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.

In this issue:

Avoiding Accidental Political Activities

By Robert C. Louthian, III, McDermott Will & Emery

Few, if any, non-profit organizations intentionally violate the proscription against political activities imposed by section 501(c)(3) of the Internal Revenue Code. Nonetheless, from July through November each election year, tax-exempt practitioners' phones light up on a regular basis to assist organizations with political activities "situations" they have found themselves in unexpectedly—situations that could potentially result in loss of tax-exempt status. Given the level of divisiveness currently gripping the country this election cycle, the possibility for accidental political activities this election season is particularly high.

This article will identify the most common questions that arise during each election cycle with respect to section 501(c)(3) organizations and potentially proscribed political activities. It also looks at voluntary actions non-profit healthcare organizations may wish to take to best protect themselves should accidental political activities occur.

Background

For background purposes, section 501(c)(3) organizations are strictly prohibited from intervening, directly or indirectly, in political campaigns of candidates for public office. Included within that proscription, organizations are precluded from forming or funding political action committees (PACs) to engage in such activities. For purposes of the prohibition against political activities, a "candidate for public office" is anyone who offers him/herself, or is proposed by others, as a contestant for an elective public office. It is irrelevant for purposes of the political activities proscription whether the public office is national, state, or local in origin. Individuals who have announced their candidacy for public office are clearly "candidates." In addition, however, even an individual who has not announced his/her candidacy may be considered to be a "candidate for public office" depending upon the facts and circumstances.

The prohibition on political activity includes not showing financial or other support for a candidate. Thus, non-profit hospitals and health systems may not make contributions to a PAC or a candidate's campaign committee (even if otherwise permitted under applicable election laws), purchase tickets to political fundraisers, or provide non-financial support (such as providing space or mailing lists, sponsor a political event, or permitting its name to be used to solicit contributions) to a PAC or candidate's campaign committee.

In addition to prohibiting direct political activities, the Internal Revenue Code prohibits indirect political activities as well. For example, it is not acceptable for individual employees of the organization to make a contribution or pay to attend a fundraiser, and then be reimbursed for this expenditure by the organization (either directly or through a disguised bonus payment designed to reimburse such expense). Likewise, it is not acceptable for a non-profit healthcare organization to transfer funds to a non-exempt organization (for example, a coalition or a for-

profit subsidiary) and then have the non-exempt organization make the contribution. The IRS scrutinizes exempt organization political activities closely to curb and prevent abuses in this area. In applying this scrutiny, the IRS has been aggressive in treating indirect transactions as political activity of the exempt organization.

Frequently, individuals closely associated with section 501(c)(3) organizations make statements or engage in actions that may be interpreted as intervention in a political campaign. In order to avoid attribution of such political activities, any individual who is closely associated with the organization and who engages in political activities should make it clear that his or her views being expressed are the individual's views, and that they are not speaking on behalf of the organization. Moreover, while the prohibition against political campaign activity is not intended to curtail an individual's freedom of expression, individuals closely associated with non-profit hospitals and health systems should avoid expressing their personal views in their organization's publications or at their organization's expense.

Frequently Asked Questions

Can a board member or senior executive start a PAC and ask other board members, officers, and/or employees for contributions?

As noted above, a section 501(c)(3) organization is prohibited from forming a PAC. Individuals, however, are free to associate together and form a PAC (provided it's consistent with Federal Election Commission rules and applicable state laws). Not surprisingly, board members and certain senior executives of non-profits frequently desire to form a PAC and solicit contributions from other board members, officers, and/or key employees of the organization.

While formation of PACs by individuals closely associated with non-profit healthcare organizations is permissible, it is fraught with potential tax-exemption (and campaign finance) issues and must be carefully planned and scrutinized. If a PAC is formed by a board member or senior executive in their individual capacity, PAC solicitations should not take place at the organization's facilities during official work hours or official staff meetings. Further, no facilities or equipment should be used in connection with such solicitations. For example, the organization's email system should not be used for solicitation purposes, administrative staff should not be used in preparing or delivering solicitation requests, and, more generally, no organizational funds or personnel should be used directly or indirectly in preparing solicitation requests, collecting funds, or otherwise administering the PAC. Finally, contributions to the PAC must be voluntary. Accordingly, no direct or indirect influence should be placed on employees in requesting contributions.

May we invite a candidate for political office to speak at our events?

Depending upon the facts and circumstances of the event, a non-profit hospital or health system may invite a candidate to speak at an event without participating or intervening in a political campaign. However, careful consultation with experienced counsel is recommended prior to inviting candidates to speak at events.

If the candidate is invited to speak in an individual capacity, there is no requirement to provide equal access to other candidates. In these circumstances, however, the organization must take steps to make sure that campaign activity does not occur.

If a candidate is invited to speak in the capacity of a candidate, additional precautions are in order. For example, the healthcare organization should expressly disclaim any endorsement of the candidate in written materials for the event. The disclaimer should note that the hospital or health system does not participate or intervene in any political campaign and neither supports nor opposes any candidate for public office. In addition, when the candidate is introduced, the organization must avoid using any language that could be interpreted as supporting the individual as a candidate. If the organization invites one candidate to speak in the capacity of a candidate, it should also provide equal access to other candidates. This may be accomplished by inviting all candidates to one event or inviting each candidate to successive events.

A candidate for political office wants to tour our facilities/attend a public function and bring the media with him or her?

Candidates, like other members of the community, may attend functions that are open to the public. A candidate's presence, by itself, does not cause the organization to be engaged

in a political campaign intervention. If a candidate appears at the hospital or health system's public event, it is permissible for the organization to recognize his or her attendance. It is not permissible, however, to refer to the candidate's candidacy or the upcoming election.

A board member has been asked to make a speech/hold a fundraiser at his/her house, can they do so?

As noted above, individuals are permitted to engage in political activities in their individual capacities. The board member should make it clear that they are acting in their individual capacity and not as a representative of the healthcare organization. No funds, facilities, or assets of the organization should be used in connection with the event (including, for example, donor lists, use of email server, etc.).

The state hospital association we otherwise support has asked for our contribution to its PAC. May we make the contribution?

Most likely, the state hospital association is a section 501(c)(6) organization for which political contributions made by such organization are not an absolutely proscribed activity. Nonetheless, as noted above, a proscribed political activity by a section 510(c)(3) organization can be a direct activity or an indirect activity. Accordingly, and even though the non-profit healthcare organization may generally support the state hospital association's activities throughout the year, the organization should not make an earmarked contribution for a political campaign. The board and/or senior executives may make contributions in their individual capacities but, if they do so, such individuals shouldn't be reimbursed by the hospital or health system for these contributions.

What about Internet activities? Someone endorsed a candidate on our Facebook page, what do we have to do?

A section 501(c)(3) organization's social media sites are potential grounds for accidental political activities. With respect to social media sites, it is not uncommon these days for the most innocuous post on a social media site to break out into spontaneous (and heated) political arguments supporting or opposing a particular candidate. If a non-profit healthcare organization's social media site become a political battleground, the issue then becomes what is the organization's legal responsibility to remove all such political chatter, especially those statements expressly supporting (or opposing) a candidate. Stated simply, provided the person(s) posting the political endorsements/comments is not a representative of the organization, the healthcare organization has no legal responsibility from a tax-exemption standpoint to delete such comments from its social media page. While the social media site belongs to the organization, the content placed on such site by other persons do not necessarily represent the views of the organization and should not be attributed to it. In fact, attempting to monitor and delete political comments made by the general public could actually prove problematic if such monitoring and removal, whether intentionally or unintentionally, was not done in a non-partisan way. In short, the organization should simply enforce its existing social media policies as it normally would do and should not attempt to delete third-party content simply because it is politically motivated.

Preparing for the "Oops"

As noted above, most potential violations of the political activities prohibition are not intentional acts. Instead, potential violations are the result of unfortunate circumstances, accidental misstatements, or misperceptions by the media or the public. An organization's best offense (and hopefully best defense if needed) against such transgressions is a robust overall compliance plan to minimize the likelihood of such accidents occurring and to demonstrate to the IRS and/or the media and general public that while a proscribed political activity may have occurred, the healthcare organization had done everything that it could do to prevent such transgressions from happening and that while an individual may have made a mistake, the organization itself did not engage in a political activity. Set forth below are separate components of an overall compliance plan, none of which are legally required, that could be used either individually or in combination with others to create a robust overall compliance program:

- **Periodic education**. Periodic education of board members, senior executives, and even employees regarding the organization's limitations on participation in political activities is an important component of any compliance plan. The education can be formal with respect to the board and senior executives (e.g., short educational sessions at board or staff meetings) and more informal with respect to employees

(e.g., emails or periodicals). The purpose of the educational component is to demonstrate that even if an individual makes a mistake and engages in proscribed political activity, the organization itself had done everything possible to prevent such improper activity from occurring.

- **Adopt a robust policy and procedure**. The adoption of a robust policy and procedure regarding permissible and impermissible conduct by board members, officers, and employees with respect to political activities can be strong evidence of overall compliance on the part of the organization. A well-drafted policy can demonstrate to the IRS (or any other regulatory body) that the organization is aware of the legal limitations imposed on such entity and has made every effort to ensure that it will not engage in impermissible political activities.
- **Educate the communications team**. The organization's media/communications team should be educated with respect to the political activities prohibition for two main reasons. First, by educating the communications team, they will be less likely to release a statement, press release, or tweet that implies the organization is endorsing (or opposing) a particular candidate. Second, if the local media misinterprets or misstates a statement made by an official of the organization as being supportive of a candidate, or the local media mistakenly indicates that the organization is supporting a particular candidate for public office, the communications team will already be briefed on how and whether to respond to such misstatements.
- **Conduct periodic review of materials**. Every election year, consider conducting periodic reviews of newsletters, social media pages/actions, and local media to ensure that any accidental misstatements are identified and, if needed, clarified or corrected.
- **Steps to take before candidates visit campus**. If a candidate for public office is invited to an event, or if the candidate requests to visit the organization's facilities during an election period, it may be beneficial to send the candidate a letter ahead of time that includes an express statement that the organization may not endorse any candidate for public office, that the candidate should not discuss his or her candidacy while on campus, and that no fundraising or distribution of campaign materials should be conducted during the visit.

As may be gleaned from the above, board members must appreciate that their actions are potentially attributable to their non-profit organizations and, accordingly, must use caution when exercising their right to participate in the political activities in their individual capacities. In addition, board members need to ensure that the organizations they govern are best prepared to both avoid direct participation in political activities as well as accidental participation in such proscribed activities. To that end, boards should ensure that fellow board members and senior executives understand the proscription against political activities, that their non-profit organization has adequate policies and procedures (including social media policies) in place to protect against such activities, and that someone periodically monitors social media sites and media reports that could suggest the hospital or health system has participated in a political activity.

The Governance Institute thanks Robert C. Louthian, III, Partner, McDermott Will & Emery, for contributing this article. He can be reached at rlouthian@mwe.com.

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"I'm Personally Liable for What?": Mitigating Risks of Individual Director Liability for Corporate Misconduct

By David Bjork, Ph.D., and James Rice, Ph.D., Integrated Healthcare Strategies

As a board member of a health system, hospital, or accountable care organization (ACO), you are making ever more complex decisions about investments in physician ventures, population health partnerships, creative payer arrangements, and expensive computer systems. How comfortable are you when making these decisions that you

are minimizing risk to your organization, and to yourself as a director?

Perhaps you should be a bit less comfortable.

On September 9, 2015, the Department of Justice (DOJ) released the "Yates Memo" advising attorneys in the department to identify individual accountability for corporate wrongdoing.[1] Directors of not-for-profit hospitals and health systems have generally assumed that they are not accountable for corporate wrongdoing so long as they have been diligent in their oversight and decision making. Healthcare organizations now, however, should be sure to more carefully monitor and evaluate the organization's compliance efforts, and see that its documentation of those efforts is adequate to protect board members from liability.

Framing the Issue

Healthcare organizations are exposed to liability for improper antitrust decisions, billing Medicare and Medicaid inappropriately, paying physicians for referrals, misuse of charitable assets, and engaging in private inurement and private benefit transactions.

Transactions involving hospitals' fraud and abuse concerns are usually related to Stark and anti-kickback laws. In addition to the increasingly common prosecution of Stark law violations through the False Claims Act *qui tam* ("whistleblower") actions, there has also been a rise in Stark law settlements through the Self-Referral Disclosure Protocol program created by the Centers for Medicare and Medicaid Services following passage of the Affordable Care Act (ACA). There is a clear message from the DOJ that it is taking an aggressive stance on healthcare fraud and is using all of the tools available to combat it. In 2015, after five straight years when recoveries exceeded $2 billion, the federal government opened 983 new criminal and 808 new civil healthcare fraud investigations, filed criminal charges in 463 cases, won convictions of 613 defendants, and recovered nearly $1.9 billion in healthcare fraud cases, bringing the total recovered since January 2009 to $16.5 billion.[2]

It is now clear that board members have serious fiduciary responsibilities for seeing that their healthcare organizations are complying with regulations and avoiding or dealing effectively with these liability risks. So long as directors are diligent in overseeing compliance programs, they are presumably less at risk for being individually liable for misconduct. If they are insufficiently diligent, however, or if they approve transactions knowing that they are risky, they may now be individually liable for corporate wrongdoing.[3]

Below are five risks that board members should have conversations about with their compliance officer and legal counsel:

1. Billing Medicare or Medicaid for unnecessary services or for services not rendered
2. Paying more than fair market value (FMV) to:
   - Acquire a physician practice or hire or retain a physician
   - Pay a physician who spends time on administration and in clinical practice for more than full-time work
   - Buy or lease property or services from a physician
3. Diverting charitable resources to the private benefit for a director, executive, or physician
4. Misrepresenting financial condition, performance statistics, and liabilities in merger transactions
5. Rewarding directors or executives for completing merger transactions or sales of charitable assets

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[1] Yates Memo, U.S. Department of Justice, Office of the Deputy Attorney General, September 9, 2015 (available at www.justice.gov/dag/file/769036/download).

[2] *Annual Report for Fiscal Year 2015*, The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program, February 2016 (available at http://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf) and "Justice Department Recovers Over $3.5 Billion from False Claims Act Cases in Fiscal Year 2015," U.S. Department of Justice, Office of Public Affairs, December 3, 2015 (available at www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015).

[3] For more guidance on compliance oversight, see *Practical Guidance for Health Care Governing Boards on Compliance Oversight*, Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS), April 20, 2015.

Five Director Takeaways

Healthcare organizations would be well served by working with their CEO, compliance officer, legal counsel, and insurance broker/advisors to implement these five key initiatives:

1. **Maintain a strong compliance program with assertive compliance monitoring efforts.**
2. **Use independent consultants to evaluate physician and executive compensation.**
3. **Ask independent auditors to test compliance with existing regulation.**
4. **Keep directors well-informed about compliance risks.**
5. **Use independent counsel to advise your board on all major corporate transactions.**

Some considerations for lowering your risks include:

- Ask to have a discussion at your next board meeting with the CEO and legal counsel about how the organization is currently monitoring your board's decision-making risks.
- Ask for a short audit and presentation about your Directors & Officers (D&O) insurance coverage, especially as it relates to individual liability coverage.
- Establish a compliance department, accountable to the board, with responsibility for the full range of compliance efforts.
- Create a policy on Medicare and Medicaid billing and a process for monitoring compliance with the policy, including reporting all exceptions to the policy.
- Create policies on physician compensation and other transactions with physicians and a process for monitoring compliance with these policies, including reviewing and approving all exceptions to these policies.
- Establish a process for periodically reviewing all contracts with medical directors, physician leaders, and physician administrators.
- Use an independent consultant to periodically audit physician compensation; contracts with medical directors, physician leaders, and physician administrators; and all other transactions with physicians.
- Require an auditor to test compliance on Medicare and Medicaid billing.
- Require an auditor to test compliance with regulations on paying physicians for referrals.
- Provide periodic education to directors on compliance issues.
- Ensure sufficient due diligence in evaluating merger opportunities.
- Ensure sufficient due diligence in evaluating terms of sale of charitable assets.

The number and size of recent settlements for violating regulations indicate that healthcare organizations and their boards have not been sufficiently diligent about monitoring compliance. The risk of losing in court and the cost of defense is so high that many organizations decide to settle, rather than risk the kind of judgment that could drive a hospital into bankruptcy. Now that the DOJ is pursuing individual liability for corporate wrongdoing, board members have a compelling reason to insist on knowing how compliance risks are being handled.

The Governance Institute thanks David Bjork, Ph.D., Managing Director and Senior Advisor, and James Rice, Ph.D., FACHE, Managing Director, Governance & Leadership, Integrated Healthcare Strategies, a division of Gallagher Benefit Services, Inc., for contributing this article. They can be reached at David.Bjork@IHStrategies.com and Jim.Rice@IHStrategies.com.

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Physician Leadership Needed to Enable True Integration

By Ami Parekh, M.D., J.D., UCSF Health

As a result of the Affordable Care Act (ACA) and payment reform, payment for healthcare services is rapidly changing. Physicians and hospitals will need to work more closely together than ever before in order to deliver care that continues to be financially sustainable. This could require designing new leadership structures and roles that help integrate physician and organizational goals, work flows, and operations. Physician leaders will need to be developed, mentored, and engaged in the overall success of the hospital or health system. Putting effort into recruiting, retaining, and building trust with physician leadership will be very high yield for healthcare organizations beginning to experiment in alternative payment paradigms; however, this effort will not be easy given current physician burnout rates and the impact of electronic health records (EHRs) on physician workflow.

External Changes Increasing the Need for Physician–Hospital Integration

There are significant external changes to the delivery system itself that are making stronger physician–hospital integration a necessity. Two major changes are alternative payment and increased value placed on patient experience.

Nationally, CMS has stated its goal of having 50 percent of Medicare payment through alternative payment models (APMs) by 2018. Along similar lines, 90 percent of payments will be linked to quality and value.[4] National commercial health plans are also strongly promoting their versions of accountable care by linking payment to quality and total cost of care.[5] It is becoming clearer that physician leadership is central to success in the new payment paradigms. In the limited data that currently exists about what leads to high value in alternative payment, physician leadership is emerging as one of the keys.[6]

Simultaneous with this increase in APMs, in the push to increase rates of insurance there has been growth in high-deductible plans. Patients who are facing high costs of care expect their physicians to be able to articulate the costs of services such as imaging, labs, or hospitalizations. Without increased physician–hospital integration, patients with these high-deductible plans will be unable to make informed decisions about how and where to receive care.

As payment for healthcare services is rapidly evolving, so are patient expectations of real-time access and answers to their questions. New healthcare delivery models such as One Medical Group® are challenging hospitals and health systems to think about how easily their patients can access care. Consumers also expect full transparency and ease in healthcare as they are starting to get in other aspects of their life such as travel booking and purchasing of consumer products. This coupled with increased reliance on patient experience in value-based payment has increased the importance of highly patient-centered care. Providing patient-centered care necessitates greater alignment between physicians and hospitals. Physicians are the face of the healthcare organization and if there is not alignment, hospitals and health systems will not be able to meet patient expectations.

Internal Healthcare Delivery Shifts That May Hinder Improved Alignment

In addition to the external changes happening in healthcare delivery, major internal shifts have occurred in the last five to 10 years that may make physician alignment more challenging despite the fact that it is becoming more important. Two primary challenges worthy of consideration are the rise of physician burnout and the mass implementation of electronic health records.

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[4] *Path to Value: The Medicare Access & CHIP Reauthorization Act of 2015*, Centers for Medicare & Medicaid Services (available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf).

[5] For example, see www.anthem.com/ca/health-insurance/about-us/pressreleasedetails/CA/2015/1953/anthem-acos-targeting-chronically-ill-ppo-population-improve-patient-health-save-7-9-million-in-1-year and www.cigna.com/newsroom/knowledge-center/aco/.

[6] Carrie Colla, et al., "First National Survey of ACOs Finds That Physicians Are Playing Strong Leadership and Ownership Roles," *Health Affairs*, June 2014.

As of 2014, the rate of burnout amongst physicians was 54 percent.[7] This rate has been rising steadily and impacts all specialties. In an era where physician integration, engagement, and leadership is needed for success in care delivery, physician burnout may be the single biggest issue that healthcare organizations will need to address in order to meet the needs of new payment models and consumer expectations. Burnt-out providers will not be able to meaningfully engage in the provision of care required in new value-based payments.

Compounding the burnout issue is the near universal implementation of electronic health records in ways that do not take physician workflow or workload into account. In Robert Wachter's book, *The Digital Doctor*, he interviews physicians who comment on the initial negative impact of the EHR on their quality of life as providers. Unfortunately, many hospitals and health systems ignored the physicians' perspectives on the EHR and instead of using the implementation as a way to better align healthcare organizations and doctors, it provided more evidence as to why providers and hospitals may have different incentives and therefore distrust one another. One primary care physician who was trying to provide feedback on their hospital's EHR stated, "I eventually realized that such efforts were not only futile, but were harming me politically. The user [namely, providers] is almost blamed and risks overt or covert retaliation."[8] Hospitals and health systems must engage physicians in the improvement of now-implemented EHRs.

The Role of Physician Leaders in Achieving True Integration

Physician leaders will likely be a key to overcoming the challenges posed by burnout and EHR implementation and meeting the needs of new payment models and consumers. But future physician leaders must be carefully chosen and given training around leadership skills and the tools necessary to empower all physicians in the organization.

Specific roles for physicians should include representation on the board. A recent Price Waterhouse Cooper report stated that 56 percent of physicians did not trust their hospital partners because of a lack of physician leadership represented at the board level.[9] In order for physicians leaders to be effective board members, they must be engaged in the success of the organization and not just be there as "representatives" of the medical staff.[10] This is true even if they must serve in an *ex-officio* capacity. Alternatively physicians may serve as voting board members in newer ACO structures.

In addition to the board, physician leaders should likely fill more than the CMO role in governance and the C-suite. There is a link between quality of care and physician CEOs[11] and while this does not indicate that only providers should be leading hospitals and health systems, it does show that physicians bring a needed perspective that may lead to decisions that improve the value of care. New roles that are being designed such as Chief Quality Officers, Chief Population Health Officers, Chief Innovation Officer, Chief Experience Officers, or Chief Transformation Officers may be ideal positions to be filled with providers. Additionally, the role of the Chief Medical/Health Information Officer will be critical in ensuring EHRs are further developed with the provider experience in mind. An additional method of engaging clinical providers may be by developing strong physician advisory councils. However, given the burnout rates and workload most physicians are facing, getting engagement without some financial support will likely be difficult.

For all these roles, physicians may need additional training in order to be successful. They will also need access to reliable data and decision making in order to be respected by their physician colleagues. Physician leaders must become more than consultants in the leadership

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[7] Lyndra Vassar, "Specialties with the Highest Burnout Rates," AMA Wire, January 15, 2016 (available at www.ama-assn.org/ama/ama-wire/post/specialties-highest-burnout-rates).

[8] Robert Wachter, M.D., *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine's Computer Age*, McGraw-Hill, 2015, p. 87.

[9] Molly Gamble, "7 Tips for Physician Representation in Hospital Governance," *Becker's Hospital Review*, February 18, 2011 (available to www.beckershospitalreview.com/hospital-physician-relationships/7-tips-for-physician-representation-in-hospital-governance.html).

[10] For example, see *From Courtship to Marriage: A Two Part Series on Physician–Hospital Alignment*, Price Waterhouse Cooper report, 2011 (available at www.pwc.com/mx/es/industrias/archivo/2012-02-from-courtship.pdf).

[11] Amanda Goodall, "Physician Leaders and Hospital Performance: Is There an Association?," *Social Science & Medicine*, August 2011, pp. 535–539.

of hospitals and systems and instead truly become the organization's leaders.

Conclusion

Market changes, most dominantly payment reform and patient experience pressures, are driving the need for increased physician–hospital integration and alignment. Unfortunately, rising burnout rates and burdensome EHR implementation processes have made establishing physician–hospital trust even more challenging. Developing and investing in physician leaders at the board and executive level may be a key lever to meeting these challenges.

The Governance Institute thanks Ami M. Parekh, M.D., J.D., Executive Medical Director, Office of Population Health and Accountable Care, and Assistant Professor, Department of Medicine, UCSF Health, for contributing this article. She can be reached at ami.parekh@ucsf.edu. The opinions and ideas expressed in this article are that of the author and not UCSF Health.

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Upcoming Events

[Governance Support Forum](#)
Marriott Marquis San Diego Marina
San Diego, California
August 7–9, 2016

[Leadership Conference](#)
The Broadmoor
Colorado Springs, Colorado
September 11–14, 2016

[Leadership Conference](#)
Omni Nashville Hotel
Nashville, Tennessee
October 30–November 2, 2016

[Click here](#) to view the complete programs and register for these and other conferences.

Physician Leadership Program

September 11–13, 2016
The Broadmoor
Colorado Springs, Colorado

This leadership program is designed to strengthen the skills and knowledge of physicians who are engaged in medical staff, group practice, and performance management activities with hospital/health system practitioners. It will also familiarize participants with the growing roles of physicians in the governance of healthcare organizations, including employed group practices and ACOs. This will be an interactive program that will engage audience members through discussion of case scenarios and common problems facing physician leaders.

[Click here](#) to learn more and to register.

New Publications and Resources

[Focus on Finance: Critical Issues for Healthcare Leadership](#) (Webinar, June 2016)

[BoardRoom Press,](#) [Volume 27, No. 3](#) (*BoardRoom Press*, June 2016)

[Board Mentoring, Third Edition](#) (*Elements of Governance*, May 2016)

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