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**ANALYSIS & COMMENTARY**

**A New Quality Compass: Hospital Boards’ Increased Role Under The Affordable Care Act**

By Elisabeth Belmont, Claire Cowart Haltom, Douglas A. Hastings, Robert G. Homchick, Lewis Morris, Julie Taitsman, Brian M. Peters, Robin Locke Nagele, Beth Schermer, and Kathryn Croom Peisert

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**ABSTRACT** The Affordable Care Act of 2010 promotes a clinically integrated, systems-based approach to health care. This means coordinating a patient’s care over time and across all conditions, diseases, providers, and care settings. The aim is to achieve optimal results in terms of the overall quality of care as well as its efficiency, cost, safety, and timeliness. Hospital boards, which are legally accountable for the quality of the care their institutions provide, need to develop and implement effective quality oversight processes to achieve these objectives. Boards will have to focus less on the competence of individual providers and more on the functioning of the entire system of inpatient and outpatient care. We discuss the increased role of the boards in a systems-based approach to quality, and what steps they can take to meet the quality mandates of the Affordable Care Act.

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The Affordable Care Act of 2010 creates a new framework for the delivery of health care in the United States. The act adopts a comprehensive national strategy for quality improvement in health care whose foundation is clinically integrated, systems-based practice. Clinical integration means that independent providers such as hospitals or health systems, physician practices, individual providers, and outpatient diagnostic centers integrate their services through shared electronic health record systems, clinical guidelines, unified practice management, and other techniques. In optimal systems-based care, each patient’s health care needs are evaluated and treated comprehensively as part of a “system” of care for that person.

The result is patient care that is coordinated across all conditions, diseases, providers, and care settings, and over time. The goal is to achieve optimal results in terms of efficiency, cost, safety, and timing, as well as overall quality of care.

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New Programs In The Affordable Care Act

The act expands existing programs and creates a host of new mandatory programs and voluntary demonstration projects that promote clinically integrated, systems-based practice. The goal is to direct federal health care dollars toward improving the quality and efficiency of care.

"NEVER EVENTS" “Never events” is the colloquial term used to describe hospital-acquired conditions—those that patients develop during the course of hospital care, such as pressure ulcers and postsurgical infections—that the Centers for Medicare and Medicaid Services (CMS) has deemed to be avoidable in most cases through the exercise of reasonable care. The never-events payment policy that CMS initiated in 2008 as the result of a legislative mandate included in the Deficit Reduction Act of 2005 defines never events for which CMS will not pay providers. CMS’s policy—along with similar policies adopted by commercial payers and by state governments, using a range of different mechanisms such as statutes, regulations,
and agency bulletins or policies—has increased financial pressure on providers to improve patient safety and, specifically, to change clinical practices and procedures to follow recommended quality guidelines more closely.

The Affordable Care Act will extend the impact of this existing federal never-events policy by legislating new financial penalties for hospitals that fall short of quality expectations. Starting in 2015, section 3008 of the act will impose a 1 percent annual penalty on the quartile of hospitals reporting the highest percentage of never events experienced by their patients. And sections 3025 and 10309 mandate that, beginning in fiscal year 2013, Medicare payments be reduced for hospitals with higher-than-expected readmission rates (with the specific thresholds to be determined based on a mix of current measures and modifications to be made by CMS).

Furthermore, section 2702 requires all states to implement “never events” policies or lose their eligibility to receive federal Medicaid dollars. The policies must include all of CMS’s “never events” to the extent that they are applicable to the Medicaid population, which differs demographically from the Medicare population. The state policies must also incorporate current state practices to the extent that they differ from the CMS approach—for instance, because they employ different standards or procedures, or impose different types of penalties than those used in the federal program. This will add to the financial pressure on hospitals to implement clinical practice guidelines that are designed to reduce or eliminate these undesirable outcomes.

**Value-Based Purchasing** The Affordable Care Act will exert additional pressure on hospitals to meet mandated quality benchmarks through its value-based purchasing program, described in sections 3001 and 10335. Starting in fiscal year 2013, Medicare payments to all hospitals for specific conditions—including heart failure, myocardial infarction, pneumonia, and surgical infection—will be reduced by 1 percent, and that reduction will increase to 2 percent by fiscal year 2017. The pool of funds created by these reduced payments will be reallocated to reward the hospitals that have done the best job of meeting the quality benchmarks that CMS will establish annually. CMS has issued proposed regulations that list eighteen quality benchmarks for the fiscal year 2013 reporting period—seventeen concerning the “process of care” and one concerning patient satisfaction—and three additional benchmarks for fiscal year 2014, all concerning thirty-day mortality statistics.

The scoring system designed by CMS evaluates hospitals based on their total scores as well as discrete scores reflecting improvement and consistency in meeting the mandated benchmarks. Hospitals are measured in relation to their peer institutions. To receive any financial reward, a hospital must score within the top 50 percent of all hospitals. Moreover, CMS’s announced goal is to progressively raise the quality bar by adding new quality benchmarks and retiring those that have “topped out”—those that enjoy such a high rate of compliance that they are no longer helpful in distinguishing between high- and low-performing hospitals.

**Bundled Payments** A new pilot program in sections 3023 and 10308 of the Affordable Care Act will provide bundled payments for hospital “episodes of care.” Under this program, CMS will bundle payments for an entire episode of care for one or more of ten selected medical conditions, such as a hip implant, cancer treatment, or ongoing treatment of a chronic disease. Episode-of-care payments will cover the period from three days prior to a qualifying hospital admission through thirty days following discharge.

Bundled payments made under the pilot program will cover the costs of acute care inpatient services; physicians’ services delivered inside and outside of an acute care hospital setting; outpatient hospital services, including emergency department services; postacute care, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital; and other services that CMS deems appropriate.

Section 2704 of the act creates voluntary demonstration projects to evaluate the use of bundled payments for other types of episodes of care that include hospitalization. The goal of the demonstration projects is to give providers an opportunity to show how they can use a systems-based approach to improve the quality of care while reducing total expenditures. Participants must generate the data necessary to monitor outcomes, costs, and quality and to evaluate the effectiveness of the program in meeting benchmarks for cost and quality.

The bundled payment methodology will require providers to further refine their systems-based approach to care. Theoretically, hospitals that are able to collaborate with physicians and postacute and outpatient providers to move patients seamlessly through the preadmission, acute, and postacute phases of care will be better positioned than other hospitals to reduce medical errors and admissions, provide more cost-effective service, and generate a reasonable profit margin.

**Accountable Care Organizations and Shared Savings** The Affordable Care Act’s
Shared Savings Program, discussed in sections 3022 and 10307, promotes the development of accountable care organizations. These are groups of providers—such as hospitals, physician groups, and other providers of outpatient services—that jointly take responsibility for providing coordinated care to a minimum of 5,000 Medicare fee-for-service patients.

Each accountable care organization will have the opportunity to share in any savings to the Medicare program generated as a result of its enhanced quality and efficiency, if it meets certain quality benchmarks. For example, the proposed Shared Savings Program regulation issued by CMS on April 7, 2011, listed sixty-five potential benchmarks across five quality domains: patient and caregiver experience, care coordination, patient safety, preventive health, and at-risk populations (such as the frail or the elderly). The benchmarks range from ensuring timely appointments and courteous treatment of patients by office staff to documenting spirometry results for patients older than age eighteen who have chronic obstructive pulmonary disease. To achieve success in this program, hospitals will have to provide and promote high-quality care for their patients in both the inpatient and outpatient settings.

**MEDICAID WAIVER FOR DISEASE MANAGEMENT**
Section 2703 of the act includes a new Medicaid waiver program through which states can develop “health homes” for the treatment of patients with chronic conditions such as mental illness, substance abuse disorder, asthma, diabetes, heart disease, or obesity. A health home is a designated provider operating in coordination with a team of other health care professionals to provide comprehensive and coordinated care.

Hospitals will have to position themselves to work effectively with health homes as part of the coordinated care network. For example, they will need electronic health record systems to coordinate their acute services with care before admission and after discharge.

**INCREASED PUBLIC REPORTING**
The Affordable Care Act also imposes new reporting requirements designed to make hospitals use systems-based approaches to improve quality. A number of the new requirements focus on physicians.

For example, sections 3015 and 10305 require the secretary of health and human services to make available to the public, through standardized websites, health care performance information summarizing data on various quality measures. The Physician Compare website, for quality data on physicians, has already been launched. Under section 10331, it will expand by 2013 to include information on quality and patient experience measures. Sections 3002 and 10327 of the Affordable Care Act require CMS to reduce Medicare reimbursement to 98 percent of the existing fee schedule for physicians who fail to submit the mandated data on the quality of their performance by 2016.

The increased reporting required of physicians will affect hospitals that employ or are affiliated with physicians and thereby increase the pressure to raise the institutions’ quality. Public reporting of quality data has been identified as one of the most effective means of increasing the quality of care.

**The Systems-Based Approach To Quality**
Hospital boards are accountable for the quality of care at their institutions, under federal reimbursement regulations and accreditation standards. Therefore, hospital board members should take an increasingly active role in quality oversight to ensure that the Affordable Care Act’s new mandates are met.

Given the act’s emphasis on clinically integrated, systems-based care, hospital boards and their medical staffs need to reevaluate the design and effectiveness of their quality oversight processes, including those specifically related to the credentialing and peer review of physicians and other licensed independent practitioners on staff. Credentialing is the process of verifying that physicians and other practitioners have the necessary education, training, and experience to practice competently on a hospital’s medical staff. Peer review is the ongoing quality oversight process for practitioners once they are granted privileges to practice on a hospital staff.

Currently each practitioner is evaluated—in both credentialing and peer review—in isolation and in accordance with what is called the community “standard of care.” The Affordable Care Act’s pervasive emphasis on systems-based medicine challenges this individualized approach by suggesting that the primary question is not so much whether a practitioner demonstrates reasonable judgment and skill as an individual, but whether that practitioner functions effectively within the system of integrated care that the act envisions.

Organizationally, this change in emphasis requires successfully coordinating the peer review functions traditionally performed by a hospital’s medical staff; the quality oversight functions typically performed through a hospital’s quality management department; and the organizational planning functions traditionally performed by the hospital’s senior management team and board.

Below we describe some specific methods that
hospitals could use to coordinate peer review, quality oversight, and organizational planning in order to implement a systems-based approach to quality oversight. Some are discrete tools that could easily be employed within hospitals’ existing organizational structure; others would involve more comprehensive changes. Each hospital board will need to carefully evaluate what approach is most practical and achievable, given its institution’s particular resources and culture.

**BOARD LEADERSHIP** A systems-based approach to quality oversight requires proactive board leadership. Recent studies demonstrate that effective implementation of a comprehensive approach to quality from the top down can greatly improve a hospital’s quality record. A successful quality oversight program therefore should be board driven.

Such a program should involve all key stakeholder groups, such as physicians, quality management personnel, senior executives, and the board. It should also promote the free flow of accurate information among the hospital’s medical staff, management, and board, so that decision makers can be kept fully informed and their decisions can be implemented effectively. And it should redefine quality standards so that they emphasize and measure not just individual competence but the quality and effectiveness of the entire system of care.

A hospital’s quality program should be clearly defined in a written policy that is approved and overseen by the institution’s board. We recommend that the policy require the board to create a standing quality oversight committee that has the authority to act as final decision maker with regard to quality, credentialing, and peer review.

Ideally, such a committee would develop specialized expertise and would include representatives from all stakeholder groups—including the board, senior managers, and the medical staff—which would allow it to become a credible source of authority on quality issues. In this suggested model, the committee would oversee the compilation and use of systemwide quality data to ensure that quality standards are being met and also to meet the Affordable Care Act’s stated goal of progressively raising the quality bar.

The effectiveness of the oversight committee will depend in large part on the quality of information that it obtains. Therefore, it is important to create a framework that ensures the unimpeded flow of accurate, objective, and relevant information between the committee and all other levels of decision making and review throughout the hospital.

Two specific measures can improve the quality and flow of information. The first is implementing effective individual and institutional conflict-of-interest policies designed to identify and manage financial incentives as a factor in the exercise of clinical judgment. The second is increasing the transparency of the hospital’s credentialing and peer review processes. In addition, we recommend that hospital boards initiate regular auditing of those processes. Regular auditing gives the board a more accurate assessment of the hospital’s quality oversight program and makes it easier to refine the program in a timely fashion, when necessary.

**COLLECTION AND USE OF QUALITY DATA** The creation of a quality oversight structure will not in itself lead to improved quality. Nor does the effectiveness of the oversight process depend only on the quality and flow of information. It is equally important for the board to act on the information it receives.

The information received and analyzed by the board must meet three criteria in order to be of value to the key decision makers in the quality oversight process. First, the information must be accurate and accessible, so that the board and other stakeholders can rely on it. Second, it must be relevant to quality interventions—for example, providing specific deviations from recognized industry standards, rather than expressing a general concern that the practitioner is “old school” or that he or she is “not a team player.” And third, it should be specific to the individual practitioner and the provider organization, to target quality initiatives effectively. In other words, hospitals should seek to implement quality standards that will lead to optimal care, given the available facilities, equipment, and staffing resources, and that will then hold practitioners accountable for practicing in accordance with those standards. Information of this sort will permit the board and others to create formal or informal interventions that can be both implemented and subsequently measured for effectiveness.

In determining whether the information coming to them meets those three criteria, boards should consider whether the data are objective, such as outcomes data from the hospital’s electronic health record system or malpractice data from the hospital’s risk management department, or subjective, such as peer reviews. The board may want to develop a reporting format for all information that includes indications of reliability.

In addition, the board should carefully consider what benchmarks and standards are used in the information it receives. In addition to the hospital’s own quality goals, an ever-increasing number of external standards must be met to satisfy regulatory, accreditation, and insurance requirements. Examples include the Joint Com-
mission’s National Patient Safety Goals, the National Quality Forum’s quality benchmarks, and the CMS policy on hospital-acquired conditions, and the benchmarks employed for value-based purchasing incentives in the Affordable Care Act.

Because many of these external mandates duplicate hospitals’ internal standards, it is important to streamline reporting so as to avoid redundancies or superfluous data. In addition to external and internal standards, some industry commentators have suggested that hospitals challenge themselves even further by benchmarking their quality against a “theoretical ideal.”

Equally important to a standing oversight committee is the quality of its own output. The sign of a highly effective quality oversight program is one that is routinely generating, updating, and refining the following material: evidence-based guidelines for clinical practice that are designed to address identified quality issues; standards of conduct for credentialing and peer review; criteria and processes for the selection, evaluation, and retention of medical leaders such as department chairs, division chiefs, and medical officers; and quality-related performance criteria, such as staffing levels for clinical programs.

**Assessing Providers’ Performance** A systems-based approach to credentialing and peer review measures the extent to which each provider engages in a number of practices: compliance with the hospital’s approved quality benchmarks and evidence-based guidelines; effective coordination with other providers and staff members, as well as the hospital’s management; and appropriate use of the hospital’s electronic health record system. For a provider whose performance is not satisfactory, the approach measures the extent to which he or she engages in disruptive conduct that creates hostility and distrust on the treatment team; uses inefficient practices that squander the hospital’s supplies, equipment, or other resources; and allows his or her personal financial interests to drive clinical judgments and decisions.

The integration of these systems-based performance standards into hospital credentialing and peer review has been slow in many places. Often a practitioner’s conduct has to become highly disruptive before it is addressed at any level.

**Quality Oversight Outside the Hospital** Hospitals will need to extend their quality oversight process as they pursue increasing numbers of collaborative relationships with physicians and other external entities. Various federal agencies have recently issued regulatory guidance with regard to the Affordable Care Act’s accountable care organization program and Shared Savings Program, and that guidance will have a major influence on the extension of the quality oversight process to the outpatient setting.

From a quality standpoint, it will be necessary to acquire and aggregate data from all of the hospital’s sites of service; evaluate incidents and events from the broadest possible perspective, including both inpatient and outpatient services; place particular emphasis on breakdowns in the system of care; and implement corrective measures at all relevant sites of service, again both inpatient and outpatient. To be comprehensive, a hospital’s quality oversight structure will need to extend across the spectrum of care, even into private practitioners’ offices.

**Legal And Operational Challenges** Hospitals face legal and accreditation hurdles in moving toward a systems-based approach to quality oversight. State licensing laws, Medicare’s eligibility criteria, and accreditation standards all may present obstacles because they reflect the historical focus on the competence or professionalism of each provider as an individual, rather than as part of a system of care. In addition, a systems-based approach requires a major cultural shift that some in the health care industry may not be ready to embrace. We discuss three of the most prominent challenges below.

**Integration of Medical and Executive Functions** One of the biggest impediments to a fully integrated systems-based approach to quality oversight is the historic division of management and medical oversight functions in the hospital setting, a separation now embodied in many state licensure laws, Medicare requirements, and accreditation standards. The Joint Commission’s accreditation standards in particular place much of the responsibility for frontline peer review in the hands of a “self-governing,” “organized” medical staff. This can have the practical effect of segregating the hospital’s medical leadership from the institution’s management structure, thus making bold action toward systems-based care less likely.

Many high-quality hospitals now employ physicians, as a means of integrating the providers more completely into the operations of the organization and better aligning the goals and objectives of hospitals and physicians. Others have placed physicians in key leadership positions, such as chief executive officer. Hospitals need to take some such steps to ensure that their physician leaders are strong and vocal proponents of systems-based care, or the approach is unlikely to be endorsed by the rest of the medical staff.

**Legal Liability for Restricting Providers’
In the current legal environment, hospitals are legally liable for actions taken to limit or restrict a provider’s practice if the ground for the action is a systems-based issue, as opposed to a matter of individual quality or competence. For example, a physician could sue the institution if his or her practice was restricted as a disciplinary measure for failure to adhere to a hospital’s clinical protocols. In fact, practice restrictions frequently lead to litigation.

If hospitals are to be able to use their quality oversight authority to promote systems-based care, they will need to work with their medical staffs to revise staff bylaws, policies, and procedures. Hospitals need explicit authority to limit, restrict, or revoke privileges based on a provider’s lack of adherence to their standardized protocols. Similarly, hospital counsel may need to play an advocacy role in educating courts and legislatures to the importance, from a public policy perspective, of upholding practice restrictions taken under this authority.

Protecting Peer Review

Another major hurdle to a systems-based quality oversight program is the requirement to comply with the confidentiality and immunity protections in state peer review laws and the federal Health Care Quality Improvement Act of 1986, beginning at section 11101. These protections are intended to make it less likely that peer reviewers will be sued by the practitioners whom the reviewers determine should be disciplined for misconduct or poor performance.

In 10–20 percent of states, however, the peer review protections are limited to entities such as hospitals, state professional societies, and health maintenance organizations and do not extend to all types of health care providers. Other states limit peer review protections to formal meetings attended only by physicians and do not extend their protections to other categories of providers. Such laws would not provide equivalent protection to participants in a quality oversight structure that included outpatient providers and evaluated all providers’ effectiveness within a system of care.

Hospitals will need to work with their legal counsel to ensure that the organizational structures they create for systems-based quality oversight take the applicable state and federal peer review protections into consideration, while also achieving the broader quality objectives of the overall health care system.

Conclusion

If hospitals are to make radical improvements in the quality and efficiency of care, their boards will need to focus less on individual providers’ competence and more on how the entire system of inpatient and outpatient care functions. Many hospitals are daunted by the prospect of moving from theory to practice in the area of comprehensive quality oversight. Various tools and approaches are available to assist such hospitals in taking the first steps.

Ultimately, each hospital’s quality oversight program is likely to be unique. It will reflect the degree of board engagement in the process, the time and financial resources available, the changing legal and regulatory environment, and the hospital’s individual culture.

This article is drawn in part from work conducted by the American Health Lawyers Association’s Quality in Action Task Force in connection with its forthcoming tool kit for hospitals and task forces to revise staff bylaws, policies, and procedures. Hospitals need explicit authority to limit, restrict, or revoke privileges based on a provider’s lack of adherence to their standardized protocols. Similarly, hospital counsel may need to play an advocacy role in educating courts and legislatures to the importance, from a public policy perspective, of upholding practice restrictions taken under this authority.

### Notes

1. Although the Affordable Care Act is facing many legal and legislative challenges, systems-based medicine is part of a larger movement in health care that will continue, even if the act’s patient protection provisions are repealed.
4. See, for example, Connecticut (Medicaid State Plan, Conn. Gen. Stat. Sec. 17b-278c [2010]).
5. See, for example, Missouri (Payment Policy for a Preventable Serious Adverse Event or Hospital or Ambulatory Surgical Center-Acquired Condition, 13 Mo. Code Regs. Ann. Sec. 70-15.200 [2010]).
6. See, for example, Kansas (Hospital providers: transition to MS-DRGs and 2009 weights and rates. Kansas Health Policy Authority, Kansas Medical Assistance Program; 2008 Nov 1 [Provider Bulletin No. 8152]).
7. See, for example, Kansas (Kansas Medical Assistance Program. Provider manual: professional. Kansas Health Policy Authority; 2011. Sect. 7010).
9. Examples of benchmarks that CMS has determined have already “topped out” include the administrations of aspirin on admission and of beta-blockers on discharge for patients with myocardial infarction. See Note 8.
10. Department of Health and Human Services. Medicare program; Medicare Shared Savings Program:
Challenges For Hospitals

Institute that is developing a new Association and the Governance Act. The authors are on a task force mandates of the Affordable Care providers, if they are to meet the individual competence of quality, instead of focusing on systemwide approach to improving that hospitals will have to take a assert in this article.

Min. 2011; 76(67):19571–90.
13 Conditions of participation for hospitals. 42 CFR, Sec. 482.12 (2010).
24 States that have more limited forms of peer review protections include Arkansas, Hawaii, Idaho, Mississippi, Nebraska, New Hampshire, and South Carolina.

Elisabeth Belmont and coauthors assert in this Health Affairs article that hospitals will have to take a systemwide approach to improving quality, instead of focusing on individual competence of providers, if they are to meet the mandates of the Affordable Care Act. The authors are on a task force consisting of members of both the American Health Lawyers Association and the Governance Institute that is developing a new resource to assist health care providers in meeting the law’s requirements.

Each of the contributing authors brings a “nationally recognized perspective” in health care quality, Belmont says. “This diversity of perspectives contributes to a comprehensive analysis of the issues as well as a sharing of real-world experiences. These experiences are of particular value to hospitals and health systems.” Belmont is corporate counsel of MaineHealth, a nonprofit health care system consisting of hospitals and other health care services, and is a past president of the American Health Lawyers Association. She earned her law degree from the University of Maine School of Law.

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