The Governance Institute's E-Briefings

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Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

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News, Articles, and Updates

Physician Integration Strategies: A Look at Evolving Models

By Anjana D. Patel and Alexandra Khorover, Sills Cummis & Gross P.C.

With healthcare reform here to stay, hospitals are increasingly seeking to align with physicians in their community in new ways so that both sides succeed as changes to the healthcare delivery and reimbursement systems unfold. As part of this evolving strategy, hospitals and health systems are entering into various hospital–physician integration transactions. This article describes certain evolving hospital–physician integration models and provides insights into the legal and practical issues these models may present.

Physician–Hospital Integration Models

Entire practice acquisition: The hospital or its affiliate (usually a foundation or captive or "friendly" professional corporation (PC)) purchases all of the assets of the physician practice, directly employs all of the physician and non-physician personnel, and assumes all equipment and space leases.

Employment and practice lease: The hospital or its affiliate directly employs all of the physicians and leases all of the space, equipment, and non-physician staff of the physician practice.

Lease of entire practice: The physicians continue to be owners/employees of their existing practice, but are leased to the hospital or its affiliate. The hospital or its affiliate also leases all of the space, equipment, and non-physician staff of the physician practice.

Purchase of ancillaries: With respect to specialties that provide significant ancillary services (e.g., cardiology), the hospital or its affiliate purchases the ancillary business in combination with the Employment & Practice Lease or the Lease of Entire Practice models. Alternatively, the hospital could only purchase the ancillaries and engage the physician practice to provide medical directorship services to the hospital-based ancillary service line.

Potential Legal Issues

Among the laws to consider in structuring these arrangements are the federal fraud and abuse laws, namely, the anti-kickback statute (AKS) and the Stark law. The AKS is an intent-based criminal law that prohibits the offer, payment, receipt, or solicitation of any remuneration in exchange for referrals of federal healthcare services. The Stark law is a strict-liability civil law that prohibits a physician from making a referral of "designated health services" (includes inpatient and outpatient hospital services) to an entity with which the physician has a financial relationship, unless the arrangement meets an exception.

The AKS and Integration

Physician integration transactions can help achieve *bona fide* goals and objectives, such as better aligning the hospital's goals with physician incentives in order to improve quality and reduce costs. However, if the transaction does not result in genuine integration between the physicians and the hospital, there is a risk that the arrangement could be viewed, under the AKS, as a sham designed to provide physicians guaranteed compensation in exchange for referrals to the hospital.

Arguably, integration is easier to achieve in models that involve the employment of the physicians (i.e., the Entire Practice Acquisition and Employment & Practice Lease models), because the employer/employee relationship inherently involves a certain amount of control that is lacking in an independent contractor situation, such as the Lease of Entire Practice model. However, any integration transaction may be suspect unless the physicians are actually required to achieve meaningful levels of integration, which can include initiatives such as:

- Participating in the development and implementation of standardized policies, including policies regarding evidence-based medicine, service excellence, clinical pathways, IT, and quality
- Participating in the development and/or implementation of hospital-wide policies and procedures and participation in hospital committees and network development, as appropriate
- Participation in quality assurance and improvement programs
- Participation in healthcare reform-related initiatives such as accountable care organizations and value-based purchasing programs (e.g., bundled payments)
- Installing and utilizing hospital EMR, EHR, and other healthcare technology
- Participating in hospital charitable initiatives, including providing services to underinsured and uninsured patients

The Stark Law's Volume and Value Standard

In order to achieve alignment with hospital goals, many hospitals are opting to compensate the physicians, in whole or in part, based on performance. One common methodology involves compensating the physicians based on work relative value units (wRVUs), although other methodologies are possible. Any arrangement that involves varying compensation could be problematic under the Stark law, unless the arrangement meets an exception.

There are several exceptions that are potentially applicable to the integration models, such as the "employment" exception, the "personal services arrangement" exception, and the "indirect compensation arrangement" exception. While the precise requirements of these exceptions vary, they all have in common a requirement that the compensation paid to the physician must not take into account the volume or value of referrals generated by the physician to the hospital—the so-called "volume and value standard."

With respect to models that involve physician employment, if the physician is employed directly by the hospital, then the Stark law "employment" exception is applicable. With respect to performance-based compensation, the "employment" exception includes a carve-out from the volume and value standard for services that are personally performed by the physician. This would allow a hospital to pay a physician fair-market-value compensation based on personally performed wRVUs or another measure of personal productivity.

Oftentimes, however, the physician is not directly employed by the hospital, but rather is employed or engaged by a "friendly" PC or other entity that is affiliated with the hospital. In such instances, the "indirect compensation arrangement" exception is potentially applicable. With respect to the volume and value standard, an argument can be made that wRVUs are a measure of the time and intensity of a physician's service and thus do not vary with the volume or value of referrals to the hospital. Furthermore, most physician office-based services are not "designated health services" and therefore, the majority of wRVUs generated will not implicate the Stark law. However, with respect to physician services that do generate a technical component referral for the hospital, a regulator could take the view that wRVU-based compensation implicates the volume and value standard because hospital billings will increase inherently with the amount of hospital-based wRVUs generated by the physicians. This argument may be especially problematic for physician specialties that do, in large part, generate revenues from hospital visits or other hospital-based services.

Compensation methodologies based on wRVUs or other variable components also implicate the AKS. There are safe harbors that, if met, would exempt an arrangement from scrutiny, including safe

harbors for employment and personal services arrangements. However, variable compensation arrangements will generally not meet the requirements of some of these safe harbors, but, because the AKS is intent based, compliance with a safe harbor is not mandatory. Instead, if it can be established that the compensation paid to the physicians is fair market value and the arrangement as a whole is commercially reasonable, then it is less likely that the payment of wRVU-based compensation will be viewed as a violation of the AKS.

"Pooled" Compensation Arrangements

In addition to the issues surrounding volume and value standard, challenges may arise in the context of a hospital seeking to compensate physicians through a "pooled" arrangement. Many independent physician practices historically "pool" revenues and pay physicians a portion of the overall profits. Generally, physicians want to continue a "pooled" arrangement in connection with any hospital integration transaction. These "pooled" arrangements often include dollar amounts relating to "referrals" amongst the physician; thus, these arrangements need to be carefully structured to comply with the parameters of the Stark law. Although, the "employment" exception is not available for these arrangements, there are various alternative ways to structure the arrangement. Hospitals that wish to offer physicians "pooled" compensation structures should discuss the regulatory intricacies with their legal counsel.

Additional Considerations

In addition to the legal technicalities of structuring a physician integration transaction, there are several other practical concerns that a hospital or health system should take into consideration when pursuing a physician integration strategy:

- The hospital or health system should carefully consider which model fits the goals and objectives of its organization. Although it is possible to integrate various physician groups through different models, it is often easier and more cost-effective to offer one model to interested physicians.
- The organization should consider to what extent physicians should be involved in the governance and management of the PC or other integration vehicle.
- If a new "friendly" PC is being formed in connection with the alignment, this entity must be formed and organized before the go-live date of the first integration transaction. Also, the PC needs to have payer contracts in place before the go-live date.
- Consider performing an audit of the physician practice's recent medical and billing records in order to confirm that any billing error rate is within acceptable parameters.
- If the alignment model involves the lease of the physician's existing office space, it is important to confirm that all rental amounts are fair market value, particularly if the space is owned by referring physicians.
- The organization should discuss any proposed alignment transaction with its benefits consultants as these transactions may potentially trigger ERISA rules.

In all the models, it is crucial for compliance purposes that all of the compensation paid to the physicians be fair market value and commercially reasonable, and be confirmed as such in a written valuation report from an independent and reputable healthcare valuation firm.

The Governance Institute thanks Anjana D. Patel, vice-chair, and Alexandra Khorover, associate, of the Health Care Practice Group of Sills Cummis & Gross P.C. in New Jersey for contributing this article. They can be reached at apatel@sillscummis.com and akhorover@sillscummis.com, respectively. The views and opinions expressed in this article are those of the authors and do not necessarily reflect those of Sills Cummis & Gross P.C.

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Toward More Engaged Oversight

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

This is the second article in a series examining the role of the board following the wave of industry consolidation.

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

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

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

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

For those reasons, it's time for a little introspection at the board level. The boards should ask itself whether or not it has a framework in place from which it can adequately exercise oversight of these

[1] The other component being the application of duty of care principles to a specific decision or board action.
[2] E.g., failing to act in the face of a known duty; a conscious disregard for the director's duties.

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

emerging new business and compliance risk challenges. *Do our oversight systems work? Do we have the right blend of expertise? Must we work harder, faster, and longer?* The board that is serious about its oversight obligations will look at the following:

- **Information flow**. The board's ability to effectively perform its oversight responsibilities depends in large part on whether the *right information* is received from management in an *understandable format* in a *timely* manner. The board—and its risk/compliance committee—has an expectation that management will provide the information it needs to address organizational risks. When that information reporting system breaks down, bad things can and will happen. In the non-profit health system, the problem usually isn't one of deficient governance, but more often one of deficient reporting. To paraphrase the old John Houseman commercials, good reporting systems "don't just walk up, bite you in the bottom, and say 'we're here.'" The board has to make it happen. In other words, the engaged board will work with management to clarify its expectations about how business and compliance risk information can be conveyed in a useful and timely manner. Be explicit. If there is something that is keeping management up at night, the board and its key committees need to hear it now.
- **Committee roles**. Effective oversight engagement also requires a clear mandate for the committee responsible for risk and compliance. Are risk oversight responsibilities fully articulated in the charter of the proper committee? Is the committee's board reporting relationship clear, and is it set at a frequency that is appropriate for the size and risk profile of the organization? Does the general counsel serve as staff to this committee? Does the board's governance structure create overlap in responsibility for these matters (e.g., between the executive, audit, and compliance committees)? Is there a risk that oversight responsibilities might "fall between the cracks" between committees with competing charters? Is there proper coordination between key committees, and of the roles and reporting relationships of the general counsel, the compliance officer, and the internal auditor to these committees?
- **Director roles**. Effective oversight engagement requires a critical analysis of the necessary time commitment expected from business risk and compliance committee members. In light of the increasing operational and risk challenges facing the health system, it's fair to assume that committee service will require additional time and commitment from its members. Meetings will be longer and more frequent. Homework assignments will be more substantial. In this regard, the workload expected of the audit committee members offers a good example. Risk and compliance committee members will also be expected to be more aware of the health system's lines of business, and more familiar with the individual risk managers and the provisions of the organization's risk and compliance plans. They will also be expected to receive specialized continuing education, tailored for their roles. Yes, these committee members will be expected to work harder, faster, and longer.
- **Director competencies**. More sensitive issues relate to the size and composition of the business risk and compliance committees. There is perhaps no better way to demonstrate oversight engagement than to populate these committees with enough members to satisfy charter responsibilities, and with members who have the background and expertise necessary to monitor business risk and compliance. Having the right number of committee members, with the right qualifications (and with a regular meeting schedule), sends a clear board statement of good faith. Like the audit committee, the membership of the business risk and compliance committees should be composed entirely of independent directors.
- **Director conduct**. It is not all a matter of process. Effective oversight engagement also involves educating risk and compliance committee members on the expected standard of conduct. *Once we have the information, what are we supposed to do with it? What's the difference between a green flag, a yellow flag, and a red flag, in terms of our response*? The general rule of thumb is that once presented with information that causes (or should cause) concerns to be aroused (yes, a pretty subjective standard), the committee member is then obligated to make further inquiry until such time as his or her concerns are satisfactorily addressed—and favorably resolved. The trigger is often material information that, on its own or in conjunction with other information known to the committee, "flags" to the committee that

action needs to be taken—that there is indeed "smoke" that must be extinguished before it bursts into flame. Absent that, there is no obligation to anticipate the future problems of the organization.

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

The Governance Institute thanks Michael W. Peregrine, Esq., partner, McDermott Will & Emery, LLP, for contributing this article. He can be reached at mperegrine@mwe.com.

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Bringing Hospitals Together to Provide High-Quality Care

Hospital consolidation is on the rise as organizations work to prepare for the changes and challenges of health reform. The new healthcare environment is calling for reduced costs, better care, less waste, and a focus on population health. By merging, affiliating, or partnering, hospitals and health systems can increase their capital and resources, allowing them to offer the highest-quality care to the patients they serve.

Finding the Perfect Partner

In early 2012, Poudre Valley Health System (PVHS) entered into a joint operating agreement with the University of Colorado Hospital creating the University of Colorado Health (UCHealth).[1] Leadership at PVHS had believed for some time that collaboration would help the organizations succeed in the future. They had started discussions years ago, and at first the PVHS board was hesitant, partly because the health system's mission statement included the word "independent." The board decided to take that word out and replace it with "integrated" to meet the times. The board believed there was no other alternative to partnering if PVHS wanted to be prepared for health reform and the many changes coming to the industry.

The PVHS board and leadership began to consider partnership possibilities and create a process for finding the right partner. Two of the key questions they led with were:

1) Can we maintain a financial structure that will give us the time to find the right partner?
2) What would an ideal partner look like?

PVHS was doing well financially so the board knew it had plenty of time to make a deliberate and reasoned decision on partnership. It brought in consultants and advisors to help evaluate the industry, provide recommendations on when to grow, and then evaluate potential partners. During strategic planning meetings and board retreats, leadership discussed partnership possibilities and even potential strategies to pursue, such as bringing in a smaller organization, selling to a for-profit, or joining a larger health system. "We outlined what it was that would make us want to partner and what we were looking for," said Rulon Stacey, president of University of Colorado Health (former CEO of Poudre Valley Health System). "We did this in a very slow, judicious manner over a couple of years, so that we were prepared when the right opportunity presented itself."

When the CEO of the University of Colorado Hospital (UCH) called to express interest, the PVHS board had already done its background work and identified UCH as being an excellent potential partner. The hospital had similar goals, a long history of focusing on quality of care and attention to patients and employees, a large network, and deep roots in the community—all traits PVHS was looking for. Both organizations

[1] The system is still waiting to receive word from the IRS to approve its 501(c)3 status.

believed that together they could accomplish more and, most importantly, bring a new level of care to patients in the region. The goal was to merge, but statutorily the two organizations both have their roots in government entities that prohibit selling. So they had to find a different way to come together, which they did through a joint operating agreement. The new system, UCHealth, recently brought in Memorial Hospital, a city-owned hospital in Colorado Springs. "This gives us a Colorado flavor and an emphasis on Colorado that no other organization has," Stacey said. "One of the things we wanted when looking for a partner was local clout and this gave it to us. We didn't think we would have the opportunity to get so much local clout so quickly, but with the addition of University of Colorado Hospital and Memorial Hospital, we are now, by volume, the largest health system in the state."

Community Health Network has been working on growing its health system for years. It opened in the mid-1950s as one hospital on the east side of Indianapolis. In 1985, it expanded to include Community Hospital North and four years later acquired Community Hospital South, becoming a three-hospital system. In 1996, the health system took on its first affiliate, Community Hospital Anderson. In the past two years, Community Health Network has formed affiliate relationships with three other organizations in central Indiana.

When looking at partnership possibilities, leaders at Community Health Network also believe preparation is the key to success. "We went through a very rigorous process about three years ago, which we have updated in the last year, where we looked at what our strategic plan was from 2012–2020," said Bryan A. Mills, president and CEO of Community Health Network. "So as we have partnership considerations, they need to fit into that plan. If an interested partner calls that is not in our geographic footprint, we believe it is our responsibility pursuant to our mission to say 'no thanks' and if they are in that footprint, then we have already identified who they are and why they are important to us." Some of the factors Community Health Network has identified as essential to being considered for partnership are geography (where are they located and how would they help us provide services within that area?), their relationship with the medical staff (is the medical staff supportive of what they are doing?), the relationship from a market tier standpoint (both inpatient or primary care in the area in which they are), and their partnership interests (what are they looking for and why do they want to partner?).

If the partnership is believed to be a good fit, the next step for Community Health Network is for Mills and the board to discuss the specifics of how the partner fits with the organizational vision. If it seems to be a good fit, they discuss the details with the potential partner, such as governance structure, reserve powers, medical staff issues, and capital needs. This helps each organization develop a clear understanding of how things will work so that they are both comfortable with the plans before signing the letter of intent. While talking to leadership is a must, Mills has found it just as critical to talk with physicians during this process. Physician insight has helped them be more nimble when making a partnership decision and helps them identify areas of concern and areas of strength during the due-diligence phase. Community Health Network also brings in outside expertise, especially for financial and regulatory review.

Restructuring Governance

Once University of Colorado Health was created, leadership came together to determine the most effective governance structure. UCHealth decided to create one system-level fiduciary board. This board consists of four members from the University of Colorado Hospital, four members from PVHS, two members from the University of Colorado School of Medicine,[2] and then the board as a collective picked Rulon Stacey to be on the board as the 11th member. They decided to meet monthly and currently don't have term limits. "We are continually looking to make sure we have the right structure," Stacey said. "We have started The Governance Institute's self-assessment, and we think that is going to give us a foundation to figure out where the board members feel they are falling short and where they can improve, as well as what educational opportunities are needed. As a new board we have a whole world ahead of us to create those kinds of structures."

UCHealth also decided to have three advisory boards, one for each of the hospitals, in order to better address issues that are happening locally at each location. While Poudre Valley Health System has two hospitals (Poudre Valley Hospital and Medical Center of the Rockies), they elected to stay as one site board representing all of Northern Colorado. Memorial Hospital created an entirely new board since it recently became part of the system. Each of the site boards is developing its

[2] The University School of Medicine is an active, loyal partner, but it is not part of the University of Colorado Health.

own meeting structure and term limits, but they all plan to meet about six times a year. The hospitals transferred the decision-making authority and operational decisions for the system to the UCHealth system board, but there were some decisions those boards could not transfer because they were required by statute (the PVHS board was developed by a special governmental district and the University of Colorado Hospital board is an authority of the state). So, for example, the UCHealth board could not decide to close Poudre Valley Hospital or the University of Colorado Hospital without permission from their respective boards. UCHealth also manages two hospitals in Wyoming and Nebraska, and those organizations also have their own fiduciary site boards.

The system board has delegated back some responsibility to the site boards. For example, the site boards will retain responsibility for medical staff approvals, they will be consulted in the selection of a CEO, and those boards approve and recommend to the system board capital expenditures and strategic plans. Each site board is also responsible for monitoring and ensuring the quality of care at their site. The UCHealth board has a quality committee that sets system goals, but the sites are responsible for implementing the directions from the system quality committee and identifying and correcting site-specific issues that arise. "The reason why the system quality committee has kept that level of control over quality is because we want people to know that when they go to our facilities, wherever that facility may be, there is a standard of excellence that will be met," Stacey said. The site boards each have a quality committee in order to keep on top of this, but currently that is the only committee at the site board level.

A couple of years ago, leaders at Community Health Network began a governance simplification process where they worked to reorganize governance and move toward an integrated delivery system. One of the major changes was to eliminate local boards from all wholly-owned hospitals so there is one network board responsible for all of those hospitals. There are 13 members on the network board, including Mills who is an *ex officio* voting member. The rest are lay members, with 25 percent being physicians. This year the board also changed its term limits so that members serve an initial three-year term followed by one-year renewable terms. The health system revamped the committee structure during this process as well to create one set of committees at the system level that oversee the entire network, including compensation, governance, quality of care, finance, and audit committees. "That has made it easier for us to be more nimble in ensuring that we don't have multiple finance committees or multiple compensation committees, and that we do have a network approach to these things," Mills said.

Mills also put extra effort into making sure that network board meetings are effective and the majority of time is spent discussing strategy, rather than operations. Over the past couple of years, the board has relied more on a consent agenda to save time for strategic discussion. The board members receive their meeting packets a week before the meeting and are expected to read them thoroughly. So, for example, committee minutes and recommended actions are in a consent agenda so that those reports aren't brought forth unless someone has questions. Mills meets with the board chair and vice chair every other week to keep them apprised of what is going on within the organization. Together they mutually agree upon board meeting agendas, making sure they are focused on topics that will continue to keep board members engaged.

When the affiliates come in, system leaders make sure these organizations do have some local power related primarily to day-to-day operations, but new affiliates need to fall in with the committee structure and the network governance structure related to key areas such as strategic planning and budgeting. This helps Community Health Network create "systemness," while respecting the fact that these entities need some local authority related to how they position themselves in their own communities. "One of the things we have learned over time, from a governance perspective, is the importance of making sure there is clarity on what the local new affiliate is delegating to the parent, and what it has within its purview," said Karen Ann Lloyd, general counsel, Community Health Network. "Anything related to audit, compensation, finance, or budgeting is delegated up to the parent board. The affiliate boards' fiduciary responsibilities include maintaining their license, their hospital, and controlling what happens within the four walls of the institution."

Community Health Network does have three other boards within its network: a foundation board responsible for spreading the health system's message and raising funds, a board for the physician group (a multi-specialty group of over 500 employed physicians), and a board for its for-profit holding company. These boards share some common members with the network board, but mostly consist of other people. The physician

group board has employed physicians from various specialties; the for-profit holding company board includes physicians and laypeople who are very involved in proprietary business; and the foundation board is typically community members who help spread the organization's message and raise funds on the community's behalf. The physician group board meets monthly and the other two meet quarterly.

"We believe that growth through partnership is in alignment with our mission, and it is an easier, cheaper way to expand our footprint and make care accessible to our patients," Mills said. Putting the patient first, providing high-quality care, and being innovative are all part of the Community Health Network mission. Through building new relationships with the right organizations it has been able to achieve this mission and provide reliable, community-driven healthcare.

This article is an excerpt from the case study, Bringing Hospitals Together to Provide High-Quality Care. *The full case study provides more details and looks at best practices in ensuring that proper communication is taking place across the system. This case study will be available soon.*

New Publications and Resources

Episode 1: Dilemma & Decision (PopCity DVD Series, March 2013)

Innovation in Healthcare: Health Systems & the Future of Accountable Care
(System Invitational Proceedings, Fall 2012)

***BoardRoom Press*, Volume 24, No. 1** (*BoardRoom Press,* February 2013)

Quality & Patient Safety: The Need for Clinical Integration and a Systems Approach
(Working Knowledge Video, December 2012)

To see more Governance Institute resources and publications, visit our Web site.

The Governance Institute Conferences

Three-Day Leadership Conference in St. Louis

In May, we are having a three-day Leadership Conference at **The Ritz-Carlton, St Louis** in Missouri. From **May 5–7**, healthcare leaders can hear expert speakers and meet others with a similar commitment to improving governance and achieving optimal board performance. This conference will provide health leaders with valuable information they can take back and use to lead their organizations.

Presenters at this conference include:

- **Kenneth Kaufman:** Hospitals Succeeding in the New Era
- **Ryan Donohue:** Considering the Consumer: Building & Positioning Value with Healthcare's Newest Change Agent

- **Nathan Kaufman:** Redefining the Role of the General Contractor in Healthcare
- **Bernice J. Washington:** Delivering Results in a High-Performance Environment

Chairperson, CEO, & Physician Leader Conference in June

On **June 2–4** at **The Ritz-Carlton, Laguna Niguel,** CEOs, board chairs, and physician leaders will come together to discuss and learn about moving forward in today's challenging healthcare world. This conference will help strengthen the relationship between the board chair, CEO, and physician leaders; address governance and healthcare topics that are relevant, timely, and pressing; and provide an opportunity to exchange ideas with other board chairs, CEOs, and physician leaders. *This conference is only available to Governance Institute members.*

Presenters at this conference include:

- **Cory Booker:** Moving Forward Together: Challenging Discussion, Courageous Decisions
- **Garrison Wynn:** Making the Most of Difficult Situations: Changing Markets, Changing Times
- **David A. Shore, Ph.D.:** Human Capital Preservation in Hospitals & Health Systems

Click here to view the complete programs and register for these and other 2013 conferences.

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