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**About the Center for Healthcare Governance**

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.
A Seat at the Power Table:

The Physician’s Role on the Hospital Board

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Overview
Today’s health care organization boards face unprecedented challenges in the areas of quality, care delivery, financing, physician relations, and information technology (see Figure 1). More often than not, trustees seek counsel from members who are successful corporate and civic leaders and philanthropists and activists who draw on their personal and professional achievements to help guide and define health care services in communities across America. Indeed, it is predominantly the board’s business dealers—and not its patient healers—who are reshaping the delivery of health care today.

But as guardians of patient and community health, physicians in boardrooms across America may be in the best position, if not the driver’s seat, to articulate and advance clinical excellence. They bring to the table their unique vantage point, skill set and understanding of process and protocols to help ensure that hospitals embrace and facilitate a mission of health, healing and access for all.

Figure 1: Today’s Challenges for Hospital Boards of Trustees

- Growing consumer demand for information and accountability fueled by the Internet, consumer driven health care and the publication of quality and pricing information by payers
- Growing demands from patients and payers for improved quality and safety
- The effect of the Baby Boomer age wave on health care financing and delivery
- Growth of complementary and alternative medicine
- Technologic innovation in care and delivery, such as telemedicine and robotic surgery
- Treatment advances resulting from genomics and new drug treatment therapies
- Increasing demand for inpatient and outpatient services that strain capacity and resources
- Increasing costs to build needed infrastructure
- Ever-declining reimbursement
- A continued nursing shortage and predicted physician shortage
- Shifting relationships with physicians—from one of seeking cordial relations to one of market-based collaboration
- Unfunded federal mandates, such as HIPAA compliance
- Cultural competence and sensitivities in delivering care to diverse populations
- Proactively managing patients with chronic medical conditions
To be truly effective, physicians on boards must connect their message to the organization’s mission and strategic goals as well as the legal and governance responsibilities for which the board is accountable. Understanding the nuts and bolts of governance can help physicians more effectively translate their vision of clinical excellence into organizational imperatives, and enlist fellow board members as partners to lead the charge toward accomplishing them.

This monograph provides the information and tools physicians need to ensure they are involved, informed and engaged members of the governance team, specifically:
• Insights and Strategies to Support the Physician Trustee;
• Boardroom Basics: A Primer for Physicians on Boards;
• How Physicians Can Maximize Their Governance Impact;
• Advancing the Clinical Agenda.

**Insights and Strategies to Support the Physician Trustee**
Physicians typically arrive in the boardroom with different skills, background, experience and expectations than their fellow board members, who frequently hail from business or corporate environments. As William Fulkerson, Jr., MD, CEO, Duke University Hospital and Deedra L. Hartung, MA, Vice President and Practice Leader, Cejka Search explain, “Most non-physician executives are trained in thought leadership and are process driven, team oriented, consensus builders, and facilitative. Physicians, on the other hand, are trained to be decisive, data driven, action oriented, and more individual focused and values driven.”1 Understanding these differences, and the board’s fiduciary duties and governance responsibilities, can help physicians maximize what they give to and get out of their board service.

**Who’s on Board**
Generally two types of physicians serve on boards. Traditionally, most hospital boards include the Chief of the Medical staff, who serves in an *ex officio* capacity, that is, because he or she holds the chief of staff position. Some boards also appoint other physicians to represent the medical staff or key physician groups. Boards also may ask retired physicians who live in the community, or outside of the hospital’s service and geographical area, to serve. The board’s expectation for these “outsiders” is the same as those for all board members—to govern on behalf of the organization’s stakeholders and in support of its mission.
Allegiance to Mission or Practice?
Physician board members nominated by key practice groups or from within the medical staff may feel pressured to represent and advance group concerns ahead of the organizational agenda. Governance experts contend that because these physicians come from specific physician groups or organizations that often expect them to advance the group or organization’s interests, they do not always vote like the rest of the board—on behalf of stakeholders and in support of the hospital’s mission. A duality of interest emerges that can polarize the board and contribute to ineffective governance. In order to govern most effectively, it is important that boards clarify expectations, roles and responsibilities for all members.

Physicians on boards face other challenges in the way of scrutiny and accountability. The Internal Revenue Service allows “interested persons” to comprise up to 49 percent of the membership of not-for-profit, tax-exempt boards. Interested persons include employees of the organization, such as the CEO, and physicians who treat the hospital’s patients or who do business with or receive financial gain from the hospital. This “49 percent rule” only applies if the organization meets specific other requirements that show it operates for the community’s benefit and not for the benefit of board members. These requirements include enforcement of a strict conflict-of-interest policy—a key issue for physician trustees as hospitals and physicians increasingly compete and collaborate in the marketplace—and periodic reviews of hospital activities to make sure that the organization operates according to its tax-exempt purpose. Further, if the Sarbanes-Oxley legislation that raised the bar on performance and accountability for public company boards were to be applied to health care, physician group representatives who serve on the board would be considered non-independent board members and would be prohibited from serving on important board committees, including the audit, CEO compensation and governance/nominating committees.

Maximize Physician Participation
Insights into what physicians bring to the table, as well as role and responsibility clarification, can better position boards for success. To make the most of physician participation in hospital governance, Orlikoff and Totton suggest:

• Clearly and explicitly distinguish the role and function of the medical staff (or other physician group) representative (“insider”) on the board from that of the
“outsider” physician trustee. Develop written job descriptions for each board position and use them as part of the recruitment process.

- As a specific component of trustee orientation, educate each new trustee about the distinction between the roles of the insider physician trustee and the outsider physician trustee. Use the written job descriptions for both insider and outsider positions as the foundation for this part of the orientation. Make certain that every physician board member receives this orientation.

- Routinely review this physician role and responsibility distinction with all board members during annual retreats and continuing education sessions.

- Educate the entire medical staff about the distinction between the two types of physician governing board members.

- Recruit physicians from outside the community, or who are not members of the medical staff, to serve on the board. Retired physicians who are truly independent-minded and removed from current medical staff politics and physician practice pressures may also be appropriate.

- Develop concrete conflict-of-interest policies and procedures for physicians on the board. These policies should clearly define those situations where specific physicians are in conflicted situations, as well as outline the procedures to follow when there is a tug of loyalties. Such procedures might stipulate abstaining from voting on an issue in which the physician board member has a conflict; recusing the conflicted physician during board discussions, and removing any information from the board agenda book relating to the situation or decision involving the conflict.

- Ensure that all board members clearly understand the roles and responsibilities physician members play on the board. During the full board and individual board member self-evaluation processes, include an assessment of how physician trustees are fulfilling their roles, and determine if the roles are properly discharged. Use the individual assessment process and the resulting personal development plans as an opportunity to identify and address specific board needs and concerns.

- Consider developing a physician leadership academy or providing other education and support to help physicians maximize their effectiveness as board members and organizational leaders.
Boardroom Basics: A Primer for Physicians on Boards

Arguably the most important strategy for empowering physicians in the boardroom, and ensuring their success as valued members, is to be certain that they recognize what it takes to govern effectively. The first step is to understand the organization’s corporate purpose as well as the legal duties and accountabilities that flow from it.

A majority of the nation’s hospitals are nonprofit organizations. According to Fredric Entin, Janice Anderson and Katherine O’Brien, health care attorneys with Foley & Lardner LLP⁴,

Nonprofit healthcare organizations have a charitable purpose that focuses on preserving the health status of the community the hospital serves…. Charitable trust law in many states considers the assets of nonprofit organizations to be held “in trust” for the benefit of the communities they serve. Taken together, these laws require that the nonprofit corporation’s purpose focus on the interests of the community and not on the individual self-interest of any person or group.

Varied Stakeholders

In this context, unlike for-profit boards, which are accountable to shareholders, nonprofit health care organization boards answer to a variety of stakeholders and constituencies. Each health care organization must define its stakeholders, and these may differ among organizations. But typically in health care, key stakeholders include: patients, employees, physicians, strategic partners, and legislative and regulatory bodies. In governing on behalf of these parties, boards safeguard the corporation’s best interest as legally accountable fiduciaries, making certain that the organization reasonably and appropriately deploys its assets and resources.

Three Primary Duties

As fiduciaries of nonprofit organizations, boards must act in accordance with key legal duties that, crisply defined, encompass care, loyalty and obedience.

Duty of Care. According to Entin et al., “The Duty of Care requires board members to act in good faith and to use the same degree of diligence, care and skill that a prudent person would use in similar situations or circumstances.”⁵ In essence, board members must:
• Make informed decisions;
• Ask questions and request additional information if facts come to light that raise issues about the validity and thoroughness of the information the board has received; and
• Follow the business judgment rule, which releases board members from personal liability if they make an informed decision, in good faith, without self-interest and in the best interest of the corporation.

Duty of Loyalty. This duty obligates nonprofit board members to protect the corporation’s business interests and decline personal gain to the corporation’s detriment. Making decisions on the corporation’s behalf demands that trustees act in good faith and without self-interest. The Duty of Loyalty requires board members to:
• Avoid prohibited conflicts of interest;
• Avoid pursuing an opportunity for personal gain that would be of interest to the corporation; and
• Uphold the confidentiality of the organization’s affairs.

Duty of Obedience. At times, this duty can supersede the others, calling on board members to:
• Comply with applicable laws, rules and regulations;
• Follow the organization’s mission, bylaws, policies and procedures; and
• Act within the authority granted to the board by the corporation’s articles, bylaws and applicable laws.

Oversight Responsibilities: from Planning to Performance
Duties of care, loyalty and obedience provide a framework in which the governing board discharges its primary oversight responsibilities, which include:
• Mission and strategic planning;
• Financial health;
• Quality of care and patient safety;
• CEO and executive management performance; and
• Board development and effectiveness.
First and Foremost: Mission and Strategic Planning

According to Orlikoff and Totten⁶, a strong mission forms the bedrock for effective governance. The mission defines the organization’s belief system, values, philosophies, and ultimately its culture. It is the basis for the board’s decision-making, strategy formation and policies. As stewards of the organization, the trustees’ most fundamental responsibility is the mission, from which all other board responsibilities emanate.

A good mission statement guides the board through difficult decisions. The values, philosophies and beliefs expressed in the mission serve as a touchstone for the board and help the organization realize and express its identity and purpose. The board can apply these noble and sound standards in each situation it confronts, to uphold consistent and predictable board policies that serve to integrate and align the organization’s disparate stakeholders.

A clear mission also becomes the basis for a focused strategic plan. The mission establishes the parameters of the strategy, providing direction for the organization’s actions. In other words, considered in the context of current market conditions, the mission should inform the strategy, and the strategy should reflect the mission.

Through overseeing the strategic planning process, a board can frame and address the tension between the often-conflicting demands of mission and market. Some boards may pursue a strategy that is incompatible with the mission, which leads to a jarring disconnect between the board’s formal belief system and the direction of the organization’s actions (the strategic plan). This inconsistency then alienates key organizational stakeholders, such as physicians, employees, patients, and payers. A pattern of erratic decisions based on circumstance rather than principle will condemn a board to profound ineffectiveness.

The strategic plan is the springboard for specific annual goals and objectives, which are tactical in nature. They detail the game plan for accomplishing, and incrementally measuring, the strategy. Both the CEO and the board operationalize these goals and requirements through annual performance objectives.
Financial Responsibilities

Trustees are responsible for their organization’s financial health and well-being. In order to discharge these duties on behalf of stakeholders they must:

- Specify financial objectives;
- Make sure that management’s plans and budgets align with and promote achievement of financial objectives, key goals, and the board’s vision;
- Monitor and assess financial performance and ensure that management undertakes corrective action to address any problems; and
- Confirm that necessary financial controls are in place.

Financial objectives are the parameters for overseeing financial planning and budgeting, for assessing financial performance, and for developing needed financial controls. Financial objectives, say Dennis D. Pointer and James E. Orlikoff⁷, should answer three questions:

- What is the board’s definition of financial health?
- What must the organization achieve financially to accomplish key goals and fulfill the vision?
- How should the organization assess financial performance?

Annually the board, with help from the chief executive officer and chief financial officer, should draft quantifiable, comprehensive financial objectives that are tied to the organization’s key goals and focused on achieving the vision.

Budgets are the end result of an organization’s financial planning process. The board uses revenue and spending estimates as guideposts to monitor the organization’s operations, cash flow and capital expenditures. Effective trustees view budgets as management’s blueprint for resource allocation to accomplish the board’s financial objectives. Therefore, good boards forgo meddling in budget details and focus their activities instead on how well the dollars and cents support organizational achievement of financial objectives.

Boards must also see to it that appropriate controls are in place to discharge the organization’s and the board’s financial accountabilities and responsibilities.
• Do functioning accounting and information systems generate accurate and timely information for review and evaluation?
• Are financial transactions handled appropriately?
• Do financial statements accurately portray the organization’s current financial status?

Boards also appoint the organization’s external auditor and review the auditor’s opinion and findings regarding the organization’s financial condition. Determining that the internal audit function is alive and well is yet another board responsibility.

Boards use a variety of tools and processes to monitor the organization’s financial well-being. Generally, indicators of financial health are selected and standards specified for each. Then the board’s finance committee, along with the entire board, routinely reviews each indicator’s measurements against previously established standards. If performance is unacceptable, the board asks management for an improvement plan.8

A financial dashboard indicator report, one tool a board can use to monitor ongoing performance, is discussed in more detail in Figure 2 on page 12.

Dashboard reports measure performance over time against an established target. Typically presented in concise, at-a-glance formats, dashboards focus attention on critical performance measures linked to strategic priorities. Often explanatory notes accompany the dashboard report to help managers and trustees interpret the information.

The financial dashboard in Figure 2 depicts an organization’s operating margin over five quarters against an annual target, and includes a revised target for the upcoming year. As shown, performance has generally exceeded the existing target, except for the most recent quarter. Questions board members might ask based on this report include:

1. Why did the operating margin so significantly exceed the established target in the fourth quarter of 2005 and the third quarter of 2006?
2. Why did the operating margin fall below target in the fourth quarter of 2006?
3. What does management anticipate the organization’s operating margin to be in the next quarter?
4. If management anticipates that performance will remain below target for the next quarter, what are management’s plans for improving performance?
5. What impact might current and projected operating margin performance have on the organization’s ability to meet the more aggressive target established for 2007?
Quality of Care and Patient Safety

In order to effectively discharge their responsibility for watching over quality and patient safety, governing boards need to first participate in and understand how their organizations define quality. Health care organizations might consider many different perspectives of quality when approaching this task, including clinician, patient, payer, hospital employee, regulatory, and public and consumer groups, to name a few. However the organization chooses to define quality, the board should make certain that the needs and views of significant stakeholders take priority.

Armed with a clear definition of quality, the board can then participate more effectively in key quality oversight activities. These include credentialing of the medical staff and other licensed practitioners, monitoring the organization’s quality and safety efforts, and evaluating overall performance.

Medical staff credentialing involves the appointment, reappointment and delineation of clinical privileges for physicians on the hospital’s medical staff. While the medical staff itself does the heavy lifting in terms of gathering the necessary data and information about a physician’s background and performance—and formulating a recommendation for the board—it is the board’s responsibility to make the final credentialing decision about each medical staff candidate. To do this, the board ensures that a fair and effective credentialing process exists and is based on criteria associated with appointing, reappointing and delineating clinical privileges. The board can then compare the medical staff’s recommendation against the criteria and either approve the recommendation if it meets guidelines, ask for additional information, or reject the recommendation if it falls short of meeting the criteria. Because physicians play such a central role in allocating hospital resources and delivering care and service, ensuring that the hospital has a competent and effective medical staff is one of the board’s most important oversight responsibilities. Physician trustees can play an important role in helping the full board better understand the credentialing process and how the medical staff makes its recommendations to the board so that board members have the knowledge and the information they need to make sound decisions.

Beyond credentialing, the board participates in upholding quality care and patient safety by deeming that systems are in place and functioning to provide performance data. Trustees must also review and analyze the effectiveness of care processes,
It is the board’s job to assess performance against the targets set for each indicator and determine whether achievements meet, exceed or fall short of expectations. When performance is below established standards, trustees ask managers to implement a performance improvement plan and share results with the board.

The sample radar chart in Figure 4, sometimes referred to as a spider diagram, is one type of report that boards can use to evaluate the hospital’s quality and patient safety outcomes. This report shows a snapshot of performance at a given time across a number of different indicators. It allows board members to compare outcomes against established targets and note possible relationships among performance measures.

The outside circle of the radar chart shows the benchmark level of performance; the next circular line shows the performance thresholds for each indicator; and the center or bulls-eye of the chart shows the poorest performance level. The boxes depict actual performance data for each indicator.

Questions board members might ask based on this radar chart include:

1. What factors contribute to low performance in the customer satisfaction category?
2. Is it time to set new goals for areas such as staff injury, percent of registered nurses or patient falls since performance in these areas has exceeded the benchmark?
Figure 4

Sample Radar Chart

ANY HOSPITAL QUALITY INDICATORS
Patient Care Services Division & Acute Care Services*
4th quarter 2006

3. What benchmarks do managers use to establish performance targets?

4. Is there any relationship between our nurse staffing ratio and safety metrics such as patient falls or medication errors?

**CEO and Executive Management Performance**

The board fulfills most of its responsibilities through the chief executive officer. Therefore, the board’s most important relationship is with the CEO—its only direct report. David A. Bjork and Dan Fairley describe the board and CEO relationship as follows:

The board’s role is to develop policy, set goals, and provide overall guidance to the CEO on strategy, plans, financial management, and investments; keep the organization focused on its mission and the community’s needs; promote improvement in clinical quality, patient safety, and customer service; and help the CEO maintain an effective, supportive medical staff.

The CEO’s role, in relation to the board, is to identify issues needing the board’s attention, set them in context, and provide information that will help the board make good decisions. The CEO should recommend or at least suggest ways to address these issues, too, especially if they require research or knowledge of financial, clinical, or technical issues.

Bjork and Fairley go on to describe the boundary between governance and management that both parties should recognize and respect:

The board’s role is more about providing sage advice than about making decisions. The decisions it makes, outside of those related to supervision of the CEO, should be limited to setting policies, goals, and performance expectations. The board should steer clear of operational and management decisions, if it wants to hold the CEO accountable for the results of these decisions. It should recognize and respect the boundary between governance and management.

The CEO’s role includes advising the board on policies, goals, and expectations, and helping the board make good decisions. But once the board has made its decisions, the CEO’s role is to implement the board’s
policies and manage the organization as well as possible to meet the board’s goals and expectations. The CEO should respect the board’s primacy in defining the organization’s mission, prioritizing its goals, and deciding how to best use the organization’s resources to meet the community’s needs.

Even though this relationship is critical to board effectiveness, many boards have not given it adequate care or attention. Boards and CEOs that work well together not only understand each other’s responsibilities, but set expectations for one another and participate in managing and evaluating each other’s performance. Trustees must cultivate and sustain this alliance, understanding that they are responsible for:

• Hiring, retaining, and if necessary firing the CEO;
• Motivating, managing, and developing the CEO;
• Evaluating CEO performance;
• Setting CEO and executive compensation; and
• Overseeing and participating in succession and leadership transition planning.

As Bjork and Fairley suggest, “…if the board accepts and acts on its responsibility to nurture this relationship, it will make the CEO’s job easier, the board’s job easier, and the organization more successful.”

**Board Development and Effectiveness**

An old adage suggests that self-regulation is a hallmark of effective leadership. The only way for boards to stay ahead of the curve, especially in the current climate of heightened legislative and regulatory scrutiny of board performance and accountability, is to take responsibility for their own effectiveness.

Strong and self-sufficient boards establish and participate in a number of activities to ensure that the right people with the right skills come on board and continue to grow and develop throughout their service. Effective governance requires that boards put into place and execute sound processes for trustee selection, orientation, continuing education, and ongoing performance evaluation.

A good board is not a chance occurrence, but rather, a carefully orchestrated and thoughtfully composed mix of individuals with complementary skills and
competencies necessary to advance organizational goals. While some board seats are held by individuals who serve by virtue of their position in the organization, such as the CEO or Chief of the Medical Staff, most boards select members to serve on behalf of the community and the organization’s stakeholders. Productive boards develop a current profile of board membership and compare it against the organization’s strategic priorities to identify gaps in skills, experience or competencies that should be filled if the board is to further organizational success. Wise boards understand that regardless of how they select individual members, every trustee serves to meet stakeholder needs and to help the organization achieve its mission and goals on their behalf.

Boards use a variety of techniques to orient new members to the organization and their governance roles. Typically, new trustees will participate in a board orientation program that reviews health care issues and trends, national and local markets and competitive issues, the health care organization’s structure and function, and the board’s key roles, responsibilities and relationships. An orientation manual can provide more depth on orientation topics and serve as a reference for board members. Some boards also pair new trustees with seasoned board and executive-staff colleagues, who act as mentors during the first year or so of service. Mentors help new trustees acclimate to the board and their governance role.

Responsible boards provide a variety of ongoing education for their members. Opportunities range from reviewing an in-depth topic at each meeting; conducting annual off-site board or leadership retreats where trustees can learn from, and network with, each other and with executive and physician leaders; and attending conferences focused on health care and governance issues of importance to the board. Some health care organizations also offer leadership development academies or similar opportunities, especially for physicians interested in assuming broader organizational leadership roles.

One of the most important ways boards can continuously improve their performance is to participate routinely in individual and full-board performance evaluation. These processes are typically survey-based, to assess and discuss overall performance and to develop action plans for improvement. Most boards conduct annual full-board evaluation and action planning, often as part of a board retreat, and review individual trustee performance at least once before the member’s term of service expires.
How Physicians can Maximize their Governance Impact

While physicians are no strangers to boardrooms across America, it is true that many have traditionally and comfortably confined their roles to serving as ombudsmen to the medical staff. They survey medical colleagues and report on the need for new technology, novel equipment and/or expanded services. When in the boardroom they are a resource for fellow trustees, fielding questions about care quality and patient safety, and serving up a medical staff perspective on issues of the day.

Physicians on boards, however, can play more pivotal governance roles by recognizing the benefits of board service and becoming more active, engaged members. For physicians, the opportunity to sit on the hospital’s board allows them to:

• Set policy that guides the organization in care delivery on behalf of stakeholders, including physicians, patients and the community.

• Help the board identify, clarify and focus on the wants and needs of key stakeholders on whose behalf the board governs. Physician board members often have better insight than their board colleagues about the needs of key stakeholders, such as patients and physicians.

• Share physician and patient needs and concerns and ensure that these stakeholders have a voice at the table as the board makes decisions. Board service affords physicians a unique opportunity to leverage their expertise and make an impact that extends beyond any individual patient to meet the needs of a broader population. The board, therefore, becomes a platform for expanding the physician’s capacity to do good and help others, which is why many doctors wanted to practice medicine in the first place.

• Influence resource allocation decisions in ways that maximize benefits across all key stakeholders.

• Help align physician and hospital interests by acting as an opinion leader and influence broker with both the medical staff and the board.

• Learn valuable skills about leading in a group setting that could translate to their own group practice or participation in medical society or other professional organization activities.

• Better understand the broader health care environment and where the advantage points and opportunities are for all providers going forward.
Making a Contribution

Physician trustees can take full advantage of these opportunities to sway colleagues by moving out of the comfort zone and into the power seat. In this way, they can do more to rally clinical and administrative troops, direct the discussion, mediate consensus, and chart the hospital’s course, which ultimately will lead toward improved community health. Indeed, there are those who argue that if physicians fail to embrace a more commanding role in the boardroom, it could prove hazardous to not only patient and community health, but in today’s climate, the very well-being of the organization itself.

Fortunately, the men and women serving in today’s hospital boardrooms generally support a changing and more pivotal role for their physician colleagues. Board members want physician peers to weigh in, and to contribute to setting the agenda on quality, retention, reimbursement, cooperation and innovation, representing the perspective of the entire medical staff, and guiding the way toward productive change and collaboration. They understand that accomplishing the hospital’s goals is dependent upon dynamic, mutually beneficial hospital-physician partnerships. And they want the physician trustee to lead the way.

Stepping Up to the Plate

Physician trustees have the wherewithal, clout and respect—from both boardroom and clinical colleagues—to advocate for the health needs of their communities and transform the delivery of services. Their unique perspective counts, maybe more than any other, in devising strategies to safeguard quality, foster access to care, and ensure appropriate utilization of services and technology.

Still, for all their collective insight and expertise, physician board members are sometimes guilty of falling short in a few key areas:

• Not putting aside personal views to focus on a broader organizational picture;
• Not representing the needs of younger physicians or those outside their own specialty;
• Not understanding the operational complexity of the organization, and its facility, labor and information technology challenges;
• Not being sensitive to the burden of regulation and accreditation; and
• Not grasping the full picture as it relates to the needs of the community served.

In fact, to help address these shortcomings, some experts advocate for more formal ways (such as developing written position descriptions) to achieve greater clarity between the roles of those physician trustees who serve in the same capacity as any other board member, and those who are typically selected by the medical staff and serve ex-officio (usually because they are either the hospital’s chief of staff or medical staff president).

**Advancing the Clinical Agenda**

Just as passengers would not want an airline’s Chief Financial Officer to fly the airplane, hospital trustees want the care-delivery agenda piloted by those who understand it best. Trustees appreciate that physicians are:

• Orchestrators of quality and clinical performance;
• Advocates for easy access and productive partnerships;
• Overseers of reimbursement trends and sound finances;
• Catalysts for collaboration; and
• Champions for information technology applications.

By capitalizing on these strengths, physician trustees can take the lead in developing, spearheading and nurturing a vision of clinical excellence.

Successfully advocating for the clinical agenda requires that physician trustees stay abreast of industry trends, the actions of peer institutions, and the needs of the medical staff and patient community. Because of their unique skills and perspective, physician trustees should not shrink from asking penetrating questions, clarifying the outcome that is expected, and charting more closely the organizational course, speaking out if hospitals and administrators appear to veer off track. However, no trustee, physicians included, should dictate the course of action to get back on track and/or meet organizational goals; that challenge is management’s job.

There are five critical areas where physician trustees can marshal forces to make a significant difference for their hospital and community\(^1\).
Orchestrators of Quality and Clinical Performance

First and foremost, the physician trustee should be the prime advocate for quality, improved patient care outcomes, patient safety and clinical care excellence (see Figure 5). Physician trustees and their fellow board peers should thoroughly understand, and tenaciously address, several key questions:

• What is the impact of transparency on our organization; specifically, how will we respond to public reporting on our quality and outcome measures, what will we implement in the way of clinical improvements to stay ahead of public data releases, and where do we stand vis-à-vis payers, who need our data, and competitors, who look to capitalize on their own outcome achievements?

• How do our patients use publicly reported data to make health care decisions?

• Do we participate in, or measure our performance against, national benchmark initiatives such as Leapfrog or Bridges to Excellence?

• Have we assessed, for example, if our patient volume—from routine to complex cases—meets the six Bridges to Excellence primary quality attributes; that is safe, effective, efficient, patient-centered, timely and equitable care delivery?

• Do quality measures include patient mortality, nurse patient index, nurse Magnet status, and patient care coordination, as appropriate?

• Does the hospital use CareMaps, best practice protocols and clinical guidelines?

Advocates for Easy Access and Productive Partnerships

The physician trustee is a proponent for community, patients and providers alike. Together with fellow board members, trustee physicians must set the tone, positioning the organization as consumer-friendly, responsive to patient and community needs, supportive and efficient for employees and providers, and easy to access for all. These questions can stimulate discussion and spark action:

• Are our constituents—patients, physicians, employees—satisfied? How do we measure their satisfaction? Are our scores where we want them to be? How do we communicate, celebrate and reward performance and leadership?

• How quickly can our patients get appointments, book surgeries/procedures, or access ancillary services?

• Are surgeries and diagnostic testing procedures scheduled and coordinated for our patients or must patients navigate a maze of services and offerings independently?
• Are we the provider of choice for all referral sources in our community? Do we actively and swiftly facilitate physician-to-hospital and physician-to-physician referrals?

• Do we have minimal errors and complaints? Do we take prompt action on patient, family and referrer incidences and complaints when they occur?

• Should we adopt innovative customer service programs such as same-day appointment scheduling, patient care coordination, online history and physicals, medical record access by patients, and provider/patient email?

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**Figure 5: Orchestrators of Quality & Clinical Performance**

There are many national organizations developing guidelines to improve quality of care and outcomes. Physician board members should be aware of these groups, their guidelines and understand the impact on both the institutions they represent as board members and on the constituencies served. Below are some thoughts to get the ball rolling:

- Is the organization up to speed on major quality initiatives such as those from The Leapfrog Group that include technology (Computerized Physician Order Entry), staffing ratios, demonstrated proficiency in high risk treatments and implementation of National Quality Forum (NQF) safe practices?

- Patient volume: in each specialty or service area, whether for care of routine or complex cases, is there sufficient volume to ensure staff competencies?

- Does each specialty or service have in place its own quality indicators that are benchmarked and monitored consistently, with immediate action taken for remedial interventions as indicated?

- Depending on the institution or patient venue, quality indicators may also include patient mortality, nurse/patient ratios, Magnet status, patient care coordination and patient/family communication. Where is the institution on these measures?

- Physicians should be the conscience of the board on quality care, reporting at least quarterly but preferably at each meeting on quality initiatives, outcomes, areas of strength and weakness, organizational needs to provide quality care.

- Physicians should be the board ‘trainers’ on quality, keeping all members up to date on initiatives by national organizations such as Leapfrog, AHRQ, CMS, IHI, NQF, etc.

- Physicians should be partnering with non-physician board members to participate in institutional quality initiatives, especially in responding to a specific community need.
• Are we prepared for the increasing demands for service excellence that aging baby boomers will make?

• Is there a better way to manage chronic care by re-examining ambulatory strategies and tactics? Can we develop and implement health systems to screen for, and prevent, chronic disease and illness?

• What will be the direction and pace of change in our organization?

**Overseers of Reimbursement Trends and Sound Finances**

Hospital management is responsible, and usually quite savvy, about reimbursement, billing and financing. However, physician trustees must be well versed in the two major environmental trends affecting patients, providers and hospitals alike: pay-for-performance initiatives and consumer-driven health plans and health savings accounts.

Insurers drive pay-for-performance criteria in order to tie reimbursement to quality improvement. Physician trustees can guide their board colleagues through these tough questions:

• Are we knowledgeable about initiatives among our payers?

• Against what criteria are our physicians measured and are there additional performance measures we should anticipate?

• How can we help our providers and clinicians improve their performance?

• Are there unintended consequences of pay-for-performance plans for which we need to prepare?

Employers are leading the charge to empower employees to comparison shop and make health care choices based on costs and customer satisfaction. It’s a fact: consumer driven health plans and health savings accounts are shifting control of purchasing decisions and dollars from insurers to patients. Physician trustees should be certain their board colleagues and the organization itself are positioned for success by asking:

• Are we ready to respond to the resulting increased consumer expectations?

• Are we set up, as an organization, to help consumers easily compare and choose our services over competitors?

• Have we ensured that expense management strategies are sound from both a quality and cost standpoint, to bolster our cost-effective position?
Catalysts for Collaboration
While physician trustees *contribute* to the board’s agenda—as orchestrators of clinical performance, advocates for access and partnerships, and overseers of finance—they should *lead* in the development of strategies to strengthen hospital/physician collaboration.

Today’s hospital/physician collaboration agenda has two components. The first is to redefine the rules of engagement. The changing medical landscape is forcing trustees and others to re-examine the traditional relationship between hospital and physician. Orlikoff and Totten\(^\text{11}\) suggest that board members and physician leaders jointly consider these questions:

- What terms would we use to describe the current relationship between the hospital and physicians and how can we achieve the relationship we want?
- How would we characterize the traditional social contract that existed between the hospital and physicians?
- What is changing, what should we preserve in this contract, and what should we rewrite?

The second agenda is an economic and business one:

- Will our hospital partner with physicians to deliver branded services and/or facility joint ventures?
- Will the hospital offer special incentives and support for physician practices including:
  - Recruiting primary care and specialty physicians into our community?
  - Employing physicians?
  - Offering practice management services—from basics such as billing and malpractice insurance procurement, to more sophisticated offerings such as quality management/reporting and electronic medical record acquisition/support?

Champions for Information Technology Applications
It’s a wild Wi-Fi and Web-based world today, where doctors can provide care and consults off-site from remote locations, and patients can tap into portals and pages that offer health advice and diagnostics. If trustees, physicians, administrators,
managers, and indeed anyone connected with the health care organization, don’t speak the language or use the tools, or haven’t mastered the technology, it’s time for a crash course. Otherwise physician trustees—as practitioners and as stewards of the organization—risk falling behind with a new “plugged-in” generation that will soon receive all the information it needs via cell phones.

The Partners Health Care System in Boston is one forward-thinking organization that has jumped on board the technology bandwagon. Partners has adopted five signature initiatives, each supported with information technology (IT) tools:

• Investing in quality and utilization infrastructure;
• Enhancing patient safety by reducing medication errors;
• Advancing uniform high quality by measuring performance to benchmark for select inpatient and outpatient conditions;
• Expanding disease management programs by supporting activities for patients with chronic illnesses; and
• Improving cost effectiveness by tracking and managing utilization trends and analysis of variance.

Physician trustees can make an invaluable impact as power brokers to vet their own hospital’s IT initiatives from the provider perspective. These questions can help boards assess and address current capabilities:

• Where are we in introducing, implementing and/or expanding our electronic medical record capabilities?
• Is the clinical information supporting our IT tools accurate and up-to-date?
• How will our IT tools allow for improved care coordination between the hospital and its physicians?
• How will we use our IT tools to manage our costs? What is the role of our physician community?
• How will our IT tools help involve our patients in proactively managing their care and in strengthening the patient/physician relationship?
• How will we use IT to develop our own quality reporting systems to pre-empt external source reporting?
• Have we adequately funded the venture to ensure our physician community can acquire, install, integrate and optimally utilize the IT tools?
• Have we seeded the transition from paper to electronic tools with enough capital to train physicians and staff and to provide transition support?

**Coming of Age**

Physician trustees, as guardians, stewards and orchestrators, are in a unique position to shepherd health care systems and organizations through some of their toughest medical, operational and financial challenges to date. It’s a time for setting bigger goals with broader horizons, for expecting much of self and peers, and for motivating all to make the best choices for improved patient and community health. By understanding basic board duties and responsibilities, asking the right questions and investing in the right resources, personnel included, physicians on boards can help shape a pre-eminently position for their organizations. The physician trustee perspective will help ensure that community-by-community, American citizens will continue to receive the best health care in the world.

**References**

10. Oliva, J. A Seat at the Power Table: The Physician's Role on the Hospital Board *Physician Executive*. July/August 2006
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