

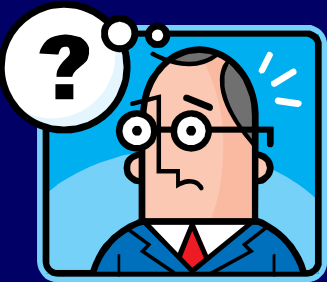
Board's Role in Quality Oversight

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Quality: Whose Responsibility? The ACO? The Board? The Medical Staff?

- Traditionally the Medical Staff has been primarily responsible for overseeing quality of care in a hospital
- In practice Peer Review is largely a Medical Staff function
- Board has ultimate authority but on the ground?
- When an ACO or other alignment strategy is layered over the existing structure the allocation of responsibilities is even less clear





The Hospital Board's Role

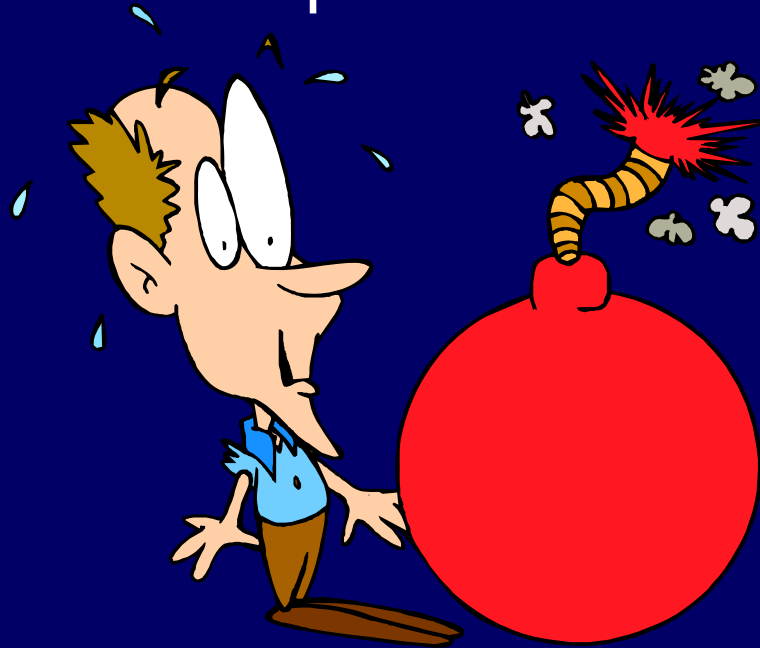


- Ultimate authority over physician credentialing, peer review decisions and quality
 - Traditional deference to Medical Staff
 - At some point, Board is responsible but where should the line be drawn?
 - When the hospital joins an ACO or other entity the board and the medical staff's obligations do not change
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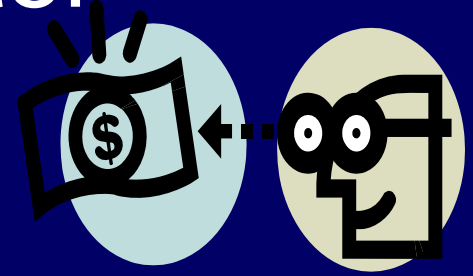


Does Quality oversight matter?

- Redding Medical Center and St. Joseph's Medical Center



Redding Medical Center

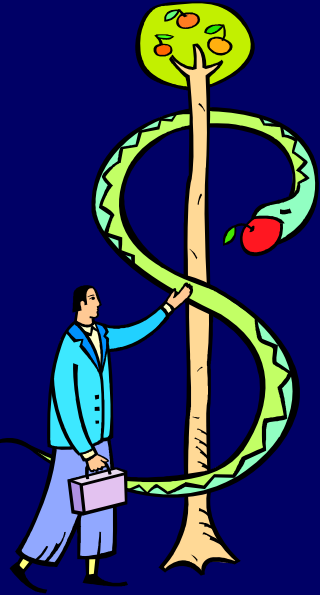


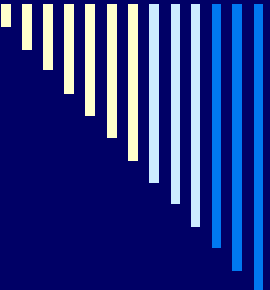
□ Redding Medical Center

- A sordid tale of greed?
- Allegations that Dr. Moon and Dr. Realyvasquez performed a large number of unnecessary cardiac procedures and that the Hospital knowingly permitted the misconduct
- Tenet paid government \$60 million and was forced to sell the hospital
- 769 Civil lawsuits– settlement \$395 million

St. Joseph Medical Center

- ❑ Interventional cardiologist, Dr. Mark Midei, accused of performing unnecessary cardiac stent procedures
- ❑ St. Joseph Medical Center sent notices to hundreds of patients advising them that they underwent unnecessary procedures
- ❑ Hospital paid \$22 million to government and faces civil suits
- ❑ Dr. Midei lost his license and faces a host of legal claims





Redding and its Progeny: A Game Changer?

- Cases suggest hospital boards have a greater responsibility for oversight of clinical care
 - Financial exposure significant
 - Damage to reputation
 - Personal liability?
 - Not yet but . . .
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Does Quality oversight matter?

- Pay for performance, shared savings, value based purchasing . . .





Pay for Performance, Shared Savings

- Quality metrics are increasingly important component of reimbursement
 - The Board (whether hospital, ACO or whatever) will be increasingly involved in quality monitoring because of the direct effect quality will have on the financial viability of the organization
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The Obstacles

- ❑ Boards are generally not well equipped to assess quality issues
 - ❑ Traditional Role of Physicians and Medical Staff
 - ❑ Peer Review and QA processes are steeped in tradition and create significant risk management and litigation risks
 - ❑ Data available to Boards often inadequate
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Hypothetical

- Hospital recruits Orthopedic surgeon, Dr. Bones
 - **Substantial investment**
 - Generates a lot of \$ for Hospital
 - Dr. Bones controls credentialing and peer review processes for his department
 - Some indications that Dr. Bones' clinical performance and perhaps that of his partners is sub standard
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Hypothetical

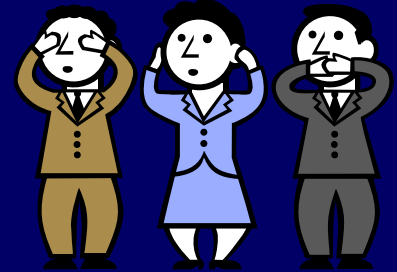
- Dr. Bones performs more hip replacements than any other surgeon in a three state area
 - Hospital forms ACO and Dr. Bones is key physician on ACO Board
 - Dr. Bones participation in ACO increases his referral base and he is now the most productive surgeon in the region
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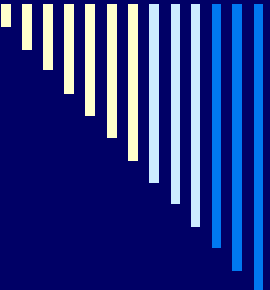
What can the Board Do?

- ❑ Refer Dr. Bones for review by Hospital Medical Staff?
 - ❑ Instruct management to monitor clinical performance and report to Board?
 - ❑ Ask ACO Board to review Dr. Bone's clinical activity?
 - ❑ Hire outside organization to undertake quality audit?
 - ❑ Wait to see if ACO meets quality metrics?
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Traditional Deference?



- What if Board does not address Dr. Bones' clinical performance?
- Risks include:
 - Malpractice exposure
 - Negligent credentialing
 - False Claims Act claim – Whistleblower?
 - Administrative Sanctions
 - Quality statistics decline – loss shared savings or P4P dollars?
 - Claims against Board members for breach of fiduciary duties?



Beyond Dr. Bones: Potential Exposure for other quality failures

- Scope of False Claims Act exposure based on quality of care is in flux
 - Claims based on lack of medical necessity on the rise
 - Growing number of claims/settlements for unnecessary care or care that puts patients' lives at risk
 - In the future possible FCA claims based on:
 - Never Events
 - Hospital Acquired Conditions
 - Failure to meet either quality or P4P standards?
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