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The Board's Role in Risk Management

Waller Lansden Dortch & Davis

Potential profit often corresponds to the potential risk.... Stockholders' investment interests will be advanced if corporate directors and managers honestly assess risk and reward, cost and benefit

– Hon. E. Norman Veasey

Although the management of a company is ultimately responsible for a company's risk management, the Board of Directors must understand the risks facing the company and oversee the risk management process. As former Delaware Supreme Court Chief Justice Veasey indicates, the director's role is to assist in managing risk, not attempting to eliminate it entirely.

Risk management is the process by which management, subject to Board oversight, assesses the nature and scope of risks applicable to a company; designs and applies appropriate controls to minimize the risks; and monitors the controls to ensure that they are working effectively.

The Committee of Sponsoring Organizations of the Treadway Commission suggests that companies evaluate their risks using the components of risk management described in its model, the Enterprise Risk Management Integrated Framework (ERM). This model emphasizes that, because risks will not always fall clearly into one category, a company should develop a comprehensive risk management plan in which the approaches to the various components of risk interact with and influence one another. The eight components of ERM are:

- *Internal Environment:* The tone of an organization is set by its leaders. Does the company have a large appetite for risk, or are its leaders more risk-averse? Does the company's culture support the risk management and internal controls process?
- *Objective Setting:* A company may set goals on many levels: strategic, operating, financial. By clearly identifying its goals, management and the Board can more clearly perceive the risks that the company may encounter.

- *Event Identification:* The Board should ask management how the company identifies new risks and opportunities. What risks and trends exist in the company's industry? What risks are associated with new products, services or acquisitions? With new competitors? How are the company's risks interrelated? The Board should also consider legal, ethical and compliance risks that the company may encounter.
- *Risk Assessment:* After identifying potential risks, management and the Board should analyze and prioritize the risks in light of their likelihood and potential impact. Each business unit should be involved in the process. What adverse events has the company encountered in the past and what lessons were learned?
- *Risk Response:* Companies may chose to respond to risks by avoiding them, or by accepting them and working to reduce their impact or dilute their severity by sharing risk with other parties. What are the costs of these alternatives? Has management allocated sufficient resources to respond appropriately? Is the company adequately insured for its insurable risks?
- *Control Activities:* The Board should work with management to develop and implement well-structured policies and procedures in response to the company's primary risks to ensure that responsive actions are carried out at all levels of the company.
- *Information and Communication:* Relevant information should be well-documented and communicated on a timely basis - vertically, up and down the chain of management, and horizontally, across divisions of a company - to ensure that all members of the organization carry out their responsibilities with respect to the company's risk management policies.
- *Monitoring:* The Board should help management establish testing and evaluation procedures to monitor the company's risk management system. Modifications to the risk management system should be made as needed in response to these evaluations.

Board committees should incorporate risk management into their regular responsibilities. A company's governance committee can ensure that the company is prepared to deal with risks and crises by evaluating the individual capabilities of the directors, nominating directors with crisis management experience and considering the time each director and nominee has to devote to the company. The governance committee should also work with management to establish an orientation program for new directors and succession plans for key executive officers.

While some companies prefer to involve the Board as a whole in the risk management process, corporate governance guide-

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lines and charters of audit committees may delegate this responsibility to the Audit Committee. Alternatively, a company may appoint a risk management officer, form a risk management committee or assign responsibility to a finance or compliance committee of the Board. The responsible committee or group should meet regularly with the company's internal auditor, the chief financial officer, the general counsel and the head of compliance and individual business units to discuss specific risks and assess the effectiveness of the company's risk management systems.

In a recent survey by PricewaterhouseCoopers, only 20% of U.S. CEOs responding believed they had enough information to manage the risks facing their companies. In many companies, the Board may have to take the lead to ensure adequate risk management procedures are in place. L&G

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This article first appeared in the June 2005 issue of the *Corporate Board Member.*

Patient Wait Times: A Benchmark Issue in Healthcare

A commentary on: Health Services Research after *Chaoulli v. Quebec (Attorney General):* New Inspiration, New Challenges

William P. Georgas and Lynne Golding

The Supreme Court of Canada's decision in *Chaoulli v. Quebec* (*Attorney General*)[1] has caused the federal and provincial governments to address the issue of patient wait times with an urgency unseen in the last several years. The governments' ability to reduce wait times may be the deciding factor in whether private healthcare becomes a reality across Canada in the future.

Notwithstanding the narrow 4-3 decision, all of the justices in *Chaoulli* found that depending on the severity of the consequences, a lack of timely access to healthcare may infringe a patient's rights to life and security of the person under section 7 of the Charter. Chief Justice McLachlan and Justice Major poignantly observed that "[a]ccess to a waiting list is not access to healthcare."[2]

While the majority and the dissent disagreed as to whether these infringements were in accordance with principles of fundamental justice and constituted a reasonable limit in a free and democratic society, the initial finding that a denial of health services within a reasonable time can trigger section 7 rights is a significant one. However, the dissenting justices in *Chaoulli* expressed clear frustration in arriving at this decision and having to ascribe constitutional norms to health policy and practice. They stated:

> What, then, are constitutionally required "reasonable health services"? What is treatment "within a reasonable time"? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require? The majority does not tell us. The majority lays down no manageable constitutional standard. The public cannot know, nor can judges or governments know, how much healthcare is "reasonable" enough to satisfy s. 7 of the Canadian Charter of Rights and Freedoms

1. 2005 SCC 35 ("*Chaoulli*").
2. *Chaoulli* at para. 123.

> ("Canadian Charter") and s. 1 of the Charter of Human Rights and Freedoms, R.S.Q. c. C-12 ("Quebec Charter"). It is to be hoped that we will know it when we see it.[3]

There is therefore considerable optimism that the establishment of benchmarks will give the Court the guidance that it seeks. Given the increased legal significance of the setting of benchmarks for wait times, Seeman and Brown point out in their article that numerous factors must be considered, not the least of which involve the removal of biases from expert opinions and the need to ensure that benchmarks are neither too stringent nor too relaxed to be effective. They correctly observe that "it will take time for benchmarks to become generally accepted among health practitioners."

At this time, federal and provincial governments are contemplating the implementation of the findings of the Wait Time Alliance's recommendations in reducing wait times in five priority areas (cancer, heart, diagnostic imaging, joint replacements and sight restoration). A target of December 31, 2005 has been set for the establishment of evidence-based, pan-Canadian benchmarks for wait times in these priority areas. It is anticipated that these benchmarks will serve to reduce and eliminate waiting times for procedures in these areas.

It is noteworthy, however, that even the most well-founded benchmarks are still subject to scrutiny, and even rejection, by the courts. Thus, these benchmarks may not have the desired effect of establishing constitutional norms insofar as rights to life and security of person are concerned.

By way of analogy, the Supreme Court of Canada has made it clear that in the context of medical negligence cases there is an obligation on the courts to rely on expert evidence in establishing whether a physician's conduct has met the accepted standard of practice. The Court has noted, however, that there will be circumstances in which the accepted standard of practice will not be acceptable. The Court stated:

> It is evident ... that while conformity with common practice will generally exonerate physicians of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be where the standard practice is "fraught with obvious risks" such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.[4]

If the decision in *ter Neuzen* provides any insight, it is that the courts will perform a rigorous evaluation of the available expert evidence in determining the appropriate benchmarks for wait times, and whether those benchmarks, even if reflecting the standard of practice, stand up to the scrutiny of the common sense of reasonable persons.

Because the right to security of person in section 7 of the Charter protects an individual from psychological harm as well as physical harm, there may be cases in which a person's right to security of person may be violated notwithstanding that a wait time falls within the established benchmark. Moreover, a patient who risks dying while waiting for health services that may nevertheless be delivered within an established benchmark wait time would surely have a claim to a violation of his or her right to life under section 7.[5] In such situations, a court may have ground to find the benchmark wait time, even if it approximates a standard accepted by the medical profession, as being nevertheless unreasonable.

Ultimately, the establishment of acceptable wait times is necessary for the reforms already needed in the strained and overburdened public healthcare system. That they may now be used as a shield against the development of private insurance gives further motivation to a federal government that is staunchly in support of a single-payer, public health system. It must be recognized, however, that benchmarks may not be the final word on what the courts deem to be acceptable for the timely delivery of health services. L&G

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The article "Health Services Research after *Chaoulli v. Quebec* (*Attorney General*): New Inspiration, New Challenges" by Neil Seeman and Adalsteinn D. Brown appeared in the August issue of Law & Governance.

3. *Chaoulli* at para. 163.
4. *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 ("ter Neuzen") at para. 41.
5. In *Chaoulli*, at para. 123, Chief Justice McLachlan and Justice Major stated: "Where lack of timely healthcare can result in death, s. 7 protection of life itself is engaged."

Medicare's Fate: Are We Fiddlers or Firefighters?

Steven Lewis

A word of caution to the private-clinic owners and National Taxpayers' Federation shills licking their chops over the imminent demise of medicare and the triumph of profiteers: It ain't over 'til it's over.

And despite Thursday's astonishing ruling by the Supreme Court of Canada that opens the door to private health insurance, there may be a silver lining in the havoc wrought by the 4-3 decision. Unpredictability seems to be the order of the day, but there are some likely scenarios.

First, though, a note on the decision itself.

If you never read another Supreme Court judgment in your life, read this one. The court was heatedly divided. The four justices in the majority didn't even agree on all of their findings, while the three dissenters were united in their reasoning. The language in some parts borders on bitchy — the majority scorning the dissenters as letting their emotions interfere with judicial reasoning, the dissenters snorting that the majority played fast and loose with the evidence and ran roughshod over the entitlement of society and governments to define the public interest.

I'd rather hear the tapes of those discussions over Grewal-Murphy-Dosanjh any day.

I'm no lawyer, but it's bad law. The majority's use of health-systems research was facile at best, glibly accepting that Canadians routinely die while waiting for treatment while, apparently, people elsewhere in the world do not by dint of the availability of private insurance. The decision also roamed far from the facts of the case — Montreal chemical salesman George Zeliotis' year-long wait for a hip operation — and essentially turned it into a class-action suit for all Canadians. Instead of presiding over virtual anarchy, the court could have considered many other remedies, such as insisting that provinces establish and monitor wait-time standards, set up rapid appeals tribunals for aggrieved patients, and actively manage their wait lists.

But it didn't, and here we are. So what's next?

There will be at least a short-term burst of private-clinic expansion, financed by investors offering lucrative salaries and spiffy quarters to physicians. It won't be cataclysmic because it's been going on for years, but it could create troublesome shortages in some public practices and institutions for awhile. Later on, the effect may diminish as expanded classes of doctors and nurses graduate.

Some clinics will want status as private hospitals, offering not just day procedures but overnight stays. Some governments will balk and stall. Others, such as Alberta, given Premier Klein's thumbs-up to the SCOC decision, may sign on quickly. If such hospitals emerge in large cities, private insurance will become more attractive in that it would secure a paying patient's access not only to physician care, but to at least some forms of hospitalization.

Blessed by their governments, some hospitals will be tempted to rent their facilities to privately insured doctors and patients to make a buck. They will tell their communities that the money they make will be used to enhance public care. They will assure the public that access will not suffer, and that everyone will win. Should this happen, the realities of two-tier service will be more visible.

Insurance executives are already surveying the market and plotting their strategies but, more importantly, businesses are also plotting theirs. Most private health insurance is employer-based (some is cost-shared). Employee health benefits are already big business in some parts of Canada, but insuring core doctor and hospital services is a major step up in cost and complexity. Canadian corporations, particularly the auto industry, have long recognized the economic advantage of medicare. They will be dragged kicking and screaming, if at all, into the private-insurance morass. But let's take a deep breath. The decision, however perverse, is a wake-up call for governments and citizens devoted to the idea of a single-payer, universal public system. All that is lost for certain is the legal crutch that politicians have leaned on to keep the privatization tide at bay.

Here are some options:

Make the public system better by doing all the things the quality-improvement gurus have told us to do for years. Manage wait lists properly and make sure waiting patients are followed up regularly. Give pharmacists a greater role in prescribing to reduce the errors and illness caused by doctors. Use nurse practitioners more effectively. It doesn't take more money. It may even take less.

Refuse to subsidize private care and personnel. Charge medical students $5,000 tuition if they sign contracts to practise exclusively in the public system, and $60,000 (more like the real cost) if they want the option to go private. Do the same for nurses and therapists.

Strike public-interest bargains with physician unions. It's doctors, not governments, who insist on underpaying primary-care physicians and geriatricians and overpaying ophthalmologists (who do cataracts by the thousand) and gastroenterologists (who earn huge incomes by scoping every available orifice).

We have, up to now, let the doctors sort out their relative incomes, and it has been a disaster. Enough already.

Create incentives to provide quality service. Fine doctors who close their office doors at 4 p.m., refuse to provide after-hours service, and punt their patients to emergency rooms. Withhold payments to hospitals and health regions that don't have systems to ensure that wait times are reasonable and that the neediest patients get served first. Educate the public about how to use a health system effectively and prudently. The privateers treat healthcare as a commodity and prosper, in part, by ministering to the "worried well". "Care for a full-body CT scan, sir? A few more tests just to be sure, ma'am?" The hawking of services will get worse before it gets better. Governments should deal with it aggressively. Hold media conferences about the dangers and uselessness of over-service. Meet with editorial boards to alert them to scams and shams.

Publish honest and thorough performance reports about the public system. Be honest about mistakes and limits. Treat the public like adults. Pay attention to complaints and public satisfaction surveys.

Enlist an unlikely ally — corporate Canada (minus the insurance companies). Their prosperity is linked to good public healthcare. Get them involved in the political battle.

And let's get the medicare questions right: How did such a rich and admired system fall prey to an impish display of jurisprudence? Why is primary healthcare in disarray? How come a 60-per-cent increase in spending since 1997 hasn't bought solutions? Why is the healthcare system a non-system, better described as anarchy than orderly and fair?

It's because we mistook a quality problem for a money problem. We allowed too many foxes to guard too many henhouses. We funded but did not really manage. And we expected legions of smart people to do a 21st-century job with 19th-century tools.

There is nothing irretrievably wrong with medicare, but there is no assurance that it will be fixed either. For decades we have shrunk from battles with vested interests that now need to be joined. We have rightly made an icon of the basic structure of the system, but have wrongly taken our eye off its tangible performance. Politicians have found it easier to shovel money and avoid conflict, proving yet again that hope triumphs over experience.

So perhaps a questionable court decision has done us all a favour by conscripting us into the fray. Every provider, every citizen and every politician needs to take a hard look in the mirror. We have all been complicit in the events that have played into the hands of that ever-chirping minority of enemies of public health care. Our values and our tough-mindedness have been put on notice. If we screw this up, the private ship will leave the dock fully booked, and over time there will be an even wider gulf between those that have and those that don't.

The choice is ours: We can be fiddlers or firefighters as Rome is set ablaze. L&G

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Newsworthy

What does the future hold? The Society for Healthcare Strategy and Market Development surveyed U.S. hospital leaders to learn their predictions for the changes over the next five years. Among the findings about what is very likely or somewhat likely to be in place on a "widespread basis:"

- Hospital electronic medical records on a widespread basis – 94%
- Exclusive contracts to providers meeting quality/ outcomes standards – 77%.
- Payers dropping providers from networks solely on the basis of cost –77%.
- Payment to physicians by hospitals for on-call services – 87%
- Payment by hospitals to physicians for participating in administrative activities such as committees – 83%.
- Gene-based disease treatment – 69%.

One development that did not rate a high likelihood: more than 50% of the population with medical savings accounts (35%).

(Source: *Hospitals & Health Networks*, July 2005)

A majority of U.S. consumers believe that electronic medical records can provide valuable benefits, especially during medical emergencies. An Accenture survey of 500 U.S. healthcare consumers showed the following:

- Almost all (93%) believe EMRs can improve the quality of care and can reduce the number of treatment errors in hospitals (92%).
- Seventy-five percent believe EMRs can lower healthcare costs.
- Although more than half (54%) are concerned about privacy and security, about the same number (55%) believe EMRs are more secure than paper.
- Fifty-two percent would be willing to pay $5 per month to have their medical records stored in electronic format.

(Source: *Accenture*, July 20, 2005)

Newsworthy items can be sent to rsharma@longwoods.com

The Commission on Systemic Interoperability, established by the 2003 Medicare reform law, will be releasing its report on October 24, 2005. Expected recommendations from the upcoming report include:

- Government incentives for healthcare organizations to implement IT;
- Encourage the adoption of interoperability standards to promote data sharing with physicians;
- Government assistance to educate people on the value of health IT;
- Help train healthcare providers to use IT and develop Web-based tools that would give small practice physicians access to basic EMR functionality;
- Immunity to the Stark Rule, which currently prevents hospitals from sharing IT tools with physicians; and
- Government assistance to certify health IT products to ensure interoperability and incentives for implementing interoperable systems.

(Source: *iHealthBeat*, August 12, 2005)

Great-West Healthcare and Harris Interactive conducted a U.S. survey to assess consumer attitudes toward healthcare and health insurance. The survey included opinions from 2,000 U.S. adults, ranging in age from 18 to 64 who are covered by an employer-sponsored health plan. Key finding included:

- 63% of respondents who themselves or a close family member received treatment for a serious illness did not know the cost until after treatment was received and 10% never found out the cost.
- 67% of consumers spend more than 8 hours researching the purchase of an automobile and less than 38% spent the same amount of time researching a doctor.
- Respondents were able to predict the cost of a Honda Accord within $300, but were off by $8,100 on a four-day hospital stay.
- 90% of consumers believe the cost of healthcare is rising, but 80% feel they have no control over the rise.
- Only 4% of respondents view cost as the most important factor in selecting a hospital while 65% view quality as the most important factor. Convenience and location were also viewed as more important than cost (9%)

(Source: *Business Wire,* July 28, 2005)

Quality Improvement Organizations (QIOs) have been tasked by CMS to play a greater role in the deployment and use of IT for quality improvement (QI) initiatives. IT Office Visits describes these organizations under the umbrella of the "8th Scope of Work" that expanded CMS' QI initiatives, particularly in the area of healthcare IT, and provides examples of how their role will change, including:

- Supporting hospitals in building business cases and effectively implementing computerized physician order entry (CPOE), bar coding, and telehealth systems; and
- Intensively working with 5% of adult primary care practices (6,000 nationwide and 80% of which will represent 8 physicians or fewer) to more effectively use IT where it is already employed and to assist practices without IT in readiness assessments, workflow redesign, system selection, and quality care reporting – particularly focused on electronic health record (EHR), patient registry, and e-prescribing applications.

Pilot studies have already been underway for two years in Arkansas, California, Massachusetts, and Utah under the CMS' Doctor's Office Quality–Information Technology (DOQ-IT) initiative.

(Source: *Journal of AHIMA,* September 2005)

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