The New Age of Accountability: Board Education and Certification, Peer Review, Director Credentialing and Quality
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The American Hospital Association’s Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.

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The New Age of Accountability: 
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Introduction

There has been a palpable shift in the public’s attitude about and expectations for health care. More than ever, health care consumers want safe, quality, affordable health care, delivered by competent, caring health care professionals; they want hospitals and health systems to be managed with efficiency and governed with integrity—and nothing less.\(^1\) We are in a time that “is marked by both a greater appreciation of the importance of governance and by forces that are constantly raising the bar on board responsibilities and best practice standards.”\(^2\) Welcome to a new era in health care: the age of accountability.

The public outcry for accountability has by no means fallen on deaf ears. Most non-profit hospitals in this post Sarbanes-Oxley era seem to have taken some steps to improve their governance practices.\(^3\) In this expanding universe of developing and often disparate health care governance practices, there appears to be a constellation of four consistent, emerging trends that aim to increase board accountability, namely: board education and certification, peer review, director credentialing and quality.

The most obvious example of these emerging trends is the advent of hospital board and director certification programs. Various state hospital associations have begun to develop and implement these programs. In 2007, there were two such programs.\(^4\) By 2010, there are twelve.\(^5\)

Boards are also beginning to explore various forms of “director peer review” to enhance their individual and collective performance. As the challenges of hospital and health system governance increase, boards are beginning to look to new tools, like “director credentialing” to evaluate not only the skill sets and effectiveness of directors, but also to implement important functions such as board recruitment and succession planning. Finally, hospitals and health systems continue to move the quality agenda into the boardroom as they engage in serious discussions on accountability—better ways to track, measure, monitor and improve quality.

This monograph will evaluate each of these four emerging governance activities. It will begin with director education, and explore such developments as board and director certification, pay for governance (P4G), and the New Jersey mandate for governance.

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1. See e.g. www.checkMD.com (A Web site launched in July 2008 that allows health care consumers to discuss quality and to make informed decisions about their health care).
4. The Texas and Tennessee State Hospital Associations certification programs.
5. The following states have announced or added a board certificate/certification in 2008: Georgia, New Jersey, Minnesota, West Virginia and Nebraska.
education. It will then turn to peer review and continue with a discussion of director credentialing, before examining the ever-expanding role of hospital boards and directors in quality of care.

**Director Education**

Hospital boards have historically received little in the way of formal training in governance. Most directors learned how to be hospital or health system directors through “on the job” training. Formal board education, to the extent it took place, was a matter left to the discretion of each individual board. However, in recent years, it has become increasingly apparent that informal, unstructured board and director education is not enough. In its 2007 report on good governance and ethical practice, the Panel on the Nonprofit Sector took aim at governance education, noting specifically that:

> The board should establish an effective, systematic process for educating and communicating with board members to ensure that they are aware of their legal and ethical responsibilities, are knowledgeable about the programs and activities of the organization and can carry out their oversight functions effectively.6

Today, the vast majority of hospitals and health systems participate in some kind of regular, ongoing director education. Educational programs, as part of annual education and development plans, provide necessary building blocks for great governance. The cornerstone of director education continues to be board orientation programs. Every health care governing board should have a structured, planned orientation program that familiarizes new directors with the organization, the issues facing it, board structure and operations, and the roles and expectations of individual trustees. As part of a general board orientation, each new director should receive, at a minimum, training on the board’s duties and policies and on current legal trends. In addition, directors should become familiar with the hospital’s mission, operation, structure, compliance issues, conflicts, code of ethics and quality and safety performance. The problem is, many boards do not go much further than board member orientation, with little in the way of structured, ongoing board education. Given the increasingly complex nature of the industry, governing boards need to do more.

The critical question has become: “[C]an untrained trustees, or unevenly trained trustees—no matter how well intentioned they are—effectively direct a hospital or system, one of the most complex organizations in the country?”7 In response to this, a trend toward more formal director education has emerged. Specifically, several state hospital associations have begun to offer director certificate and recognition programs. These programs, which have

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7 Orlikoff, James, E., & Totten, Mary, K. “Trustee & Board Certification: A Future Trend?” *Trustee Workbook, Trustee* (February, 2006).
been independently developed and structured, provide curriculum-based educational programs for health care boards in specified areas (e.g. quality, safety, finance and compliance). Further, some hospitals are now using board education as a condition of reappointment.

Recent trends in board education go beyond these certificate/recognition programs. Massachusetts has instituted a “first of its kind” pay for governance (P4G) program, which formally links board education to Blue Cross and Blue Shield pay for performance contracts. New Jersey has gone one step further and mandated governance education for all hospital directors. A more detailed exploration of each of these developments appears below.

**Board and Director Certification**

Recognizing the need to develop the knowledge and expertise of individuals willing to serve on the boards of non-profit hospitals, a number of state hospital associations have implemented voluntary certificate or certification programs. Some of these programs are designed solely for individual directors; some focus on the entire board, awarding certification, certificates or special recognition status; and some states are doing both. As of 2010, twelve (12) state hospital associations have such programs in place: Alabama, Georgia, Iowa, Massachusetts, Minnesota, Nebraska, New Jersey, South Carolina, Tennessee, Texas, Washington, and West Virginia. Colorado also has announced that it is developing its own certification program.

By offering these programs, state organizations hope to lead the industry in the pursuit of higher governance standards. At least two of them introduced their certification programs by alluding to the Enron and WorldCom failures. Others have their own home grown scandal to point to. According to these state associations, the provision of capable, informed and independent leadership, free of conflicts of interest, will help to maintain or regain public trust. Moreover, the hospital associations that have taken the lead in this area suggest that excellence in governance makes sense from a business perspective—that good governance

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8 Although the New Jersey Hospital Association published voluntary certification criteria, the state has also imposed mandatory director education, as discussed later in this monograph.

9 Copies of individual state certification materials may be accessed from each state hospital association’s Web site.

10 The Tennessee and Georgia state hospital association programs.

11 The Iowa state hospital association refers to the Iowa scandal around the Central Iowa Employment and Training Consortium (CIETC) governing board, whose CEO and board chairman improperly spent $1.3 million in job-training grants on employee bonuses and six-figure executive salaries.

12 Id.

13 Id.
is good business. Lenders, bond rating agencies, accreditation bodies and other third parties have begun to evaluate the quality of hospital boards when making economic decisions that have the potential to impact not only individual institutions but the industry as a whole. Some programs also raise the specter of legislatively mandated director education programs, as happened in New Jersey.

Eight state hospital association programs that provide education programs offer director certification. These programs are designed to produce directors who have the skills that will “enable hospitals to utilize governance best practices, to promote the coordination of care and the best use of resources, and to demonstrate to their community, lawmakers, regulators, physicians, employees, business and community stakeholders that health care organizations are committed to excellence in governance.” The programs themselves focus on both traditional good governance principles, such as fiduciary duty and institutional advocacy, as well as director responsibilities, such as strategic planning and quality and safety oversight, which are receiving renewed emphasis in the current environment.

Instead of requiring educational credit, some state programs, such as the Texas Healthcare Trustees Foundation’s Texas Academy of Governance, examine director actions and accolades. Specifically, the Texas Academy recognizes directors who meet certain levels of board stewardship as evidenced by their resumes, personal statements, civic activities and other accomplishments. By examining these elements, the Texas program nominates applicants who are believed to exemplify the most important aspects of trusteeship: commitment to community leadership, collaboration, vision, service and dedication to effective governance. In a similar vein, the Minnesota Hospital Association requires both educational credit as well as a minimum of one year of board experience, in order for health care directors to become certified.

In building its program, the West Virginia Hospital Association (WVHA) created a comprehensive resource guide for director education: the Governance Resource Manual. The manual contains a thorough review of many important areas of governance and hospital operations, covering topics ranging from governance accountability to grassroots lobbying.

Although the WVHA certifies individual directors, the Governance Resource Manual provides tools for both individual directors and their boards. For instance, the manual contains a board self-assessment tool kit, whose goal is to determine whether the board is

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15 Iowa
16 Alabama, Georgia, Iowa, Minnesota, Nebraska, New Jersey, South Carolina, Tennessee.
17 The Georgia State Hospital Program.
holding itself to the same level of quality improvement to which it is holding the health care institution it serves. In conducting a board assessment, the board is encouraged to: assess overall board performance in several areas of leadership and accountability; assess committee performance; identify issues and priorities facing the board; and assess individual trustee performance, including peer evaluation.

WVHA encourages its member hospitals to utilize the resources and tools it has provided in “certifying” the governance education provided to board members. WVHA has developed a spreadsheet to track the hours of education directors receive from any educational source. Once tracked and aggregated, WVHA makes a summary report to the West Virginia Health Care Authority on director education. The educational topics tracked by the spreadsheet include: mission, vision and strategic direction; hiring and overseeing the CEO; evaluating CEO compensation and performance; quality and patient safety; medical staff credentialing; organizational structure (management and governance); regulatory compliance; financial performance; legal and ethical integrity and compliance; governance accountability; and advocacy/community connections.

The South Carolina Hospital Association offers a hybrid program combining both director certification and the Pay for Governance (P4G) model outlined below. The South Carolina program follows a formal approach, with levels of certification, beginning with a basic course including six “Essentials of Healthcare Governance” modules. The course takes six hours, and certification is good for three years. Additional courses are also becoming available. Participants are tested as part of each course. Courses are offered on-site or online for trustees and health care organization leaders and participants can retake the test as often as necessary to pass and become eligible for incentives from insurers.

Five states (in addition to their director certification programs) also offer health care board certification programs: Tennessee, New Jersey, Georgia, Texas and Nebraska. These programs examine both the actions of the board’s individual directors as well as the interactions between directors and their boards. For example, the Tennessee and New Jersey certification programs certify health care boards on the basis of whether the board’s individual directors are certified. Each program provides for a transition period that will grant individual directors, and thus the entire board, the time needed to receive individual certification. A Tennessee hospital board will receive certification under the Tennessee Certification Program, if in the board’s first application year, 60 percent of its individual directors are

18 the fiduciary role of the board, mission, finance, quality care, CEO relationship and governance
19 "As a component of the 2011 Hospital Recognition Program, participating hospitals who have 75 percent of their board members and senior hospital leaders obtain certification by completing both the Essentials of Healthcare Governance and Quality courses will receive some financial support—either lump sum or increase in reimbursement—from BlueCross BlueShield of South Carolina and Blue Choice Health Plan."
certified; this required percentage increases by ten percent each year for the next four years after which time 100 percent of the directors must be individually certified in order for the board itself to be deemed certified. Furthermore, the Tennessee program grants new directors a two-year period during which time they must become certified; during this grace period the new directors will not be counted toward the required director percentage.

In contrast to the Tennessee and New Jersey certification programs, the Georgia and Texas programs focus their examinations upon the actions of the hospital board itself. According to the Georgia certification program materials, board certification will be awarded based upon an examination of whether the board has “adhered to specific, predetermined governance standards that exemplify community accountability and outreach responsibility for quality and safety of care to address identified needs, and the characteristics of a high-performance board.”

Although similar to the Georgia requirements in that it requires an examination of the full board, the Texas board recognition criteria are more similar to its own individual director recognition criteria. Specifically, in order to receive recognition, Texas hospital boards are required to submit copies of their policies, bylaws and procedures, minutes, resolutions and agendas, hospital orientation manuals, evaluations and assessment materials, and insurance policies, educational plans and videos.

The Nebraska Hospital Association has merged the requirements of the Tennessee/New Jersey and the Georgia/Texas programs to create a hybrid: the Nebraska certification program examines both the certification of a board’s individual directors, as well as the actions of the full board in its determination of certification. Furthermore, as with the Georgia and Texas certification programs, boards of Nebraska hospitals must demonstrate “a commitment to care management and coordination of resources” as well as provide examples of their community accountability and transparency to the Nebraska Hospital Association in order to receive certification.

With the exception of South Carolina’s program, most state hospital associations’ processes for evaluating directors and their boards for certification are remarkably similar. After completing the requisite educational requirements, each director and/or board submits a completed application, which is usually verified by the hospital CEO, to the appropriate state hospital association for approval. Once such approval has been obtained, the directors and/or boards are able to represent themselves as “approved” entities. South Carolina’s program differs in that it requires participants to pass a test in order to receive certification.

The governance improvement programs implemented by these hospital associations reflect a commitment to take the lead in increasing competence of hospital governing bodies beyond
paying mere lip service to the hard lessons learned from other industries. Although the programs certainly constitute a good first step, the effectiveness of these voluntary programs has yet to be established and quantified. As the industry matures, more criteria to define and measure governance effectiveness will develop; the marketplace demands it. Boards that can demonstrate their efforts to follow and exceed best practices will be at a competitive advantage over those that do not.

**Pay for Governance (P4G)**

Another initiative related to director education is “pay for governance” (P4G). Massachusetts took the lead when Blue Cross Blue Shield of Massachusetts sponsored a governance initiative with the Massachusetts Hospital Association (MHA) to fund a director education program. Specifically, the MHA, through its Trustee Advisory Council, formed a Trustee Steering Committee that commissioned the Center for Healthcare Governance to design a quality curriculum for hospital board members. This curriculum focuses on improving quality performance and patient safety initiatives. Specifically, it is designed to:

- Enhance board members’ abilities to make the clear connections between their work in the boardroom, the performance of their organization, and the well-being of patients and the community;
- Provide the tools board members need to effectively drive their hospitals’ quality and safety initiatives; and
- Fit with an individual organization’s strategy, mission and vision.

Perhaps more significant is that Blue Cross Blue Shield of Massachusetts directly ties director participation in the Quality Curriculum for Trustees to its pay for performance (P4P) contracts. In order for hospitals to receive more favorable P4P reimbursement, they must demonstrate that 80 percent of their directors have participated in and have been trained in the Quality Curriculum for Trustees. Blue Cross Blue Shield of Massachusetts recognizes the role of governance in both the quality and cost of health care, and now provides financial incentives to hospitals that demonstrate director compliance with educational requirements.

In 2010, South Carolina joined the P4G movement by tying governance education and evidence of learning to incentives. The South Carolina Hospital Association (SCHA) is offering an Essentials of Healthcare Governance course with additional courses in areas such as quality and finance. When 75 percent of a health care organization’s trustees and executive leaders complete the Essentials and Quality courses and pass the test for each course, they will receive incentives from Blue Cross Blue Shield of South Carolina and Blue Choice Health Plan.
Legislatively Mandated Director Education

Mandated director education stands in stark contrast to voluntary director/board certification programs and the Massachusetts pay for governance program. In 2007, New Jersey became the first state in the country to establish a legislative mandate that all “new hospital” trustees receive formal education in financial governance within six months of their appointment to the board.20 However, the law was subsequently amended and expanded to require that all hospital trustees receive such training.21

The law was enacted in response to findings reported by the New Jersey Commission on Rationalizing Health Care Resources and was part of a package of four new laws aimed at ensuring state hospital viability. In consultation with the New Jersey Hospital Association, the Hospital Alliance of New Jersey and the New Jersey Council of Teaching Hospitals, the state commissioner proposed amendments and new rules to the regulations for implementing the law. The law took effect on February 4, 2009 with completed training required by August 4, 2009.

Although some see the codification of educational requirements as a meaningful step toward insuring director development, others see it as a hollow gesture. As one New Jersey assemblyman commented, “Last year, New Jersey committed over $700 million to health care and it will no doubt commit the same or more this year... For those kinds of dollars committed, I believe the state has good reason to obligate our hospitals and health care institutions to have trustees who can act as an independent body to oversee hospital functions to ensure the efficiency of hospital operations and financial and budget oversight.”22

The required program must be seven hours in length and cover: the ethical and fiduciary responsibilities of individual hospital board members; the role of the governing body in improving health care quality and the mechanisms available for doing so; hospital financial management and understanding the financial statements of health care institutions, reimbursement and payment systems; hospital organization and governance; and legal and regulatory compliance issues.

The program may be offered in-person in a classroom or seminar as well as online or via audio or simulcast. At least 60 days prior to offering the program, a hospital must submit a program description to the state Department of Health and Senior Services as well as to the Office of Certificate of Need and Healthcare Facility Licensure.23

20 N.J.S.A. 26:2H-12.34
21 Id.
23 Published, New Jersey Register, November 17 (2008).
Peer Review

Most directors understand, at least in concept, that they are charged with the duty to govern the hospital or health system—how it’s managed and operated and the quality of care that it renders. However, in this new age of accountability, boards are increasingly aware that it is difficult (perhaps even impossible) to be accountable for the actions of others without first being accountable for their own. This section will begin with an evaluation and critical assessment of the peer review tool that is most commonly used by boards in health care and industry—the board self-evaluation. It will then explore board meeting and committee evaluations and director peer review as additional tools that boards and directors can use to enhance governance and foster accountability.

Board Self-Evaluation

The essential purpose of a board self–evaluation is to help the board and its directors “improve their ability to function as a collective body.”24 Serious examination of the board’s structure, membership, composition and core practices on an ongoing basis—along with real commitment to changes as a result of these examinations—are among the keys to improving governance effectiveness.25 This is why many regulatory or quasiregulatory bodies in both the non–profit and for–profit sector (e.g. The Joint Commission and the New York Stock Exchange) require that boards use self-evaluations on a regular, if not annual basis.26

The best practice for hospital board self-evaluations is to benchmark evaluation results with other organizations on both a regional and national basis. Further, it is helpful to compare evaluation results with other organizations that are similar in revenue level, size and other characteristics. However, the real challenge may be less in conducting the board evaluation survey and more in the board’s underlying commitment or ability to change.

A recent survey found that while about 90 percent of community health system boards engage in such formal assessments, only 56 percent of those boards indicated that the survey resulted in actions that “substantially changed” their board practices.27 On the one hand, the data show that health system boards were able to use the self-evaluation to effect meaningful change. On the other hand, the data raise questions about the extent to which board self-evaluations/assessments are making a meaningful impact in improving governance.28

One option for the high–functioning board that aspires to best practices is to go further to foster open, constructive communication in the interest of good governance. One way to accomplish this is to evaluate board meetings.

26 Id.
27 Id.
28 Id.
**Meeting Evaluations**

Meetings are the lifeblood of hospital and health system governance. Well-organized, well-run meetings not only advance the essential mission of the organization, but also can invigorate directors, keeping them both engaged and focused. Meeting evaluations give directors the chance to comment and say what is often left unspoken, that is: “Was the meeting effective or did I waste my valuable time?” Post-meeting surveys need not be time-intensive or laborious; rather, they should be short and to the point. Survey questions might include:

- Did the meeting meet your expectations? (Explain why or why not.)
- Was the information valuable?
- Did presenters make appropriate use of meeting time?
- Was the agenda followed?
- What, if anything, would have made the meeting more effective?
- Was there anything discussed at this meeting that you would like to see explored further at a follow-up meeting?

Evaluation forms should include an opportunity for the board to analyze and evaluate meetings both objectively and subjectively. Evaluations should be completed at the end of every meeting and results reviewed at the beginning of the next regularly scheduled meeting. If done correctly, meeting evaluations enable directors to break down communication barriers, allowing them to talk about the effectiveness of the meetings and about their own and each other’s contributions in ways that would otherwise not likely occur. Evaluations promote candor and provide a meaningful avenue for better meetings, which translates into better governance.

**Director Peer Review**

Very few, and only exceptional boards, engage in director peer review, according to leading business consultant and author Ram Charan. He notes that most boards are concerned about the negative consequences of having board members ‘grade’ each other and resist doing it even when the CEO advocates it. He adds that this trepidation is understandable because peer review is a process that is difficult to execute well.

Clearly, there are potential risks in trying to employ director peer review. When there is distrust between directors and the CEO or among board members, director peer review can further disrupt board dynamics. Add to this the dilemma of non-profit hospital boards—all too often, board members are overworked, under-appreciated and uncompensated for their efforts. Raising the specter that they should conduct and receive performance evaluations in connection with their volunteer service might not be well-received. Notwithstanding, says Charan, hospital and health system boards that are able to “execute properly” peer review in
the boardroom will find “the efforts of peer review are far more positive then negative”—that it is “a powerful tool for helping directors...[to]...learn how to be more effective members of the group.”

Following are three methods of director peer review that boards can consider, depending on the board’s receptiveness, culture and level of trust:

- **External Evaluation or Facilitator.** External evaluations are especially effective for gaining peer review information when it is too difficult for the board to conduct individual director peer review or when there are matters that might be viewed as too sensitive to broach. They typically involve confidential board member interviews by an independent third party.

- **Committee Peer Review.** Individual director peer review may be conducted through a committee of the board (e.g. the Governance Committee). However its use is inherently limited because this approach often reflects only a representative sample of peer opinion. For this reason, committee peer review often tends to focus on “high-level,” more objective criteria (e.g., meeting attendance and participation) as compared to the approach to individual director peer review discussed below.

- **Individual Director Peer Review.** The most potent form of performance review is director peer review, where individual board members are reviewed by their peers against performance criteria. This means not only using objective criteria (e.g., meeting attendance and participation) but also subjective, probative information such as knowledge of and adherence to board policies and procedures; perceived value and quality of directors’ meeting participation; and overall contribution to the hospital or health system.

Implicit in director peer review is reliance on governance instruments such as director job descriptions that define and set forth director expectations and formal board assessments that establish specific criteria against which directors are measured.

Performance reviews and evaluations are commonplace at almost every level of business and industry—including health care—except at the board level. Now this is changing. “Mature” high-performing boards are migrating to director peer review, knowing well that critical feedback, though sometimes difficult, is an essential component of governance performance improvement.

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Credentialing Directors

How does a hospital know its directors and board are competent? The Joint Commission is increasingly posing this question to hospitals throughout the country on hospital surveys seeking to verify compliance. In response, hospital governing boards are turning increasingly to credentialing, although, in some respects, director credentialing has been going on for years.

Nominating Committees (and now, more often, Governance Committees) have long vetted the training, education and experience of board candidates and directors, looking for talented persons with competence and high character to serve on hospital boards. However, boards may need to go beyond a candidate’s resume and delve further for objective, measurable evidence of his or her competence and fitness to serve. Boards need to take the next step and credential their directors to make certain that they possess the requisite training, education and experience to serve on the board. Boards that undertake director credentialing should use it as more than a perfunctory process (i.e., compliance with state, or board-mandated educational requirements); rather, it should be expanded to include performance and process improvement and director development.

Most hospital bylaws include basic criteria individuals must meet to qualify as directors. These include broad-based standards of competence and character as well as hospital-specific needs for knowledge, skills and business expertise. Non-profit community boards typically go further and seek to have members who are representative of the community/communities they serve.

Hospitals and health systems may want to use a uniform and approved “director’s application” that asks for appropriate, relevant and probative information. It should be drafted in a manner that encourages the applicant to disclose such matters as training and education, unique skills, potential conflicts/business relationships and criminal convictions and civil litigations (go to www.americangovernance.com and click on the Center for Healthcare Governance Resource Repository to view a sample application in the Governance Toolbox.)

Depending on the state in which the hospital is located and the particular standards it has adopted, it may be appropriate to obtain and track director training and education, such as completion of board orientation; documentation of core competencies, such as those developed by the AHA’s Blue Ribbon Panel on Trustee Core Competencies (go to www.americangovernance.com for more on the panel’s report); state-mandated education; evidence of acquiring board certificate/certification and continuing director education.

Many hospitals are required by federal or state law to demonstrate board and director compliance in other areas—all of which should be addressed when considering standards for
director credentialing. For example, tax-exempt organization boards must meet various requirements related to independence, conflicts of interest, and community representation.30

Finally, depending on the hospital’s or health system’s culture and its ultimate pursuit of good governance, peer review has the potential to become the most significant component of director credentialing.

Once the board has agreed on the type of information it wishes to review, it then must consider the credentialing process itself and the standards of review. The process should address the steps the board will take to review and recommend trustee appointments and reappointments. Typically, an initial recommendation is made by the Governance Committee and forwarded to the full board for final action. However, the process can be more complicated in multi-hospital systems depending on corporate structure and the role and relationship between the parent company and its subsidiaries.31

In addition to defining the credentialing process, the board should define what information should be reviewed and the standards of review. What characteristics of a director are important? How are the standards and expectations agreed upon and communicated? Most importantly, what underlying purpose does the board desire to achieve through the credentialing process? Director credentialing that amounts to a perfunctory, paper process of appointing and approving officers and directors falls far short of its potential. Director credentialing at its best incorporates peer review information,32 uses director credentialing as an opportunity to give and receive feedback, and develops a board culture of continuous quality improvement. Boards that use director credentialing as a development tool can foster a more satisfied, engaged board that is on the road to realizing meaningful, effective governance.

Hospital and health system boards are increasingly challenged to recruit qualified directors who are willing and able to dedicate their time and talents.33 Additionally, the complexity of health care requires not only directors with special/professional skill sets (e.g. law, finance, auditing) but also directors who are critical thinkers.34 Accordingly, “most governance experts and trustees agree that boards must think strategically about their future needs before they arise; that the Governance Committee should assess the board’s strengths and weaknesses and determine key skills the board may need in the future.”35

33 Id.
34 Id.
35 Id.
Quality

Case law has made it clear for some time that boards of non-profit hospitals are accountable for the quality of care delivered in the hospital. However, most directors have perceived themselves as unqualified to pass judgment on patient care matters or to make judgments with regard to quality. In 2006, the Joint Commission recommended that directors invest in education to expand their knowledge about quality, invite patients to share their hospital experiences with the board, and that individuals with experience and expertise in quality issues be added to the board.\(^{36}\) Many hospital boards are beginning to do just that.

Although most board members will never be experts in the clinical complexities of patient care, they can contribute much to the quality improvement process. Hospitals are devoting more resources to board education, much of which is dedicated to quality improvement issues. Boards also are adopting processes for routine review of data on patient care and safety issues.

Boards are becoming more comfortable with interpreting quality data, an essential skill in an environment where boards are increasingly pressured to become more involved in matters of quality. Issues driving greater board involvement include: pressure from consumers demanding increased quality, transparency and accountability for health care services; changes in reimbursement methodologies to withhold payment when substandard care is provided; and the use of the False Claims Act (FCA)—and to a lesser extent other state and federal regulations—by the federal government to prevent payment for substandard care received by the beneficiaries of government programs.

Some boards are embracing the call for increased quality and using it to forge a competitive advantage in the marketplace. For example, an advertisement for Hackensack (N.J.) University Medical Center that ran in *The New York Times*\(^{37}\) proclaimed that the hospital was “raising the level of health care to save lives,” as evidenced by its inclusion on HealthGrades America’s Best Hospitals list. Clearly the purpose of the advertisement was to differentiate the hospital from its competitors based upon quality measures. The ad stated, “[W]e were the only hospital in New York, New Jersey or New England to make the list.”

The advertisement pointed out that Hackensack and the 49 other hospitals on the list were recognized for their ability to “institutionalize” or “operationalize” quality health care, a major selling point for both the public and payors. In this era of accountability, “branding” a hospital as a quality provider could very well be a winning strategy.

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Another important trend promoting accountability for quality of care is pay for performance, or P4P, used by both public and private payors. P4P programs vary in what they measure and reward, but all of their rewards, whether in the form of public recognition or payment, relate to improved quality: better quality associated with higher reimbursement is clearly the trend.

The flip side of P4P is also at play. As of October 1, 2008, Medicare stopped paying health care institutions for treatment associated with preventable errors, which have become collectively known as “never events”. Such events include falls, mediastinitis (an infection that can develop after heart surgery), urinary tract infections (which typically result from improper use of catheters), pressure ulcers, vascular infections (that result from improper use of catheters), objects left in patients during surgery, air embolisms and blood incompatibility. Private insurers are also adopting similar no-pay policies. Obviously, failure to control the occurrence of these events could have devastating effects on a hospital’s bottom line.

Perhaps the most dramatic factor changing board behavior related to quality may be increasing enforcement activity by both state and federal regulators regarding the quality of care paid for by government programs. Government enforcement authorities, including the Office of the Inspector General, the Department of Justice and state attorneys general, are increasing their focus on quality of care provided to beneficiaries of federal health care programs and are working collaboratively to address cases where substandard care has been delivered. Sanctions can range from monetary penalties to permanent exclusion from government health care programs when providers fail to meet the quality of care obligations applicable to government program providers.

With increasing frequency, government regulators are using the False Claims Act (FCA) to crack down on health care providers, including hospitals, for providing poor quality of care or unnecessary services. In fact, in recent years the FCA has been called “the government’s most powerful tool to enforce quality of care.” Traditionally, the FCA was used to prosecute providers who fraudulently submitted claims for services that were simply not rendered at all, or providers who billed in a manner that did not accurately reflect the services that were provided. However, in recent years, the FCA has been used to prosecute providers who submit claims for care deemed either substandard or medically unnecessary.


42 Id.
The theory behind this expansion of FCA prosecutions is that Medicare and Medicaid are only responsible for costs that are reasonable and necessary for the diagnosis or treatment of illness or injury. When a provider submits a claim for reimbursement for care that is either medically unnecessary or substandard, the provider has submitted a false claim to the government for payment. In doing so, the provider becomes exposed to potential civil and criminal sanctions. This position taken by the government has obvious consequences for compliance initiatives at hospitals and the board oversight of such initiatives.

Another major quality-driven undertaking by the Centers for Medicare and Medicaid Services is the Recovery Audit Contractor (RAC) program. Under the RAC program, recovery audit contractors review the Medicare claims of physicians, providers and suppliers to identify overpayment or underpayment. In exchange for their services, the audit contractors receive a percentage of all overpayments they identify. The RAC pilot program targeted inpatient hospitals in Florida, California and New York; the recoupment from these three states alone was estimated to be nearly a billion dollars. The expansion of the RAC pilot now underway has obvious implications for hospitals nationwide.

Clearly, these recent developments in the health care industry present a major challenge to non-profit boards of directors. Recent studies have shown that hospital boards that are committed to quality improvement efforts can have a significant impact on improving the care rendered by their institution; however the quality transformation needs leadership and commitment. How does a board, populated mainly by lay directors committed to the mission of the institution and the community served transform itself to offer meaningful oversight on quality issues and take appropriate action when problems are identified? The Institute for Healthcare Improvement (IHI) cites several specific steps that boards should take to improve quality of care:

- **Set aims.** The IHI recommends that hospital boards make a clear and public commitment to measure improvements in quality and safety.

- **Seek data and personal stories.** Boards should audit at least 20 randomly selected patient records to examine all types and levels of injury and conduct a “deep dive” investigation of one major incident, including interviews with the patient, family and staff.

- **Establish and monitor system-level measurements.** Board should track progress across the entire organization by reviewing such quality metrics as medical harm per 1,000 patient days or risk-adjusted mortality rates over time.

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45 See http://www.medicalnewstoday.com/articles/114759.php
• **Change the environment, policies and culture.** Boards should require respect, communication, disclosure, transparency, resolution and all the elements intrinsic to an organization that is fully committed to quality and safety.

• **Encourage learning.** Boards need to identify the capabilities and achievements of the best hospital boards and apply those standards to themselves and their leadership.

• **Establish accountability.** Boards should set the agenda for improvements in quality and safety by linking executive performance in these areas to compensation.

The board’s priority must be to infuse into the culture of the institution a commitment to continuous quality improvement and begin to take steps to institutionalize the quality improvement process. A government-industry roundtable called “Driving for Quality in Long-Term Care: A Board of Directors Dashboard” outlines a number of recommendations applicable to the boards of all health care institutions seeking to institutionalize quality improvement processes. The roundtable concluded that: it is vital for the board to receive quality data on a regular basis from which it can make assessments and benchmark improvements; the data need to be presented in a comprehensive and meaningful way so that it is understood by the board; trustees must be continually educated about quality and the data used to measure it; the board should have access to internal and external experts to validate the data presented by management; and the board should evaluate the appropriateness of the corrective action taken to address identified problems. Boards will have to work with management to define the data they need to perform their oversight duty and to interpret the data in meaningful ways.

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46 See “Driving for Quality in Long-Term Care: A Board of Directors Dashboard” available at www.hcca-info.org.

47 Id.

48 Similarly, the Center for Healthcare Governance (CHG) has published its own approach for getting boards to understand and discharge their obligation to oversee and monitor quality patient care through a quality curriculum. The CHG’s Quality Curriculum for Trustees is a six-hour interactive program designed to give board members practical information on how to organize their work through the board’s quality committee, select appropriate quality measures, develop quality leadership and make the quality connection in addressing both the patient’s and the community’s needs.
Conclusion

One might ask when all is said and done, whether these trends (board education, peer review, director credentialing and quality) will help make hospital and health system boards better and more accountable or whether they are just a passing fad. Some experts think these activities just may be the beginning and that director and board certification will not only be a trend, but standard practice in the future.49

A better approach might be simply to step back and consider the larger picture. The New Jersey and Massachusetts experiences suggest, if nothing else, that regulators and payors were dissatisfied with the current state of board education. Voluntary board certification programs may not offer a perfect or even the best solution—but they are a start. As history has often shown, industries that are perceived to have failed in regulating themselves and in being accountable are ultimately the target of external regulation. Unquestionably, hospitals and health systems continue to face persistent and unrelenting financial challenges and seemingly unending criticism, scrutiny and pressure from a number of sources.50 In this environment, hospital and health system boards will view the governance trends discussed here as either another burden or an opportunity. Boards that have the foresight to embrace these challenges will be better positioned to meet the higher expectations of this age of accountability and ultimately will come to embrace the perspective that “good governance is good business.”

49 Orlikoff, James, E., & Totten, Mary, K. “Trustee & Board Certification: A Future Trend?” Trustee Workbook, Trustee (February, 2006).

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