflect all the competencies we need for effective oversight?
5. Do we have the ability, and resolve, to address director "fitness to serve" issues?
6. Is the board sufficiently involved in the strategic planning process? How should our strategy evolve to account for changes in the industry?
7. Do we have a proper understanding of the organization's risk profile, and how risk issues are communicated to the board and evaluated?
8. Are we working closely enough with our general counsel?
9. What changes do we need to make regarding the board's relationship and methods of communication with the management team?

Introduction

The healthcare sector is in the midst of seismic, generational change—prompted by a variety of economic, legislative, competitive, and quality-of-care forces with which most Governance Institute members are increasingly familiar.

THE FORCES SPARKING THIS CHANGE ARE DRASTICALLY reshaping the traditional approach to both organizational structure, and the delivery of care. They are impacting the manner by which corporate governance will support new organizational and delivery of care models created in response to such change. These forces, and the changes they are unleashing, are creating board agendas of unprecedented complexity and challenge. They are also prompting increasing expectations of fiduciary conduct of individual board members. It will be incumbent on hospital and health system board members to anticipate and plan for these new governance challenges. Yet these are challenges that are easily met by the committed board and, once met, will greatly support the long-term sustainability of the organization.

The board's ability to address these challenges will depend in part on its awareness of the law's expectations of its conduct. This refers specifically to an understanding of what is meant by "the law," why the law cares about the board's response to transformational change, and how it expects the board to respond to such change. For matters of corporate governance are, without doubt, legal concerns first and foremost. Any transformation-prompted governance evaluation must be grounded in an understanding of applicable law if it is to be successful.

Consistent with the mission of The Governance Institute, the goals of this white paper include:

- ***Acknowledging*** the relationship between industry change and governance
- ***Identifying*** the specific governance challenges prompted by this change
- ***Underscoring*** the fundamental nexus between the law and governance
- ***Suggesting*** ways in which boards may successfully deal with these challenges
- ***Confirming*** the extraordinary value of the role of the governing board

This white paper will pursue these goals by discussing how industry change and related "over the horizon" developments will affect:

- Expectations of governance conduct and the application of fiduciary principles
- Board composition and size
- Traditional governance structures
- Governance processes and special governance issues
- Typical corporate system structures and intra-system relationships
- How corporate, governance, tax, and charity laws intersect with an organizational response to such change

We hope that this white paper will serve as a resource for individual hospitals and health systems that seek to enhance the ability of their corporate governance to both a) make informed decisions and render effective oversight, in the context of a thoroughly transformed environment, and b) affirm and strengthen the organization's commitment to its charitable mission.

The Forces of Change

Hospital and health system governance is being fully tested by a transformative healthcare sector that is experiencing change at virtually every level.

THE TRADITIONAL HEALTHCARE FINANCING model has been dramatically altered by a number of factors, including shifts made in advance of, and in connection with, the Affordable Care Act (ACA). Related factors include federal budgetary and reimbursement changes, refocused business models by payers and employers, and a broad-based focus on quality of care (and the related link to payment).

The direct financial implications of the ACA will impact the provider sector over many years in the future.[1] Particularly significant elements of the ACA include lower reimbursement rates from insurance products sold on the new healthcare exchanges, an increase in the insured population through the ACA's individual mandate and the expansion of Medicaid eligibility (in states that have elected to do so), the uncertain impact of the exchanges on patient volumes and bad debt, and reimbursement reductions due to ACA-mandated cuts to Medicare and Disproportionate Share Hospital (DSH) payments.[2]

The evolving financing model has combined with other economic and quality factors to fuel an extraordinary period of provider mergers and acquisitions over the last several years. Community hospitals have pursued protection with local health systems; many former local systems have combined to form larger, regional systems; and formerly regional-based systems have combined into larger, multi-state systems. Other regional systems have formed loose collaborative ventures as an alternative to joining (or forming) larger systems. The largest non-profit systems have continued to grow until becoming national in scope. Prominent proprietary companies are merging to form larger enterprises.[3] This activity has resulted in a dramatic consolidation of the non-profit healthcare sector, and an evolution away from traditional corporate platforms. It has also led to a corporate stratification of sorts that is emphasizing, for well-established and appropriate reasons, the size and scope of the ultimate enterprise.

Industry change is further evidenced by a renewed shift towards physician employment. Hospital–physician alignment has become a crucial means of achieving the cost containment and quality-of-care assurances necessitated by the ACA.[4] Indeed, the competition among hospitals and health systems to recruit and retain well-managed, productive, high-quality physician groups is substantial. It has also attracted the attention of the antitrust enforcement agencies.[5] The altered financing model has prompted a dramatic shift away from inpatient-centric operations (the so-called "bed tower" mentality) towards greater focus on the delivery of services in outpatient—and even retail—settings. There is significant regulatory and payer emphasis on quality of care, and an increasing interest in pursuing population health and other new models of care.

It is the expectation of the law—as manifested through regulatory agencies and the courts—that boards will examine their existing governance structures and make changes where necessary. The basic question presented is, will the organization's governance structure remain effective in the midst of this dynamic change? The answer the law expects is, "Boards should make sure of this."

Horizontal and vertical joint ventures are being pursued with a broad cross section of partners and competitive challenges are arising from new entrants to the healthcare market. Collaborative arrangements between provider insurers are on the rise. The influence of technology in the delivery of care and the communication of health information is increasingly profound. Greater reliance on electronic health records, telemedicine, and "cloud"-based technology is placing increased emphasis on security and privacy concerns. The healthcare organization is larger, with more assets under ownership or control and with a board agenda that

1 See, e.g., Louise Radnofsky, "How the ACA May Affect Health Costs," *The Wall Street Journal*, February 23, 2014; Shelley DuBois, "Hospitals Face Whole New World Under Health Law" *USA TODAY*, October 20, 2013.

2 Moody's Investors Service, "2014 Outlook—U.S. Not-for-Profit Hospitals," November 25, 2013.

3 See, e.g., Moody's Investors Service, "U.S. For-Profit Hospitals—The Drive for Size," November 5, 2013; Dan Goldberg, "Hospital Acquisitions in the Age of Obamacare," *Capital New York*, February 27, 2014. View at www.capitalnewyork.com/article/albany/2014/02/8540832/hospital-acquisitions-age-obamacare.

4 See, e.g., Elisabeth Rosenthal, "Apprehensive, Many Doctors Shift to Jobs With Salaries," *The New York Times*, February 13, 2014; Moody's Investors Service, "Doing More with Less—Credit Implications of Hospital Transition Strategies," May 9, 2012.

5 Beth Kutscher, "Judge Rules St. Luke's Must Give Up Saltzer Medical Group," *Modern Healthcare*, January 24, 2014.

has never been more complex. The change is more pronounced, more widespread, and more evolutionary than ever before.

The economic, operational, and regulatory forces prompting this activity are drastically reshaping organizational models. For governance models to remain relevant in response to such dramatic structural change, they may need to adapt accordingly. It is the expectation of the law—as manifested through regulatory agencies and the courts—that boards will examine their existing governance structures and make changes where necessary. The basic question presented is, will the organization's governance structure remain effective in the midst of this dynamic change? The answer the law expects is, "Boards should make sure of this." And in making sure, the greatest focus can be expected in the following key areas: core fiduciary principles and the standard of conduct by which board members will be held, governance structures, board and committee size and composition, governance processes, and the overall level of engagement of individual board members.

What Change Means for Non-Profit Governance

- New challenges are arising in a hyper-competitive environment.
- Healthcare organizations are becoming much larger—more assets under ownership.
- The focus is on new models of delivering care.
- Board agendas are increasingly complex.
- Healthcare boards have greater opportunity to make a significant difference.

Note: This may have an impact on the regulatory perspective of the board's standard of conduct.

Basic Expectations of the Law

Healthcare boards must understand that with transformative change comes an expectation under the law that they will evaluate the impact of such change on existing governance practices and procedures (i.e., change begets change).

BY "THE LAW," WE REFER TO THE APPLICATION OF BASIC "duty of care" principles in the context of how the board navigates fundamental industry change. For by its very nature, the evaluation of governance effectiveness is primarily a legal exercise as opposed to a standard consulting engagement.

Relevant Legal Principles

In essence, the duty of care speaks to the obligation of directors to exercise the proper amount of care in the performance of their duties. In most states, the duty of care requires directors acting "in good faith," with that level of care that an ordinarily prudent person would exercise in like circumstances, in a manner the directors reasonably believe is in the best interests of the corporation.

The duty of care is designed to protect the director who acts with common sense and informed judgment, and who innovates and takes informed risks consistent with corporate goals and objectives.[6] The duty of care does not require that a director act with excessive caution or be a guarantor of success of a particular investment or activity. Rather, "it allows leeway and discretion in exercising judgment."[7]

Duty-of-care responsibilities arise in the context of two distinct functions:

- **The decision-making function**: this applies duty-of-care principles to a specific decision or action a director (and the board) may be called upon to make.

- **The oversight function**: this applies duty-of-care principles to the general activity of the board in monitoring the day-to-day business operations of the corporation (i.e., the exercise of reasonable care to ensure that corporate executives pursue their management responsibilities and comply with applicable law).

In most states, the duty of care requires directors acting "in good faith," with that level of care that an ordinarily prudent person would exercise in like circumstances, in a manner the directors reasonably believe is in the best interests of the corporation.

Aspects of Duty of Care

The non-profit director's duty of care has several important component parts. Furthermore, several ancillary concepts (e.g., application of the business judgment rule, and the ability of certain parties to assert standing on duty-of-care matters) are important to consideration of the duty. These ancillary concepts are worthy of separate discussion:

- **Good faith/reasonable belief**: "Good faith" typically refers to the honesty of the director's intention and purpose.[8] Is the director acting with honest intention in the best interest and welfare of the organization? Courts will make a fact-intensive inquiry into the director's state of mind in evaluating compliance with this component of the duty:
  - » Did the director's action reflect honesty and faithfulness to the director's duty and obligations?
  - » Was there any intention to take advantage of the corporation (related to the duty of loyalty)?
  - » Did the director *in fact* believe the action was in the best interest of the corporation?[9]
- **Best interests**: This refers to satisfaction of the related duty of loyalty, and the need for the director to act with disinterest as to the matter at hand.

6 *Model Nonprofit Corporation Act*, Third Edition (henceforth, *MNPCA*) , American Bar Association, August 2008, Section 8.30(a)(note).

7 Daniel L. Kurtz, "Safeguarding the Mission: The Duties and Liabilities of Officers and Directors of Nonprofit Corporations," C726 ALI-ABA Course of Study 15, 1992, pp. 22–23; see also, *Guidebook for Directors of Nonprofit Corporations,* Third Edition (henceforth, *Guidebook*), American Bar Association, Section on Business Law, Committee on Nonprofit Organizations, August 2012, p. 26.

8 Kurtz, 1992; Thomas Lee Hazen and Lisa Love Hazen, *Punctilios and Nonprofit Corporate Governance—A Comprehensive Look at Nonprofit Directors' Fiduciary Duties*, University of Pennsylvania Law Review, February 2012. View at www.law.upenn.edu/journals/jbl/articles/volume14/issue2/Hazen14U.Pa.J.Bus.L.347(2012).pdf.

9 *MNPCA*, Section 8.30(a), Official Comment, note 1.

- **Ordinary prudent person**: The concept of ordinary prudence takes into consideration a number of factors. It is typically interpreted to require directors to possess and demonstrate informed, practical judgment and common sense, while pursuing the exercise of innovation and informed risk taking. It also assumes a baseline level of attentiveness (i.e., that the director will devote enough time to corporate affairs to position herself/himself to be reasonably familiar with matters requiring her/his attention). Prudence, however, does not equate to excessive caution.[10] Just as "ordinary" does not connote "mediocre," prudence does not require special skills from the director.[11] The law has traditionally been reluctant to require some basic level of expertise, such as "the ordinarily prudent businessman" standard, of voluntary directors.[12] Furthermore, the ordinarily prudent person is not perceived as a guarantor of success of a particular corporate initiative.[13]

- **In a like position**: The duty of care recognizes that non-profit directors "in like positions" may have different goals, objectives, and resources than their for-profit counterparts.[14] The attendant level of care is that which the "ordinarily prudent person" would have exercised if he/she were a director of the corporation at issue.[15] Thus, "like position" generally means that a director's actions will be evaluated with respect to the unique nature of his/her corporation, taking into consideration the size and location of the corporation as well as the sophistication of corporate affairs. Courts will also consider the background and credentials of the director and will evaluate their actions in light of facts known or reasonably available to the director at the time of their decision.[16] Even so, this standard should not be interpreted as insulating from liability exposure the director who lacks particular expertise in exercising sound practical judgment and common sense.[17]
- **Under similar circumstances**: The concept of "under similar circumstances" is intended to compensate for the wide variety of circumstances in which a director may be called upon to render a decision.[18] It involves not only the unique nature of the non-profit corporation, but also the special background and qualifications of the individual director.[19] Courts will consider a director's special background, and will assess whether the director was elected to raise money, to make contributions, or because of special legal, financial, or medical expertise in evaluating compliance with the duty of care.[20] Employee-directors bear a special burden in this regard. This is true because the "lay" directors are normally entitled to rely heavily on the directors who are elected because of their particular professional expertise.[21] Whether the non-profit director is serving on a voluntary or compensatory basis may affect an evaluation under this criterion.[22]

These duty-of-care principles are embedded in the not-for-profit corporation statutes of each state; in judicial decisions that interpret these principles; in federal law identifying the requirements for maintaining tax-exempt status as a charity, and non-private foundation status; in regulatory guidelines developed, and enforcement actions pursued, by state and federal regulators; and in recognized "best practices" principles that seek to go beyond statute regulation and case law to establish aspirational goals of conduct, which, if satisfied, carry with them a presumption of good faith.

The regulatory bodies most invested in fiduciary standards of non-profit healthcare directors are:

- The state attorney general, with jurisdiction over enforcing the provisions of state not-for-profit and charitable trust statutes, and compliance by corporate officers and directors with their fiduciary duties established under those statues and the common law
- The Internal Revenue Service, with jurisdiction over the terms and conditions by which tax-exempt status under Internal Revenue Code 501(c)(3), and non-private foundation status under Code Section 509(a) are granted (the IRS long being of the view that effective corporate governance is essential for compliance with tax-exemption principles)
- The U.S. Department of Justice and the Office of Inspector General, Department of Health and Human Services, to the extent that their respective enforcement of Medicare and Medicaid anti-fraud statutes implicate the compliance oversight obligations of the governing board

The collective concept of "in a like position and under similar circumstances" is of bedrock importance as it relates to interpretation of duty-of-care obligations. This concept is based on the premise that a director's approach to a particular matter will depend upon the circumstances with which he/she is confronted. This is the "cards you're dealt with" analogy. Well-laid military plans will be affected by how the general views the battlefield; making a musical recording will depend on how the artist interprets the recording studio; executing a football game plan is subject to how the quarterback reads the defense. Even a director

10 *MNPCA*, Section 8.30(a).
11 *MNPCA*, Section 8.30(b), Official Comment, note 2.
12 Dennis J. Block, et al., *The Business Judgment Rule: Fiduciary Duties of Corporate Directors* (Fifth Edition), Aspen Law and Business, 2002.
13 *MNPCA*, Section 8.30, Official Comment.
14 *MNPCA*, Section 8.30(b), Official Comment, note 2.
15 Block, 2002.
16 *Ibid.*
17 *Ibid.*
18 *Ibid.*, Official Comment.
19 *Ibid.*
20 *Ibid.*
21 *Ibid.*
22 Kurtz, 1992.

lacking either relevant experience, or particular qualifications, will be expected to act consistent with "common sense, practical wisdom, and informed judgment."[23] The key is that the individual director apply his/her unique perspective—formed from whatever source or experience—to the matter and circumstances at hand.

Directors' obligations to monitor the effectiveness of corporate governance in a transformed healthcare environment arise within the context of both the oversight and decision-making functions. With respect to the *former*, it involves the board's duty to monitor the presence, extent, and magnitude of industry change and its implications to the organization. With respect to the *latter*, it involves informed decision making by the board with respect to possible changes to the form and structure of its system of corporate governance. The performance of these duties will be evaluated by courts and regulators within the context of the "in a like position and under similar circumstances" concept introduced above. The manner and extent to which directors address the impact of industry change will depend on a number of factors:

- **First** is the transformative nature of industry change. Courts and regulators are likely to recognize the significance of this change and hold board members to a higher level of attentiveness and care as a result. They will assume that fiduciaries will exercise the (higher) level of engagement necessary to respond to such seismic, generational change (i.e., a recognition that from a governance perspective, this is not "business as usual"). They will also assume that management will provide the level of support necessary to enable the board to evaluate the implications to the hospital or health system and its mission from such change.
- **Second** is the size and sophistication of the individual organization. Health systems, for example, whether organized as not-for-profit or for-profit in nature, are very substantial business enterprises—in many cases one of the leading businesses in the market area and with annual revenues in the nine and 10 figures. They operate with complex business agendas and through a diversified operational portfolio. They are likely one of the leading employers in the service area and contribute substantially to the greater economy of the service area. Thus, the director's duty of care is likely to be interpreted through the prism of a large, complex, sophisticated business enterprise as opposed to that of a typical not-for-profit charity. It is important that boards not cling to antiquated visions of deferential treatment afforded charities by courts and regulators.
- **Third** is the unique business structure of the healthcare sector and the significance attributed to the oversight and decisions made by hospital and health system directors. The "stakes" involved in the board agenda are enormous as they relate to the competitive position of the organization, its financial results, its delivery of care, its status as a major employer, and the delivery of quality healthcare services—as well as the long-term sustainability of the enterprise.

The application of these and other factors is likely to support application of a higher standard of care in terms of the board's obligation to monitor the effectiveness of corporate governance in a transformed healthcare environment. Courts and governance regulators may well interpret the duty of care in these circumstances and are requiring an enhanced level of engagement by the board in connection with this emerging issue—*working smarter, longer, and faster*. A good-faith response would be a board-driven examination of whether current governance processes are sufficiently responsive to the transformed healthcare environment. The specific focus would be on the need to position the board to make informed decisions and provide attentive oversight to an increasingly complex agenda and in the context of a highly regulated, evolving operational environment.

23 The American Law Institute, *Principles of the Law of Nonprofit Organizations*, Tentative Draft No. 1, Sec. 315, Comment a(1), March 19, 2007.

Applying Legal Principles to a Governance Review

As the previous sections demonstrate, the basic theme of this white paper is that the board has a special obligation to consider the implications for its governance structure arising from the transformed environment.

THE QUESTION THEN BECOMES *HOW* MUST IT RESPOND TO that environment—to the changed circumstances? What is the right course of action?

It is a well-established governance best practice that the board should periodically review its own size and structure in order to ensure the continuing adequacy of its oversight and decision-making practices, and commitment to the organizational mission.[24] There are potentially great benefits arising from an evaluation of the board's ability to fulfill its role as effectively as possible. Indeed, fundamental fiduciary principles *presume* that attentive boards will periodically pause to examine their responsibilities and processes in a conscious and progressive manner, with a view towards improvement.[25]

The law's expectation regarding governance self-review becomes more acute in periods of great economic, regulatory, legislative, or societal change. For example, many large corporations conducted major governance reviews in response to such significant events over the last decade (e.g., Sarbanes-Oxley, Dodd-Frank, and the great recession of 2007–2009). In these and similar events, sophisticated boards took time to contemplate and pursue new and improved ways of promoting organizational/mission goals and objectives. So it is likely to be with respect to healthcare boards and the transformative change generated by the ACA and collateral events. Courts and regulators are likely to interpret the nature of health sector change as so complex and consequential as to (almost) *mandate* board evaluation of what change implies for the hospital or health system, which now faces the demands of a recalibrated environment.

The issue is almost less about specific elements of change, and more about the willingness to consider, in a focused manner, whether change is necessary. It's primarily about asking the question, in a serious and deliberate way. After all, there is no prescribed manner by which boards are expected to respond to ACA-prompted change. There are no "best practices" specifically adopted for that purpose. In that context, a good-faith effort to review the adequacy of existing governance processes should be the immediate goal. And it's also an estimable goal. That's because "good faith" (i.e., acting with an honesty of purpose and acting with honest intention in the best interests of the organization) is often interpreted by the courts as a prophylactic for director liability. So there's a basic recognition of benefit in having made the effort, no matter what the result.

The issue is primarily about asking, in a serious and deliberate way: Is change necessary? There is no prescribed manner or "best practices" by which boards are expected to respond to ACA-prompted change. In that context, a good-faith effort to review the adequacy of existing governance processes should be the immediate goal, because "good faith" is often interpreted by the courts as a prophylactic for director liability. However, a review process that is limited or superficial that does not formally engage the full board or the governance committee, or one that results in few identified changes or revisions, will likely be viewed with circumspection and may undermine the good-faith effort associated with pursuit of the process.

That is not to suggest, however, that the law's expectation is solely about process—about simply making the effort to "kick the tires" of the existing governance structure. A review process that is limited or superficial that does not formally engage the full board or the governance committee, or one that results in few identified changes or revisions, will likely be viewed with circumspection and may undermine the good-faith effort associated with pursuit of the process. To truly satisfy the expectations of the law, the sophistication of the review must be commensurate with both the nature of industry change (substantial) and with the sophistication of the hospital or health system. In other words, what may be sufficient for a community-based health network is likely to be woefully insufficient for a billion-dollar, multi-state health system. Just as the "circumstances" of transformative change drive the need to reevaluate the effectiveness of the governance

24 Panel on the Nonprofit Sector, *Principles for Good Governance and Ethical Practice: A Guide for Charities and Foundations*, Principles 18 and 19, October 2007.

25 *Guidebook*, p. 306.

structure, the "circumstances" of the specific organization will drive the scope and intensity of the reevaluation process.

Against a backdrop of increased expectations, an ACA-prompted governance review is likely to reflect several broad considerations:

- **First**, the rigor of governance processes must be consistent with the organization's scale, scope, and complexity of operations.
- **Second**, the board's willingness to challenge engrained perceptions—to "push back" against an "if it ain't broke, don't fix it" mentality and reject assumptions that a governance structure designed to address a particular (pre-ACA) environment is well-suited to meet the needs of a dramatically changed environment.
- **Third**, the principal governance goal should be how best to ensure the long-term sustainability of the organization and its mission. Depending upon the circumstances, this may involve special emphasis on the development and maintenance of the organization's physical and financial (including but not limited to stewardship) resources.
- **Fourth**, the need for the board to address not only basic fiduciary responsibilities and near-term issues, but also to preserve sufficient agenda time to address the major strategic challenges and opportunities facing the organization. It is important that board processes reflect the discipline necessary to focus on the "big picture" and avoid excessive concentration on the transient, transactional, and tactical.
- **Fifth**, a recognition that there is at least a "grey" (if not "black") line distinguishing the roles of governance and management, and that the forces prompting a more engaged and attentive board do not require the conflation of those roles.
- **Sixth**, and final, is the importance attributed to the board's ability to balance competitive strategies, organizational ambition, and innovation with informed risk taking, with a careful calibration and management of risk—especially as the organization enters a more uncertain and potentially volatile regulatory environment prompted by ACA-related change forces.

The balance of this white paper is intended to address themes that can serve to guide the board through the review process. This transformational change will increase the complexity of board agendas, by presenting new issues and challenges that are beginning to emerge on the horizon. The ability of the board to respond to these issues can best be evaluated by examining their impact on the following elements of governance:

- Fiduciary principles
- Governance structures
- Board composition
- Governance processes
- Corporate structure

Review Components: Fiduciary Principles

A primary focus of board attention should be on the extent to which transformational change will affect the fiduciary standard of care to which it is subject.

BY WHAT BASELINE STANDARDS WILL IT BE JUDGED? ARE there elements of change that will require board members to apply a heightened degree of engagement with respect to all, or any particular aspect of, their duties? Simply put, the question is whether transformational change will require board members to work "smarter, faster, and longer."

As a general matter, the answer is likely to be "yes." Hospital and health system boards can most certainly find themselves devoting considerably more time, effort, and energy than in the past. It's only reasonable to assume that greater attentiveness will be expected by the law and regulators from healthcare directors, given the extent of industry reconfiguration. The duties of care—and loyalty—as applied to healthcare directors are likely to become materially more rigorous as regulations increase, the scope of operations become more sophisticated, and the value of assets under ownership or control become greater. It's not that the basic fiduciary principles themselves will change, but rather that the prism through which courts and regulators interpret those duties will change. That's because of the dramatically different circumstances in which non-profit healthcare boards now find themselves.

In some respects, the standard will be "hybrid" in nature—applying the basic corporate-styled standards generally applicable to business corporations, with an overlay of the unique stewardship obligations attributed to not-for-profit corporations and other charitable enterprises. In some states, it may also involve a confusing mix of charitable trust principles, which will only serve to frustrate boards and their legal counsel to the extent such principles contradict established state corporate law standards.[26]

This may be upsetting to some board members who cling to outdated notions of non-profit charity governance—of simpler and less complicated terms of service. Yet the inescapable fact is that the post-transformational healthcare organization will represent one of the most complex and operationally sophisticated of non-profit organizations.

Any heightened standard of conduct will likely be most significantly implicated in the board's exercise of at least five specific tasks—those that relate to strategic planning, risk management, quality of care, conflicts of interest, and executive search (and there may be others).

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Strategic Planning

Increased board involvement in the strategic planning process arises from the rapidly changing competitive landscape within which many organizations find themselves operating. (We're no longer worried only about competition from the other hospitals in town.) The current period of transformative change is serving to recast the universe of competitors from both vertical and horizontal perspectives. Hospitals and health systems now face direct and indirect competition from a hugely diverse set of enterprises, not just other hospitals and health systems in the service area, but also from national systems providing service line venture support; physician ambulatory, diagnostic, and other entrepreneurial ventures; and insurance, pharmaceutical and medical device companies, retail pharmacies, information technology firms, research enterprises, and the like.

This may require positioning the board to be more engaged in connection with market-based matters. The board will be better

26 *Guidebook*, p. 227; see, .e.g., Illinois Charitable Trust Act (760 ILCS 55/).

able to respond to management initiatives with respect to the competitive landscape if it is more informed about the strategic direction of the market, publicly available information about the direction of competitors, and about trends that are developing in similarly situated markets across the country.

With strategic planning assuming such an important fiduciary role, it is fair to assume that the board's involvement in that process will assume a heightened level of expectation. The board should expect to be more assertive both to the extent in which it directs management to prepare a strategic plan, and in which it reviews, understands, and monitors the implementation of the plan. It should be clear that while management may have the responsibility to prepare the actual plan document, the board has overarching oversight responsibility with respect to plan development and application. The board will also be expected to be more attentive to the relationship between the strategic plan and executives' achievement of strategic-based incentive compensation goals.

Risk Management

Virtually all governance trends for corporations in regulated industries reflect a sharp increase in board commitment to matters of risk oversight. While much of this focus has its foundation in events within the financial services industry over the last several years, the principles of effective risk oversight apply across all industry sectors. These principles are centered on improving the process by which risks are identified, assessed, managed, and communicated through the organization.

Special emphasis is placed on enhancing the manner in which risk information is communicated to the board, the context in which that information is communicated, and the attentiveness given to it by the board or risk committee. Indeed, this trend is leading some sophisticated corporations to increase the expectations placed upon members of their audit and risk committees (with, in many cases, a corresponding increase in compensation and staff support). In healthcare, governmental fraud recovery statistics, the level of fraud-related whistleblower activity, and announcements/reports of regulatory investigations and judicial decisions combine to evidence the dramatic increase in fraud enforcement in recent years. Much of this is rooted in the new anti-fraud provisions of the ACA, and related initiatives, to reduce the impact of fraud on the cost of affordable healthcare.[27]

The regulatory risks associated with the broad shift towards hospital–physician integration add to the importance of a more focused risk management process with close board involvement. The Tuomey decision alone should be a dramatic fiduciary warning sign.[28] These types of developments reflect a trend that cannot be ignored by governing boards in the exercise of their Caremark-based risk and compliance oversight responsibilities.[29]

Increased board attentiveness can be manifested in several specific ways, all of which are consistent with a broader trend across the spectrum of regulated industries to emphasize the more direct role of governance in risk management:

- **First** is providing directors with a greater understanding and awareness of the enforcement climate—the ability to effectively exercise risk oversight will depend in large part on a meaningful appreciation of the level of enforcement activity and of the government's general theories of fraud, Stark, and False Claims Act liability.
- **Second** is establishing a reporting relationship between the line management, the compliance and legal affairs officers, and the board that provides timely and understandable information on legal and compliance issues, including those that "keep management awake at night." Governance-driven corporate culture must encourage management to report "bad news" to the board.
- **Third** is adopting a more defined internal management/board process by which business transactions and arrangements involving material legal risk (e.g., physician alignment proposals) are reviewed and approved.
- **Fourth** is having the board adopt a risk tolerance position/risk profile, that more directly engages the board in the awareness of risks associated with individual arrangements and transactions, and establishes a template from which the board may determine whether arrangement-specific risks as identified are acceptable to the organization.
- **Fifth** is ensuring appropriate horizontal communication, on both governance and management levels, between individuals responsible for compliance, internal audit, audit, and legal affairs matters—to help ensure better internal coordination on risk management issues.

Quality of Care

The evolving healthcare environment is forcing boards to reevaluate their approach to quality-of-care concerns. The board's quality oversight role is being impacted by larger organizational structures; complex and diverse contractual arrangements with physicians; multiple delivery of care models; acute risk management concerns; reputational, rating, and patient satisfaction matters; and the intense focus of government and private payers. Additional pressures are arising from the organized medical staff and executive leadership, each of which have their own perspectives on the proper role of the board with respect to quality of care. These factors combine to compel the board to reconfirm for internal constituencies its "claim" to an oversight role.

27 Michael G. Scheininger and Brad Samuels, "Anti-Fraud Provisions in the New Health Care Law," Law360, March 12, 2010.

28 Karen A. Gledhill, John B. Garver III, and Amit Bhagwandass, "The October 2013 Tuomey Order: What Happened, What Can We Learn, and What's Next," North Carolina Bar Association, Health Law Section, February 1, 2014. View at http://bit.ly/1emy95k.

29 *In re* Caremark, International, Inc. Derivative Litigation, 698 A.2d 959 (Del. Ch. 1996); see also, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors,* Department of Health and Human Services (Office of Inspector General) and American Health Lawyers Association, September 2007. View at https://oig.hhs.gov/compliance/compliance-guidance/compliance-resource-material.asp.

Pursuit of this goal invites a more aggressive, collaborative process between the board, management, and medical staff leadership.[30] For while there is substantial clarity on the need for greater emphasis on quality of care, there is much less clarity on the board's role in the process by which the board, medical staff, and management should work together on quality matters. The board can effectively achieve its quality-of-care oversight responsibilities through an integrated, coordinated risk management process that focuses on the six specific dimensions in which quality-of-care issues most directly implicate board responsibilities.

These dimensions include licensure and accreditation, payer reimbursement, ACA themes, regulatory compliance and enforcement, organizational reputation, and financial risk. The expectation is that such an integrated approach will work to confirm the appropriate role of the board—for not only individual board members themselves, but also for members of executive leadership and the medical staff. It is critical that all of these constituencies understand why and how the board must be involved in quality oversight.

Six Dimensions of Oversight

The board's quality-of-care duties are affected by its:

1. Traditional oversight of the organization's **licensure and accreditation** arrangements
2. Traditional oversight of the organization's participation in governmental and private insurance **payment programs**
3. Obligation to monitor the organization's compliance with the **Affordable Care Act** and to work with management to implement ACA-based responses
4. Obligations to provide **oversight of the organization's corporate compliance programs** and system of legal controls
5. Obligation to protect the **reputation of the organization** (as an important asset)
6. Obligation to serve as attentive **stewards of the organizational fisc** (i.e., to monitor its financial affairs and to take necessary and prudent steps to minimize financial risk)

Conflicts of Interest

Virtually every board has some form of process or policy by which it identifies and addresses conflicts of interest amongst its board members and officers. That's not the concern. Rather, the concern is that those processes and policies may be materially insufficient to address new duty-of-loyalty issues emerging from the transformed healthcare economy. Board members will be expected to adopt a more vigorous approach to the manner in which conflicts are identified, disclosed, reviewed, and—in appropriate circumstances—managed (i.e., the process by which conflict-of-interest transactions approved by the board are subject to ongoing monitoring).

The transformed healthcare economy is prompting organizations to invest in a much broader portfolio of enterprises, clinical partnerships, research ventures, new programs for the delivery of care, creative investment vehicles, and other relationships and arrangements. The diversity of these relationships and associated opportunities for partnership and investment will serve to significantly increase the potential for conflicts involving fiduciaries or affiliates. At the same time, the regulatory and judicial enforcement of conflict-of-interest arrangements has become much more engaged. The types and nature of relationships that can create (or create the impression of) a conflict of interest are expanding significantly, beyond traditional concepts of direct financial, employment, and investment relationships. There is a broadening policy concern with the types of arrangements involving fiduciaries that could somehow bias the board's decision making or oversight policy.

For those reasons, the board's approach to conflict matters must be materially more robust—commensurate with the size and sophistication of the enterprise and the diversity of its business portfolio. The evaluation process must be looking "down the block and around the corner" in terms of potentially problematic relationships. Board members must adopt a more expensive appreciation for the types of relationships that have the potential for creating conflict. Reliance on the IRS' template conflict policy won't work; a policy that is a good fit for the local area blood bank won't work for a health system generating hundreds of millions in terms of annual revenues. The legal and reputational risks associated with an insufficient conflict orientation are substantial. Thus, the likelihood is that the transformed environment may prompt a revised approach to board-level conflict-of-interest review and resolution.

Executive Search Process

The transformed healthcare environment is also likely to place additional pressure on a more "micro" aspect to the board's duty-of-care obligations—carrying out the executive evaluation, transition, and search process. General trends reflect a substantial increase in CEO turnover, across industry sectors. Not surprisingly, the data suggests that such turnover is particularly high in the healthcare sector, no doubt reflective of the fluid nature of the industry.[31] These circumstances—together with the increasing complexity of the healthcare business model—combine to substantially increase the fiduciary "stakes" associated with the role of the board's CEO search committee.

The higher "stakes" are attributable in part to the fact that, for many organizations, the search committee has often failed to receive the degree of board-level attention, in terms of organization and operation, than the circumstances would ordinarily

30 Michael W. Peregrine, Sandra M. DiVarco, and Anne M. Murphy, "The Board's Quality of Care Responsibilities: Six Dimensions of Oversight," E-Briefings, The Governance Institute, Vol. 11, No. 1, January 2014.

31 "Year-End CEO Report: 1,246 CEO Changes in 2013, More Women in Top Spot," Challenger, Gray & Christmas, Inc. View at www.challengergray.com/press/press-releases/year-end-ceo-report-1246-ceo-changes-2013-more-women-top-spot.

warrant. This inattentiveness has often been manifested by the following types of concerns: disunity on the search profile; lack of specificity and direction in the committee charter; the absence of committee members with search process experience; unrealistic timetable expectations; a committee budget that is insufficient to support the needs of the committee; deficient due diligence, both in terms of the identification of qualified search consultants and of identified candidates; insufficient committee oversight of, and engagement with, the search consultant; and limited communication between the search committee and the full board.

The higher stakes are also attributable to the fact that the profile for a qualified CEO candidate has evolved dramatically, consistent with the evolution of the industry generally. The search committee "playbook" may need to be rescaled in order to create a profile that matches the needs of an organization in a transformed environment; the qualifications that may have been ideal the last time the organization pursued a search process may well be obsolete now. Similarly, the qualifications of the search committee members, the capabilities of the search consultant, the extent of the committee's involvement with the consultant, and the committee's "homework" with respect to the candidate—all may be in play. Thus, in a transformed healthcare environment, the board's CEO search committee may be thrust from the relative "backwater" of governance processes, to the forefront thereof.

Note that while the above elements of the board's obligations are those that experience suggests will be most likely subjected to enhanced fiduciary attentiveness, they may not be the only elements. *The review process should broadly examine the potential for transformative change to increase the level of board engagement in terms of its established duties.*

Review Components: Governance Processes and Structures

The board should examine the extent to which the level of transformational change will affect its established governance structures and practices, and its ability to implement thereto needed efficiencies in order to reduce certain administrative burdens on board members.

THE SPECIFIC QUESTION IS WHETHER THERE ARE ELEMENTS of change that will require board members to amend the approach to such key procedural matters as meeting schedules, use of committees, reserved powers, advisory and "management" boards, communications and reporting relations, and agenda management. To a large degree, the board's position with respect to these elements of process and structure will reflect its perspective on the nexus between transformative change and corporate governance.

Meeting Schedules

The calendar for scheduled meetings of the governing board will need to take into consideration increased agenda items arising from transformation-based developments and challenges. Understandable efforts to achieve governance efficiencies, and to reduce administrative burdens on directors, typically include the possibility of both reduced meeting schedules and time limitations on individual meetings. While these are laudable goals, they must be balanced with assurances that directors are devoting a sufficient amount of time to corporate affairs in an organized, formal manner. The governance committee should give careful thought to the scope of future agendas, and to the intensity and complexity of matters coming before the board, in setting the board calendar.

There will be a (reasonable) assumption on the part of regulators and other third parties that agendas are likely to become more—rather than less—complex, given the diversity of transformation-related issues coming before the board. Indeed, many transformation-related issues may involve new or unique concerns and opportunities. Thus, the time required for board deliberation may actually be longer—and extend over a period of time—than more traditional issues that have regularly come before the board. (This is certainly a factor to be considered before committing to any significant efficiency-based reduction in meeting schedules.) This underscores the renewed importance of "agenda management" (i.e., that a more disciplined, general counsel-driven approach to agenda development preserves more meeting time to be spent on critical matters such as strategy, compliance, transactions, financial performance, and quality of care). Remember that in the context of regulatory investigation or third-party litigation, items such as agendas and meeting minutes can be evidence of the level of attentiveness attributed by the board to specific matters.

Reserved Powers

Transformation-related issues and initiatives may also warrant an evaluation of the control powers that the health system parent retains over its subsidiary organizations and joint venture investments. Many of these "reserved powers" were initially structured to address traditional issues coming before the boards of subsidiaries. The transformation-related question is whether the reserved power structure should be updated to give the parent the ability to maintain an appropriate amount of control over subsidiary investments and initiatives. For example, would the existing reserved power structure be sufficient to allow the parent board the (expected) ability to approve a hospital subsidiary's proposed commitment to innovative initiatives such as new service-line joint ventures, investment in population health initiatives or other forms of increased risk assumption, implementation of "cloud computing" solutions, or large-scale physician alignment arrangements (especially where the regulatory risk is material)? Many new transformation-related initiatives considered by various entities within the organization will be unique in nature and will require a higher degree of evaluation and risk analysis. The question is whether the current arrangement for intra-system reporting and reserved powers will be sufficient to allow the parent board the ability to apply the level of oversight and (if necessary) approval that may be warranted.

Reporting Relationships

On a related point, the intensity and complexity associated with transformation issues prompts a second look at the effectiveness of traditional management-to-management and management-to-board communications and reporting relationships. Do they work to ensure that information is provided on a timely basis to those with a "need to know," and in a context that will assist the recipients with the review and comprehension? While the

importance of effective reporting relationships has been most acute of late in the context of risk management (see discussion above), it is also of great importance when multiple organizational constituencies are pursuing/managing/directing a broad array of transformation-prompted initiatives and programs.

In this regard, there should be a sensitivity to the potential for bias or conflict to arise within reporting relationships, and to provide solutions (e.g., futility bypass arrangements) to prevent important messages from being muted or blocked due to conflict. This has been a particularly significant issue with respect to the reporting relationships of such key officers as the general counsel, compliance officer, and chief financial officer. In these and similar instances, the government seeks to ensure both that the voices of these key officers are heard by other key officers and by the board, and that they are not required to report to an officer who, by the nature of the position and its duties, could be in a position to negatively affect the ability of the reporting employee to pursue his/her message.[32]

A similar concern is whether there is a *clear understanding* between management and the board on lines of authority, just as it must be between the parent board and subsidiaries. As multiple transformation-related initiatives "percolate up" through the healthcare organization, it is important to have clarity on the established review and approval processes. With respect to the CEO, it is helpful that there be an understanding as to what matters can be pursued on the CEO's initiative, what matters require notification to the board as part of the implementation process, and what matters require board approval before implementation. In the context of reserved powers and lines of authority, written "governance matrices" assume greater organizational value and importance, helping to ensure that boards are more fully informed in a timely manner, and that CEOs do not move forward without the necessary board input or authorization.

All of these issues mean that, given the intensity of the transformed healthcare environment, long-standing perceptions about reporting and intra-system relationships may need to be adjusted.

Committee Formation

The impact of health sector transformation will also be felt in terms of the structure and charter of the committees of the board. The question that should be asked is whether the existing committee organization will be adequate to address the challenges that can be expected from the evolving environment. Which committees still have valid purposes and which don't? Which committees should be added and which should be dropped or merged? Do charters of existing committees need to be amended to focus more clearly on new issues?

The following committees can be expected to continue to play a prominent board role:

- **Finance**: This committee will likely assume a critical role in monitoring the financial stability of the organization, and how it is impacted by ACA-driven changes in federal reimbursement/Medicare payment rates and arrangements with private insurers. This is especially the case given the general uncertainty associated with the financial implications of health sector transformation. Together with the quality committee, it will be expected to focus on new operating models that will better position the organization to be responsible and accountable for the quality, cost, and overall care of the patient community, including consideration of possible new forms of physician integration, such as accountable care organizations and medical homes. The finance committee will be expected to work closely with the organization's investment bankers to address the credit rating implications of transformation-related matters and further ACA-related developments.
- **Executive/strategic planning**: As noted above, the governing board will be expected to place an increasing focus on strategic matters, whether directly through a standing strategic planning or similar committee with jurisdiction over strategic matters. Certainly a primary task of this committee will be to work with the senior management team in the development, implementation, and monitoring of the strategic plan. This committee will also be expected to take a leading role, working with management, in monitoring strategic marketplace developments and related opportunities for collaborations and affiliations arising from transformation-related challenges.
- **Governance/nominating**: As noted elsewhere in this white paper, a vital governance task will be an evaluation of proper size and composition of the governing board and its committees. This is particularly the case with the emerging emphasis on competency-based boards. The committee's task will include ensuring the proper mix of committees, the right qualifications for new directors, and implementing board and committee evaluation processes. The committee is likely to be charged with the responsibility for reviewing and responding to disclosed potential conflicts of interest as disclosed by officers and directors. As stated above, the emphasis on a sophisticated, committee-driven conflict review process will be especially important given the conflict issues likely to arise from new operating models and diversified corporate investments prompted by the transformed healthcare sector. This committee will also be charged with maintaining adherence to thoughtfully developed board standards on director independence.
- **Executive compensation**: With greater scrutiny of all the factors that contribute to rising healthcare costs, board compensation committees will face increased pressure to support reasonable executive compensation decisions. Particular importance will be on establishing appropriate incentive compensation arrangements that speak to the achievement of transformation-specific goals and objectives (e.g., targets such as quality of care, merger integration, physician alignment, and mission support/expansion). The committee will be called upon to respond to increasing public and regulatory demands for transparency, and to limitations on certain elements of compensation. The committee will also increasingly be expected to evaluate the implications of elements of incentive compensation and how they

32 Michael W. Peregrine and Joshua T. Buchman, "Managing the General Counsel/Compliance Officer Relationship," *AHLA Connections*, American Health Lawyers Association, October 2011.

relate to the achievement of both short-term operational goals and long-term cost containment goals.

- **Audit**: The audit committee can be expected to play an outsized role in terms of monitoring the operational integrity of the hospital or health system, ensuring the transparency and accuracy of financial statements, and confirming the effectiveness of internal controls. In that regard, it will be expected to establish policies with respect to, and monitoring compliance with, the new supplemental requirements for Internal Revenue Code Section 501(c)(3) tax-exempt status for hospitals (e.g., the provisions of Internal Revenue Code Section 501(r) and associated Treasury Regulations). The committee will expand its traditional role of working with the independent auditor to include the likely consideration of new accounting changes and rules prompted by reform legislation and initiatives.
- **Quality**: The agenda of this committee will be expanded to focusing on new transformation-based challenges with respect to clinical processes and outcomes, patient care, and utilization. A particularly important new task for this committee will be the coordination of all areas of governance, management, and medical staff that touch on the multiple dimensions by which the organization approached quality-of-care issues. These include licensure and accreditation arrangements, government and private insurance payment programs, quality-of-care provisions of the ACA, the organization's compliance plan and its compliance oversight efforts, the basic governance responsibility to preserve the reputation of the organization, and the board's duty to be attentive stewards of the organizational fisc (i.e., to monitor its financial affairs and to take necessary and prudent steps to minimize financial risk). It should be the committee's responsibility to ensure that there is no "silo effect" when it comes to coordinating quality and safety efforts within the organization.
- **Compliance**: The continuing importance of this committee in a transformed healthcare sector cannot be underestimated. With the guidance of the general counsel, the committee will be expected to respond to the many significant new anti-fraud provisions introduced by the ACA and the corresponding dramatically increased government enforcement emphasis on eliminating Medicare/Medicaid fraud and abuse. The committee must be the focal point of governance efforts to satisfy the government expectations that the board assume responsibility for ensuring an organizational culture of compliance. The committee will want to focus in particular on the compliance/regulatory/legal issues associated with transformation-driven hospital–physician alignment proposals. In this regard, the compliance committee may wish to work closely with other board committees that have jurisdiction over initiatives that may have significant legal/compliance implications, in order to better monitor the identification and resolution of risk.

To the extent the hospital or health system combines the audit and compliance board oversight functions, that practice should be reconsidered. The question is whether the necessary board oversight of compliance issues confronting the organization will be fully effective through a committee with dual responsibilities. The larger the organization, the more difficult it becomes to justify such a combined approach; it will only serve to marginalize the compliance oversight efforts in terms of both practical implementation, and from the perspectives of both the organization's constituencies and the government. That begs the question of whether other committees (e.g., physician alignment, information technology, delivery system formation, and cybersecurity/privacy) should be formed in order to ensure the most effective breadth of board oversight, and to increase the efficiency of the board's overall practices.

Certainly, these are not the only elements of the board process and structure that should be considered in the context of a transformation-prompted governance review. They are, however, some of the most obvious and represent a starting point for a comprehensive analysis of whether existing processes and structures position the board for success in a post-transformation environment.

Review Components: Board Size and Composition

A critical issue for board consideration is the extent to which the level of transformational change will affect its current approach to board size and composition.

THE SPECIFIC, AND FUNDAMENTAL, QUESTION IS WHETHER the board is of sufficient size, and reflects the expertise and qualifications, that will position it to provide effective and informed decision making and oversight in the context of the evolving healthcare sector. It's nothing more complex than asking: Do we have the right number of board members to do the job, and are we selecting people who have the skillsets we need to address the challenges we know will be coming before us? For there will be likely no greater and more self-evident demonstration of the board's good-faith commitment to addressing transformational challenges than how it addresses the related issues of size and composition.

Matters of Size

It is well established that there is no such thing as a "best practice" when it comes to the appropriate size of a governing board. Most authorities suggest that board size should be commensurate with the size and sophistication of the organization. It is generally recognized that there are governance concerns with boards that are so large that they hinder effective operation and decision making. Large-board governance through executive committee mandate carries with it particular risks. Similarly, there are governance concerns with boards that are so small that they cannot give adequate attention to the pressing needs of the organization.[33] Determination of board size must be a very informed decision by the board in normal circumstances—and it requires a particularly deliberate reevaluation in circumstances of seismic industry change.

A discussion about the continuing effectiveness of current board size should be guided by a number of important factors, including:

- The size and sophistication of the organization, the regulatory environment in which it operates, the nature and geographic scope of its mission and activities, its financing model, the volatility of its competitive market, and similar "macro"-type issues.
- The board must be large enough to ensure that it is able to provide effective oversight of management, ensure compliance with applicable laws, safeguard its assets, and promote and further the underlying non-profit, charitable mission.
- There must be a serious determination of both the ability of the current board to effectively respond to the issues that it faces, as well as to the issues that will be arising as a result of the transformation process (e.g., the board size may have worked in the past to address the current universe of issues, but will it work in the future to address the issues we know are arising over the horizon?).
- As noted elsewhere in this white paper, there is a direct link between the adequacy of board size and the meeting attendance, preparation oversight, and information review needs/expectations of the board. Proper board size should anticipate the extent to which those tangible assignments/obligations may increase as a result of transformation.
- Also as noted, the benefit of adding board members with specific, needed competencies may affect board size (i.e., the need to "make room" for competency-focused candidates).
- There is an increasing trend in governance law with respect to the "over-boarded" director—there is more of a "seller's market" now for the services of highly competent, experienced board members. Adding individuals who concurrently serve on more than three or four other boards (there is no "magic" number) may significantly dilute the potential contributions of such a director.
- Assigning specific duties to committees with board-delegated authority, and populating those committees in part by individuals who are not voting members of the board, may be advantageous if allowed under state law.
- The most effective board size may be impacted by an increase in the number of board committees in response to transformational and regulatory considerations (e.g., separating audit from compliance and adding new committees to address emerging topics such as quality of care, information technology, cybersecurity, etc.).

33 Internal Revenue Service, "Governance and Related Topics—501(c)(3) Organizations," February 2008. View at www.irs.gov/pub/irs-tege/governance_practices.pdf.

- Preserving a majority of directors who satisfy existing board protocols and applicable law on director independence will continue to be an important governance consideration.
- Warning signs that a board is already too small include situations in which board members have three or more committee responsibilities and cannot effectively devote sufficient time to those responsibilities, and where the presence of a conflict of interest of a leading director or two may affect the ability of the board to take action on a matter.
- Warning signs that a board is already too big include situations in which the board has difficulty in obtaining a quorum for meetings, or if it has evolved to a practice of relying principally on executive committee action to provide oversight and decision-making direction.
- Any evaluation of board size and composition should reflect the growing public policy emphasis on increasing the participation of women in governance.

When considering board size and composition, boards should ask: Do we have the right number of board members to do the job, and are we selecting people who have the skillsets we need to address the challenges we know will be coming before us? For there will be likely no greater and more self-evident demonstration of the board's good-faith commitment to addressing transformational challenges than how it addresses the related issues of size and composition.

Matters of Composition

The traditional non-profit healthcare governance model has historically focused on community and other constituent-based representation, and the IRS exemption standards for hospital board composition (the so-called "independent community leaders" requirement). While this standard has been in place for almost 45 years, it may prove to be a limiting (if not outmoded) platform for designing healthcare governance in a transformed environment. As this white paper has attempted to reflect, non-profit hospitals and health systems are shifting from community to regional and even national entities in terms of scope and operation. That fact, together with the need to respond to the broadening scope of transformational challenges, is prompting a reevaluation of how hospitals and health systems populate their boards. Satisfying the "independent community leader" standard may be increasingly difficult as healthcare organizations grow in terms of size and geographic scope.

Composition will be directly affected by the evolving nature of board agendas; transformation is prompting board agendas of previously unanticipated complexity and challenge. And, depending on the type of board, as well as the scope of its work and challenges, very different directors with different competencies may be required. The board member qualifications and expertise that formed the basis for effective community hospital governance may not continue to be the "right fit." Nor will they automatically translate to effective regional or national health system board service, no matter the good faith or meritorious intentions of the individual director in question.

Of course, the specific work of each board will determine the competencies required to function effectively at that particular level. Nevertheless, the "universal" challenge is that the scope of board oversight must expand in relation to the new responsibilities and issues hospitals and health systems are now confronting. It is well recognized that healthcare organizations are no longer merely an aggregation of hospitals; rather, they are expanding regionally to pursue initiatives such as clinically integrated networks, population health, and wellness for entire communities. They—and their boards—are confronting a host of new issues and evaluating many new opportunities unique to this transformed environment.

Boards will also be overseeing a broad portfolio of businesses, complex partnerships with clinicians and other providers; new programs to implement the continuum of care in a standardized fashion to ensure quality; investment in immensely expensive technology systems; and possibly the assumption of risk for population health, either directly or with insurance carriers or capital partners. Increasingly, the board will be responsible for the oversight of a diversified portfolio of activities, enterprises, and investments, and the board's composition must be structured accordingly.

As noted above, community leaders have historically formed the core with non-profit hospital and health system boards. While this type of director may still add value to the board, additional skill and diverse backgrounds are increasingly being called for. The competencies required to serve in the new model of care environment will in many instances be less traditional, more sophisticated, and more expansive. Increasingly, organizations will seek governing boards that are capable of evaluating the entire "chess board" to determine how each initiative is supportive of the strategic plan, while substantially rescaling the inpatient experience. The competencies needed to evaluate such initiatives as population health and wellness, extenders to the continuum, telemedicine, retail partnerships, and new data that maps risk and quality represent the "first round" of new skillsets that will emerge "over the horizon" in healthcare.[34] Indeed, the health industry rating agencies are encouraging boards to "cultivate informed leadership" and populate boards with expertise in information technology, commercial insurance, financial services, and regulated industries in which compliance is deeply embedded within organizational culture.[35]

It will be the responsibility of the board (acting through the governance or similar committee) to anticipate the future corporate agenda, develop competency profiles for organizational

34 "Over the Horizon" client memoranda series on emerging legal issues in healthcare, accessible at www.mwe.com/info/overthehorizon/.

35 Michael W. Peregrine and David Nygren, "Toward the Professional Board: Governance Considerations for a Consolidated Sector," *AHLA Connections*, American Health Lawyers Association, August 2012.

needs, and then develop the governance profile of new members capable of fulfilling evolving needs. The responsibility for evaluating and nominating candidates for the board will assume far greater importance, and specific, pre-established board membership criteria can serve as an effective reference for the committee in the nomination and renomination process.

Governance appointments that run counter to this competency-based approach to board building—such as "legacy seats," "constituent representation," and others—can pose problems for continued effectiveness of board-level oversight and decision making. Board and committee composition must reflect an understanding of how integrated care is changing the agenda and information needed to support governance duties. Governance/nominating committees may thus be among those select few board committees for which greater effort and commitment is expected.

The governance committee will need to identify prospects from a more diverse pool of candidates if they are to achieve competency goals. Candidates who are community-based or closely associated with inpatient provider operations should not dominate the selection process because of their limited background. Increasingly, boards may turn to professional recruitment firms to achieve their recruitment goals—especially with respect to so-called "fly-in directors" and directors from related industries (DRIs).

The practice of using board seats as "currency" in merger/affiliation transactions should be discouraged. Offering a potential partner position(s) on the parent board has long been a recognized negotiating tool, particularly in change-of-membership transactions. Yet, in a transformed sector this bargaining "chip" can frustrate the ability to add competency-based board representation. It also may increase the risk of intra-system conflicts of interest arising from perceived dual loyalties (i.e., to the health system and to the hospital the director may be "representing").

The pool of potential directors may expand to include representatives from the proprietary of the healthcare world; e.g., individuals serving in an executive or board capacity with for-profit/publicly traded companies with healthcare service lines. (The governance committee will be challenged to educate directors with for-profit orientation on the unique mission and legal aspects of the non-profit corporation.)

Board Composition: "Over the Horizon" Considerations

- The director nomination process will experience a shift towards developing more leaders with expertise in emerging competencies critical to hospital and health system diversification (e.g., population health and wellness, information technology/digital enterprise, cybersecurity, etc.).
- Closer focus will be applied to whether the size of the board allows it to efficiently and comprehensively address the issues with which it is presented on a regular basis.
- Substantial "constituent representation" and reliance on executive committee practice are to be avoided.
- Increased vigor and sophistication will be expected from governance processes that monitor director independence and the identification, disclosure, and evaluation of conflicts of interest across the organization.
- As the responsibilities of the audit committee increase, so must the qualifications and commitment of its members, and efforts to protect its charter from dilution by unrelated tasks.

Other competency- and composition-based issues that may need to be considered in evaluating the most appropriate transformation-responsive governance include:

- **Commitment to serve**: This is a factor that incorporates such important issues as the willingness of a director to spend the necessary time on board matters, as well as the practical ability of the director to do so. Leading hospitals and health systems generally seek director candidates who have a sophisticated background and are likely to have significant commitments to both employment relationships and service on other boards. There are many competing "calls" on their personal agenda. The nomination process should not only select appropriately credentialed candidates but also ensure their willingness to reduce the number of competing commitments. Highly qualified board members are of little governance value if they are unable to attend meetings on a regular basis, or unable to fully participate in those meetings.
- **Conflicts of interest**: Conflict-of-interest issues may assume a larger role in the nomination process in the context of efforts to identify competency-based and other similarly skilled candidates. As organizations expand their corporate agenda in the transformed environment, the potential for board member conflicts of interest will increase. It is simply a function of the more diverse, sophisticated model of care and investment the organization elects to pursue; the potential for bias and conflict arising from the new agenda will automatically increase—and the governance committee must be attentive to related concerns. Dual parent/subordinate board service will raise additional conflict issues. And it is not only actual conflicts but also the appearance

of conflicts and organizational reputation issues that must be carefully considered. Regional system and national system boards must insist on a sophisticated conflict-of-interest policy/procedure to protect the unique duty-of-loyalty issues presented to the organization, the board, and individual directors in such circumstances. This determination requires a thoughtful process by the board, as opposed to a "check the box" review.

- **Director independence**: Efforts to pursue competency-based nominations may similarly confront expanded challenges in terms of maintaining control of the board in "independent" directors. New board candidates will need to be vetted for their ability to satisfy independence criteria in the context of their unique business and professional relationships and expertise that form the core of their competency attraction.
- **Compensation**: A board compensation program may prove to be a valuable director recruitment and retention tool, where it is allowed by state law. Compensation may well be an expectation, particularly given the expanded description of director duties, and the competitive market for certain types of directors. To be sure, several leading non-profit hospitals and health systems already compensate their directors commensurate with their level of duties, their time commitment, and travel required. Where allowed by state law, healthcare organizations may wish to give greater consideration to the value of director compensation in a transformed governance environment, particularly if they are to effectively compete for the best-qualified directors.
- **Legal/tax considerations**: Careful corporate tax planning will be an important element of any shift toward a more competency-based board. For example, parent health system tax-exempt status is derived from the parent's relationship with some or all of its tax-exempt related subsidiaries. A health system parent will be considered an "integral part" of the operations of its affiliated tax-exempt hospitals, and thus be entitled to derivative tax-exempt status, if it engages in activities that have a "close and intimate relationship" to the functioning of its affiliated tax-exempt organizations and it provides a "necessary and indispensable" service to such tax-exempt organizations (e.g., headquarters-type support). There is also the issue of the health system parent's non-private foundation status, which may require a continued degree of overlap between the board members or officers of the health system parent and the affiliated tax-exempt organizations from which the health system parent derives its tax-exempt status. These important and complex tax-planning issues are likely to be implicated by a competency-based board member selection process.

A Unique Responsibility

The transformed healthcare environment also serves to involve the governing board more closely with the role of the corporate general counsel as she/he confronts new ethical and professional issues.

THE GOVERNING BOARD MUST BE SENSITIVE TO THESE ISSUES, and supportive of the general counsel's efforts to resolve them.

The general counsel of a healthcare organization is typically tasked with multiple roles: as a licensed attorney, a departmental administrator, a corporate agent in relation to third parties, an executive employee, a "guardian" of the corporate reputation, a member of the senior leadership team, and an important corporate and business counselor.[36] Complications from these multiple roles can arise from the general counsel's dual role as both a business and legal counsel to the corporation. On the one hand, the general counsel is expected to provide the organization with technically competent legal advice (e.g., assessing and managing legal risks and counseling the organizational client on the legal implications of particular options and circumstances). On the other hand, the general counsel is often asked to provide perspective and advice as a businessperson and not as a lawyer—to be a creative, collaborative, and proactive business partner to management team colleagues.

These are somewhat mutually inconsistent roles. It gets tougher when the general counsel, naturally, develops loyalty to superiors and to other members of the management team. One would expect the general counsel to be reluctant to create a divisive relationship with executive team colleagues. From this arises what commentators describe as the "partner-guardian tension" that is firmly at the core of the general counsel's role.[37] It is a tension that can be moderated by the general counsel's exercise of professional judgment in the interests of the corporate client. But it is a tension that will be exacerbated by the challenges and business opportunities emerging in the transformed healthcare environment.

Many of these new challenges and opportunities reflect a level of legal uncertainty. They don't offer best practices, safe harbors, case law, regulatory guidelines, or enforcement history to help the general counsel structure her/his advice. The application of health law to these new arrangements is in an embryonic state. Unfortunately, competitive demands may serve to shorten management's evaluation period. Decisions may need to be made within short timeframes. When "the pressure is on," there is risk that the decision-making process may not allow for thoughtful legal analysis, and that management may be intolerant where the circumstances require a legally conservative approach. The "tug and pull" pressures between the general counsel's "partner" and "guardian" roles will increase exponentially when the strategic importance of the proposed opportunity or arrangement is heightened.

Both the CEO and the board have a shared responsibility to understand the professional ethics challenges inherent in the general counsel's partner-guardian role, and to support the general counsel in the resolution of those challenges. This is particularly the case in the context of the new legal issues that will arise from "over the horizon" arrangements and opportunities.

In these circumstances, the general counsel may need support from board leadership in order to fulfill her/his responsibility to protect the corporation's interests. This is especially true when their answer may need to be "No"—yet she/he is receiving substantial management pressure to convert their answer to be "Yes." Certainly, both the CEO and the board have a shared responsibility to understand the professional ethics challenges inherent in the partner-guardian role, and to support the general counsel in the resolution of those challenges. This is particularly the case in the context of the new legal issues that will arise from "over the horizon" arrangements and opportunities. But given the board's overarching compliance oversight obligations, its support could be crucial. That support could be demonstrated in a variety of ways: through "tone at the top" conduct of the board; through allocation of responsibility in the charter of a key board committee (e.g., audit/compliance); through clarification in the CEO's job description; and most importantly, through the specific actions of board leadership. The board will be expected to support the general counsel's satisfaction of her/his ethical duties, as they may be implicated by the challenges at hand—regardless of competitive pressures, strategic imperatives, or the uncertainty as to the relevant legal risks.

36 Michael W. Peregrine, "Emerging Legal Issues Present Ethical Challenges for General Counsel," *Health Lawyers Weekly,* American Health Lawyers Association, Vol. 11, Issue 36, September 13, 2013.

37 Ben Heineman, Jr., *The General Counsel as Lawyer-Statesman*, Harvard Law School Program on the Legal Profession, September 2010. View at www.law.harvard.edu/programs/plp/pdf/General_Counsel_as_Lawyer-Statesman.pdf.

The Board/Management Dynamic

Successfully responding to the governance challenges of a transformed healthcare environment will require a close working relationship between the governing board and senior leadership.

THIS SHOULD BE A RELATIONSHIP THAT RECOGNIZES THAT, IN a period of intense industry change, traditional roles and duties may be pressured and may bend, but should ultimately be preserved. It should be a relationship that involves constant dialogue to avoid misperceptions and misunderstandings. While in most instances it will be the CEO who advises the board of these governance challenges, any process designed to address these challenges must reflect a closely coordinated effort between management and the board. Such a collaborative process is crucial if the leadership group is to avoid fracture or division.

That's because any reasonable governance response to transformation forces will likely involve an expansion of the role of governance and a reduction of the role of management—even if slight in scope or extent. If the presumption is that the board may need to work "smarter, faster, and longer" in the new environment, that effort is likely to be manifested through a more focused, involved, and engaged board. In such circumstances, the key is for the parties to work together to ensure that any governance response does not work to needlessly inject governance into the role of management. Yet, the risk of that happening is acute in such circumstances.

In that regard, the following concepts should be kept in mind by both management and the board:

- There may be built-in tension on both sides—the board perceiving an urgent need to take action in order to respond to the environment, and the management team worrying that the board's response will be "over the top" and unnecessarily infringe on the duties of management. Both are probably a given.
- Management should respect the basic notion that extraordinary times truly require the board to reevaluate the effectiveness of the governance model.
- The board should respect the basic notion that any form of governance reorganization is not an invitation to become more involved in the day-to-day business affairs of the organization.
- State law makes it clear that while the board retains the ultimate responsibility for the business affairs of the corporation, it is authorized to delegate day-to-day management responsibilities to competent executive management.
- The exercise of the necessary constructive skepticism by the board does not mandate an adversarial relationship with management—nor is it desirable.
- It is similarly undesirable (and impractical) for board members to attempt to manage the corporation directly and comprehensively.
- There are inherent limitations (e.g., expertise and experience) on the ability of outside directors to assume any management activity.
- The basic expectation of the board's role is focused on strategic/policy/oversight matters, stewardship of assets, and the long-term sustainability of the organization and its mission.
- The roles of governance and management are unified with respect to their obedience to supporting the mission of the organization.

Thus, a successful response to the governance challenges imposed by the transformed healthcare environment may well be predicated on an understanding between management and the governing board that any related changes will not be intended to alter the basic and traditional separation of their respective duties and responsibilities.

Conclusion

As this white paper demonstrates, it is imperative for hospital and health system boards to acknowledge the relationship between industry change and governance and understand the specific governance challenges prompted by the current health-care sector transformation.

There is a fundamental nexus between the law and governance, which reinforces the extraordinary value of the role of the governing board in times such as these.

Conducting a careful governance review of the board's fulfillment of fiduciary duties, governance structures and practices, and board size and composition, with a rigorous consideration of whether change is necessary, will enable hospitals and health systems to make informed decisions and render effective oversight, in the context of a thoroughly transformed environment, and affirm and strengthen the organization's commitment to its charitable mission.

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