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Nurses in the Boardroom

by Kimberly McNally

Transformational change is occurring rapidly as hospitals and health systems move to value-based care delivery focused on the Triple Aim—better care, better health and lower cost. To achieve these aims, exceptional leadership at the CEO and board levels is essential. Governance experts suggest that high-performing boards are composed of individuals with a variety of professional backgrounds, life experiences, and personal characteristics to ensure that diversity of opinions and independent thought are present during important deliberations.

A board member/trustee with a nursing background brings a unique voice to governance conversations focused on the Triple Aim. Nurses bring expertise in and valuable perspectives about community health, quality, safety, patient experience, workforce development, staff engagement and financial stewardship. Nurses can offer new ideas to address challenges and frame opportunities as health care transformation occurs. This article discusses the value nurses bring to the boardroom and suggests ways to recruit a trustee with a nursing background.

Value of the Nursing Perspective

Nursing leader, university professor, and past AARP (formerly the American Association of Retired Persons) board chair, Joanne Disch described a specific viewpoint or “nursing lens” that nurses bring to decision-making. This lens is a way of thinking informed by understanding people and their needs throughout the lifespan, and by understanding issues from a systems perspective, coupled with a set of interpersonal skills to engage diverse stakeholders.¹

The 2011 Institute of Medicine’s (IOM) report *The Future of Nursing: Leading Change, Advancing Health* emphasizes the importance of nurse leadership in improving America’s health care system: “By virtue of its numbers and adaptive capacity, the nursing profession has the potential to effect wide-reaching changes in the health-care system. Nurses’ regular, close proximity to patients and scientific understanding of care processes across the continuum of care give them a unique ability to act as partners with other health professionals and to lead in the improvement and redesign of the health care system and its many practice environments.” The report states that “Private, public, and governmental healthcare decision makers at every level should

include representation from nursing on boards, on executive management teams, and in other key leadership positions.”²

In their *Journal of Healthcare Management* article, “Nurse Leaders in the Boardroom: A Fitting Choice,” authors Hassmiller and Combes state, “As hospitals and health systems explore how to meet the challenges of the coming decade, they would be well-served to realize the breadth and depth of skills and capabilities that nurse leaders can bring to board positions.”³ The American Hospital Association’s (AHA) Center for Healthcare Governance recommended that boards “include physicians, nurses and other clinicians....Their clinical competence and viewpoints are valuable to other board members and will help the board better understand the needs and concerns of several of the organizations’ stakeholders.”⁴

Ensuring high-quality, safe care is both a fiduciary and strategic responsibility of hospital boards. The board sets the organization’s culture and ensures the resources necessary for physicians, nurses and other team members to carry out the quality and patient safety vision. Nurses bring to the board an essential point of view on safety, quality, and patient experience – all critical to producing high-value outcomes. Without physicians, nurses and other clinicians serving on the board, oversight for quality and safety performance runs the risk of being hampered at best and misguided at worst.

Hospital boards play a role in facilitating strong partnerships in the community. Nurses

2 Institute of Medicine (IOM). 2011. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press.

3 Hassmiller, S. and Combes, J. “Nurse Leaders in the Boardroom: A Fitting Choice,” *Journal of Healthcare Management* 57:1 January/February 2012.

4 AHA’s Center for Healthcare Governance. *Building an Exceptional Board: Effective Practices for Health Care Governance. Report of the Blue Ribbon Panel on Health Care Governance*. Chicago: AHA’s Center for Healthcare Governance; 2007; p. 13.

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1 Disch, J., “The nursing lens”. *Nursing Outlook*, Volume 60 , Issue 4, 170-171, 2012.

understand what it takes to build trusting relationships with others to facilitate effective community partnerships. Nurse leaders ensure that policy and financial decisions are made from the perspective of those receiving and providing care. They bring their deep knowledge and experience with patient care delivery and community health to the board table. Nurses have experience with building care management systems and know the importance of integrating physical and behavioral health and addressing the social determinants of health, such as lack of education and poverty. Nurses know the challenges associated with care transitions and the importance of promoting wellness and preventative care. They also have experience with direct observation of populations of patients in need, gaps in care and services, and barriers and challenges to delivering services.

Nurses bring a front-line perspective on engaging employees and important insights on discussions related to future workforce needs. They understand that health care's business model is based on the premise of people caring for people. They also bring a patient and family-centered lens to decisions about capital improvements and the impact of facility design on care.

Nurses are Under-represented on Boards

While nurses serve in leadership roles in many settings and can add significant strength to governance conversations, they remain largely absent in boardrooms. A recent AHA survey of more than 1,000 hospital boards found that just five percent of board members were nurses; while 20 percent were physicians.⁵

Despite recommendations to add more nurses to boards, little progress has been made. The AHA's *2014 National Health Care Governance Survey Report* noted "... while clinical representation is essential as hospitals strive to continually improve quality and patient safety, the percentage of clinical board members has declined." Researcher Lawrence Prybil has studied governance best practices extensively and advocated for engaging nurses in governing health care organizations for a number of years. He suggests several barriers leading to this under-representation

including gender disparity in boardrooms, a lack of awareness of nursing's impact on health care quality and misperceptions about nurses lacking preparation for board service.⁶

Specific concerns sometimes surface in conversations about adding nurses to the board. Comments that reflect these concerns and my responses to them appear below.

- "We already have several physicians on the board who provide clinical input" – *Nurses bring a separate and distinct perspective that is complementary to the physician viewpoint. We're not focusing on bringing more nurses into governance to balance the input physicians provide to the board, but rather to augment and add to the perspective shared by physicians.*
- "The Chief Nursing Officer attends the board meeting, isn't that good enough?" – *The CNO is a vital member of the senior management team and should attend and contribute to board and committee meetings. However, the CNO is an employee of the organization and cannot serve as an independent director.*
- "If we appoint a nurse, he or she will act as a representative for nursing rather than focus on the needs of the entire organization." *When nurses are prepared for board service they understand their role and can make their optimal contribution on behalf of the entire organization. Of course, this response applies to any professional. I have never heard anyone say, "If we appoint an accountant, he or she will act as a representative for the finance department, rather than focus on the needs of the entire organization."*

Even board members and CEOs who understand the value of recruiting a nurse to serve on the board ask, "Where would we find someone?" Many nurses hold executive positions in health care organizations; lead quality improvement initiatives; serve as expert clinicians, researchers, policy analysts and consultants across health care settings; and have deep expertise in myriad clinical,

operational and systems issues. Hospital boards in small communities might consider recruiting a nurse from outside the community or from the local college. Looking for a recently retired nurse leader interested in contributing to the community may be another option. The American Nurses Foundation is creating a database to match qualified nursing leaders with boards. Organizations can submit a request to <http://anfonline.org/nurseboardleadership>.

Increasing the Number of Nurses on Boards

Nurses across the country are preparing themselves to serve on hospital and community boards. In response to the IOM report, *The Future of Nursing: Leading Change, Advancing Health* (2011), which recommended nurses play more pivotal roles on boards and commissions in improving the health of all Americans, other important efforts are underway.

At the national level, the Nurses on Boards Coalition, supported by the Robert Wood Johnson Foundation and AARP, is implementing a strategy to bring nurses' valuable perspective to governing boards and to state and national commissions with an interest in health. The goal is to put 10,000 nurses on boards by the year 2020. The coalition was founded by 21 nursing and health care organizations, including the American Nurses Association, American Organization of Nurse Executives, National League for Nursing and Sigma Theta Tau International. Its aim is to increase the presence of nursing on health-related boards.

At the state level, nursing leaders are working to provide educational opportunities and networking for nurses aspiring to serve on a community or hospital board. For example, The Texas Team Action Coalition, working in collaboration with Texas Healthcare Trustees, launched an effort in 2013 to equip nurses with the governance skills needed to succeed in board positions. The coalition is offering their program in each of eight Texas regions, with the goal of preparing 400 nurses statewide for board service. In New Jersey, nurse leaders' resumes have been collected and catalogued in a database housed at the state hospital association and are used to match candidates with organizations looking for nurses to

5 AHA's Center for Healthcare Governance. *National Health Care Governance Survey Report: 2014*. Chicago, IL: Center for Healthcare Governance; 2014,11-14.

6 Prybil, L., Nursing Engagement in Governing Health Care Organizations Past, Present, and Future, *Journal of Nursing Care Quality*, 2016, Vol. 00, No. 00, pp. 1-5.

serve on their boards. The Arkansas Action Coalition (AR AC) has created a list of nurses serving on community boards and organizations. Talking points about the value of nurses on boards are shared at professional nursing meetings across the state. New trustees with a nursing background have been paired with an informal mentor from the AR AC leadership team.

What Can Health Care Organizations Do?

As hospitals and health systems focus on achieving the Triple Aim, recruiting and selecting a nurse for board service will

add an important voice to governance work. Nurse leaders have the education, clinical practice, leadership experience and personal characteristics to help the board balance the business of health care with clinical and patient outcomes and add value to board discussions about health care transformation and community health improvement strategies. (See sidebar with perspectives from nurses serving on boards on pages 3-5).

By adding at least one nursing professional to the governing board, hospitals and health systems can join the ranks

of forward-thinking organizations better equipped to govern for advancing health in their communities.

Kimberly McNally, MN, RN, BCC, serves as a board member of the American Hospital Association, Health Research and Education Trust, UW (University of Washington) Medicine and Seattle Cancer Care Alliance. For the last 18 years, she has led McNally & Associates, an executive coaching and consulting firm serving health care leaders, teams and boards. She can be reached at kamcnally@me.com.



An Interview with Gerry Lewis-Jenkins, RN, MBA: American Hospital Association Committee on Governance, immediate past trustee

Gerry Lewis-Jenkins has been chief operating officer of COPIC Insurance Company for the past year, after serving in several capacities for the Denver-based medical professional liability insurance provider since 1991. She currently serves on the advisory committee for the University of Colorado Center for Bioethics and Humanities, and is a past chair of the Colorado Regional Health Information Organization and Platte Valley Medical Center in Brighton, Colo.

How would you describe your leadership journey?

“My career evolved from being a bedside nurse to a nursing manager, then from department supervisor to hospital supervisor. Then I was asked to start working in administration to support the development of a women’s health center. From there, I was recruited to Humana Health Care Plans—they wanted hospital people to manage their operations. I opened up the Colorado managed-care market for Humana in the ‘80s. Then a member of the COPIC board asked me to consider joining the organization because they were concerned about how managed care would affect medical liability and they wanted to learn more about it. I joined the company and my role evolved over time to eventually become executive vice president and then COO.”

Can you cite an example in which your point of view as an RN was especially useful in helping the board better understand an issue or reach a decision?

“When we reviewed our quality indicators during hospital board meetings, I would ask ‘Why isn’t this better? Why are we settling for marginal improvement?’ Lots of discussion ensued and those trustees who were not clinicians began to understand what those indicators really meant. I had the opportunity to help educate my fellow board members on those hows and whys, and on how to improve outcomes.”

What are the most important qualities nurse trustees bring to the hospital board?

“At Platte Valley, I learned about the complexities of the organization and the multiple masters that all departments must serve—the vast number of compliance and regulatory hurdles that a community hospital has to go through while providing care and remaining financially viable. I fostered a continuing discussion about patients and families—making sure we made patient-centric decisions, remembering why we do what we do.”

Why is it more important than ever to have nurses on the board?

“I think it’s always been important to have nurses on the hospital board. It saddens me that nurses are the hospitals’ largest employee base, but it’s the changes in reimbursement that are finally drawing focus to their importance. From a staffing perspective, I believe nurses are the only employees in the hospital who have a 360-degree view of hospital operations. You name it, they’ve seen it.”

What advice would you give a CEO and board for recruiting the right nursing talent to the board?

“Hospital associations are good places to look for nurse trustees; but first, the CEO and board must want and recognize the value and insight nurses provide as clinical experts to improve the organization. And they need to make it clear to nurses who join the board that their expertise is supported, and they expect them to share it—in other words, that they will be treated as peers.”

What advice would you give a nurse who wants to join a board? Where to start?

“As a first board experience, nurses might begin with a small not-for-profit volunteer board in an area that interests them. That provides an opportunity to network and learn the basics of serving as a trustee in a non-intimidating environment where they can have an impact. What matters most though, is to be driven by your passion.”



An Interview with Fran Roberts, PhD, RN: Robert Wood Johnson Foundation Executive Nurse Fellows program, Alumni Board President; Galen College of Nursing, Board Member

For the past four years, Fran Roberts has led the Fran Roberts Group as its founder, president and CEO. The Phoenix-based consulting and contracting practice provides expertise on health care leadership, higher education, governance, regulation and patient safety. Additionally, Dr. Roberts is a professor in integrated care at the University of Arizona College of Medicine, Phoenix. She serves on the American Hospital Association's Committee on Governance, and chairs the Presbyterian Central New Mexico Health System board. She is also the former vice president of professional services for the Arizona Hospital and Healthcare Association.

How would you describe your leadership journey?

"When I started out as a staff nurse, our concerns would go up the line of authority and appear to get lost. One of the challenges of our profession is that, often, we 'talk amongst ourselves,' meaning that we stay in our silos and only voice our patient-care and workplace concerns to each other. I saw that we had to get out of our comfort zone and move into broader spheres of influence to effect change. As the executive director of the Arizona State Board of Nursing for eight years, I became an expert in many areas of health care, and so gained a broader view of the many challenges and constraints in the field. That was a pivotal job for teaching me how to talk to and influence policy makers, CEOs, consumers and physicians."

Can you cite an example in which your point of view as an RN was particularly useful in helping the board better understand an issue or reach a decision?

"While I was on the quality committee of a hospital board, we were discussing its mortality rate, which was then in the 68th percentile (with 100 being best). We were targeting the 75th percentile, because it was suggested that if we aimed higher than that, we'd be setting ourselves up for not reaching our goal. I did the calculations, and at that percentile, we would lose 168 lives. If we aimed for the 90th percentile, we'd save those lives—that's what I proposed to the board—and that's what we did."

What are the most important qualities nurse trustees bring to the hospital board?

"Nurses are the interpreters of patient care—helping to translate the physician's orders and provide care instructions to patients and families. We do the same on boards. We translate patient safety and care concerns into quality metrics, financial implications and impact at community, state and nationwide levels. And we create and offer solutions and provide education. In many ways we are the backbone of the entire health care system."

What advice would you give a CEO and board for recruiting the right nursing talent to the board?

"Boards need people with different backgrounds, who have been in a variety of different organizations and professions in order to bring a broad and balanced perspective. It's sometimes a challenge to identify a 'renaissance nurse' with multiple areas of expertise and experience and that is the focus of the Nurses on Boards Coalition." (Affiliated with the American Association of Colleges of Nursing, the NOBC is a campaign to help ensure that at least 10,000 nurses are on boards by 2020).

What advice would you give a nurse who wants to join a board? Where to start?

"Nurses should seek board training and education. Regional Action Coalitions can help give nurses the language they need to succeed. (These coalitions are composed of nursing and non-nursing leaders working together to implement the recommendations of the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*.) Also, nurses should seek out community leadership organizations which offer individuals from all fields the ability to understand and articulate the broader questions and issues—the type of 'big-picture' perspective needed for board service. The Nurses on Boards Coalition has also embraced this effort, along with Regional Action Coalitions."



An Interview with Donna King, BSN, MBA, RN: Sisters of Charity of Leavenworth Health System, Board Member

In addition to her board service with the Sisters of Charity Health System (SCL), Donna King, vice president of clinical operations and chief nursing executive at Advocate Illinois Masonic Medical Center in Chicago, currently serves on the American Hospital Association's Committee on Governance. She is a past committee chair of Advocate Health Care system's Chief Nurse Executive Council, and continues to serve on the system-level quality and safety committees.

How would you describe your leadership journey?

"I've been very fortunate—I've had good mentors and colleagues who have recommended me to the boards on which I've served. For example, a previous board member on the SCL board recommended me to the AHA Committee on Governance. I came from an operations point of view. I've learned that my role as a trustee is not to solve the issues, but to raise the right questions."

Can you cite an example in which your point of view as an RN was especially useful in helping the board better understand an issue or reach a decision?

“There are many initiatives right now looking at the patient experience and ensuring a safe environment. I believe nurses have the accountability to raise the right questions for the board’s consideration. Quality, safety and financial performance are not [mutually] exclusive, and if I can bring my clinical perspective to the table, the discussion on metrics and goal setting becomes robust in helping to support decisions.”

What are the most important qualities nurse trustees bring to the hospital board?

“Nurses have unique listening skills. As a result, they can contribute many perspectives to board-level discussions. As a nurse executive, there’s an opportunity to influence, clarify and capture the essence of what we do. Beyond being clinically driven, we understand the alignment of the organization; and our knowledge of how it functions can help address key issues. This is a new age for leaders. Recognizing the roles of all individuals in the organization and how they intersect is crucial.”

Why is it more important than ever to have nurses on the board?

“The speed of change is unprecedented, and we must be proactive and responsive. Nurses bring the ability to share our knowledge and improve patient care in every setting. We must stay focused on quality outcomes as we approach value-based care and address workforce issues. Being able to ask the right questions at the right time will be crucial.”

What advice would you give the CEO and the board for recruiting the right nursing talent to the board?

“Bringing nurses onto boards is part of the culture change in health care. The board needs to ask itself ‘How do we want to move the organization forward to integrate all disciplines at one table?’ The voice of clinical integration needs to be at the table, which includes both nursing and medical staff. Key attributes to consider in recruiting the right talent to the board include seeking individuals who have demonstrated visionary leadership; those who are system thinkers; those who have shown the ability to build collaborative partnerships with medical staff and those who are aligned with current workforce challenges.”

What advice would you give a nurse who wants to join a board? Where to start?

“Networking is key to anyone’s success. Nurses should reach out to possible mentors in different disciplines. I would also advocate that individuals gain perspectives in a variety of health care venues to deepen their understanding of the changes in the health care landscape, and to expand the depth of their experience.”



An Interview with Barbara Williams, PhD, RN: Conway Regional Health System Board Chairperson

Barbara Williams, Chair of the Department of Nursing at the University of Central Arkansas, currently serves as chairperson of the board of Conway Regional Health System. She has served as president of the Arkansas Association of Hospital Trustees (AAHT), a member of the Arkansas Hospital Association board of directors and a delegate to the American Hospital Association’s Regional Policy Board 7. In 2014, she received the Arkansas Hospital Association Chairman’s Award for her distinguished service to health care in Arkansas.

What is your leadership background?

“The most relevant leadership experiences that I had earlier in my life that benefit me now as a board member were when I worked with others – organizations and individuals who in other experiences would have been competitors – to build coalitions to reach a higher good, a common goal. In some of those early experiences, I was so much in the framework of competition that I had to do a lot of soul searching and work

to identify areas of common interest. These experiences taught me to view the table as round and that the world is not as black and white or dualistic as I once thought.”

Tell us the story of how you joined the Conway Regional Health System board.

“I was appointed to the Conway Regional Health System board in 2010, the first nurse to be asked to serve on it. The board leadership at that time, to their credit, was seeking to become a more diverse board in terms of age, race and professions represented.”

Give us an example of a board dialogue and recent decision that benefitted from your nursing lens.

“We formed a new committee to address Quality Oversight and Compliance. There was an automatic recognition that physicians needed to be involved. I brought attention to the fact that the involvement of nurses was also critical. Up until that point, nurses were not considered important in the leadership drive to improve quality and compliance.”

What advice do you have for CEOs and boards committed to recruiting a nurse to their hospital board?

“Seek out nurses to determine their commitment and interest in serving. Nurses in academic roles are good possibilities, as are nurses who are consultants and in other forms of practice. In the health care world of tomorrow, most physicians will be affiliated with the health care system in some way...don’t be fearful of nurses who also have a tie. Many hospitals are already allowing physicians who work in practices owned by the health care systems to serve. We should consider nurses in the same manner.”

When Systems Change: Breaking Free from Traditional Governance Models - the New Optimal?

by Luanne R. Stout

*“I cannot say whether things will get better if we change; what I can say is they must change if they are to get better.”—
Georg C. Lichtenberg*

Health systems and hospitals are becoming increasingly complex, expanding beyond the traditional hospital/parent company model to include new structures and strategic partnerships to support a wide range of care for patients in their communities. Yet, many health care organizations continue to utilize the same approach to governance that they have been using for decades—for hospitals and non-hospitals alike.

The traditional community-based hospital board has been part of our culture in health care governance for so long that it has become a fixture, a constant, and something we don't often think about changing in our quest for transformational governance. The mere suggestion that a governing board in a health care organization, particularly those that are non-profit or public, might not be a community board is bound to raise a gasp or at least an eyebrow. Hospitals and health systems must maintain ties to the communities they serve. But is a community board for every business venture in a health care system the best model in today's environment?

Evolution of Community-based Boards

Non-profit boards typically serve on behalf of constituents who have a significant stake in the organization's performance and success. While these stakeholders are often broadly defined as the community served by the non-profit, most health care organizations have expanded the definition to include physicians, employees, and even suppliers and vendors.

Over the years, “the community” came to be loosely defined as the market area

served by a hospital. Board members—often business and community leaders—were selected to represent the community and to be both a voice for community needs and an advocate for the hospital.

As governance continues to evolve, today's non-profit hospitals and health systems are striving to compose their boards to better reflect the diverse populations they serve and seeking individuals with competencies boards need to carry out their work. The American Hospital Association's Center for Healthcare Governance (the Center) has identified core competencies for trustees of health systems and hospitals and created interview guides and other tools to help boards apply competencies in their work.

“As governance continues to evolve, today's non-profit hospitals and health systems are striving to compose their boards to better reflect the diverse populations they serve and seeking individuals with competencies boards need to carry out their work.”

Challenges of Community Boards Today

If organizations were truly trying to select community board members that: (1) reflect the community's age, gender, ethnic, racial, industry, political, economic and thought diversity; (2) represent the highest level of business and community leadership; and (3) embody carefully selected competencies that best support the board's work, would they have the same boards they have today?

A survey of 355 health care governing boards of all types (Peisert, 2015) indicates the average health care board has 13-16 members. Larger hospital boards (2,000+ beds) have an average of 5.1 percent females and 3.2 percent ethnic minorities, while smaller boards have even fewer (2.8-4.6 percent females and 0.6-2.4 percent ethnic minorities).

Board member ages range from 45 to 75, with an average age of 58.4. More than 62 percent of these boards have one or more board members who represent a religious sponsor; philanthropic foundation; medical group, physician organization or medical staff; or are a member of management. By and large, these data indicate many health care boards do not yet reflect the increasingly diverse communities they serve.

When it comes to competencies, the question is whether boards are focusing member recruitment on the competencies needed to govern the next evolution of health care or are continuing to look for the same blend of competencies they have always had – financial, business, legal, physician, construction, real estate, fundraising, etc. While many traditional competencies are still needed, boards also should be seeking individuals with transformational competencies such as expertise in patient-centered care, quality and safety, outcomes management,

population health management, risk contracting, value-based payments, accountable care organizations (ACOs), strategic partner development and consumerism. Competencies that reflect personal capabilities, such as the ability to deal with complexity, being skilled at navigating uncertainty or acting collaboratively, are also behaviors boards are seeking to govern more effectively in a transforming health care environment.

Recruiting for competencies, especially those that reflect skills or behaviors, can be a challenge. Some competencies are difficult to begin recruiting for because they reflect emerging areas of expertise, such as population health or value-based payment, and prospects may not be plentiful or readily evident based on professional background or prior community involvement.

Even when candidates appear to possess needed competencies, verifying them often requires specific interview methods or questions to determine whether candidates have actually demonstrated the competencies being sought. Even when candidates possess the right attributes, there is no guarantee they will apply them to board work or be dedicated to the organization and bring the still-valued community connection to their board service.

Even if a governing board has found the optimal trustee recruiting and selection method and established the perfect balance of competencies, there is no guarantee that the future pool of candidates will provide the same level of competencies and engagement. The Center's monograph *Effective Governance in Systems* (Stout, Stock, and Totten, 2015) addresses evolving recruiting challenges for boards. For example, individuals in the Millennial, Generation X and Generation Y age groups have viewpoints about community service that do not necessarily involve being on a community board. Many corporations also are no longer as actively encouraging their executives to serve on community boards, as they once did. And, assembling a great board with the right competencies is only the beginning. Once selected, best-in-class orientation and educational programs to adequately prepare new board members to make decisions in the new health care environment are critical.

For stand-alone or public hospitals, doing their best in the face of these and other challenges may be the only option; and there are those who have succeeded. For health care systems, the challenges are amplified when multiple hospitals and other entities exist, each of which has a governing board. For organizations that are adding other types of business units, such as health insurance companies, ACOs, physician organizations, free-standing emergency rooms, behavioral health centers and outpatient centers, the challenge to maintain effective community-based boards for some or all of these entities can become quite daunting, particularly since these boards may require different competencies and educational focus. Therefore, it is not surprising that some leading organizations are beginning to consider and utilize different governance paradigms.

Could Emerging Governance Models Be the New Optimal?

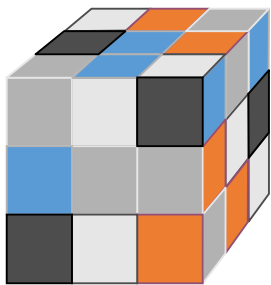
It seems unlikely that health care organizations will completely abandon community boards anytime soon. However, they are becoming increasingly creative about maximizing their trustee pool and streamlining their governance structures. *Effective Governance in Systems* discussed the emergence of several new governance models and the key features of each. Organizations are increasingly adopting these models, or features of one or more of them without embracing any one of them in their entirety.

Mirror Boards (the same individuals serve as board members of multiple corporations). There are several ways to approach this model. If separate corporations are required for legal or other reasons, a single board with the same individuals may be elected to serve each of the corporations. Another method is for the bylaws of each corporation to reserve virtually all authority to a single operating or parent board. Either way, the board would meet on a single occasion for all of the corporations.

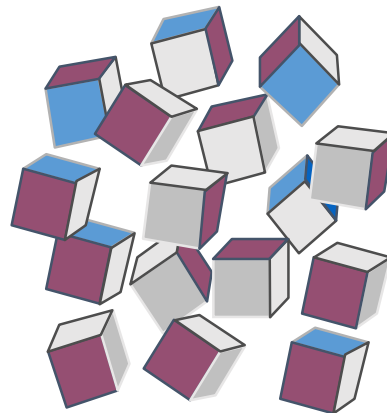
This model is beneficial in that it limits recruiting and selection for trustees to one board. The model also provides an opportunity to oversee all business lines of a particular type in a consistent manner based on a common strategic plan and goals. The model works best when the corporations are of the same type (e.g., all hospitals, all physician organizations, or all insurance companies, etc.) because the needed board competencies, experience and education would be similar.

Non-community boards. Health care delivery units are generally highly visible to the community, and community members may feel invested in their success. Because of their high profile and vital importance to communities, hospitals have long attracted people interested in serving on their boards. Service on the boards of other types of business organizations now part of today's health care systems may not have the same ap-

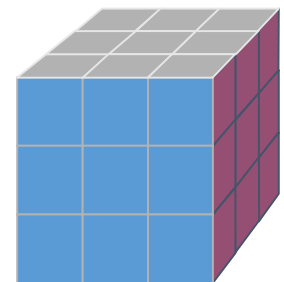
Evolving Governance Models



**Multiple
Community
Boards**



**Re-Evaluating
Traditional
Models**



**Shared/Fewer
Community
Boards**

peal. People may find serving on the board of an insurance company, an ACO, most strategic partnerships, or virtually any entity with an internally focused function less attractive than service on the hospital board. Some health systems are finding it more feasible to populate these boards with non-community individuals with subject matter expertise, either from internal management or externally contracted experts.

Parent company has the only community-based board with centralized decision-making authority. A number of health care systems have adopted a model in which the parent company board is community-based with centralized authority, and individual community boards are advisory. Advisory-only community boards at the local level create a number of potential issues: lower trustee satisfaction, difficulty recruiting top-tier community leaders, and not having the resources required to educate and support them. A viable alternative may be to have only the parent company board be community-based and having all subsidiary boards composed of non-community members (management or contracted experts) or utilizing the parent or single operating board as the board for all subsidiaries (e.g., individual hospitals). The parent or operating board may be comprised of community leaders from across the service area, thereby widening the trustee pool.

Professional/expert-based boards.

Debate is occurring about whether a board of community leaders, even with orientation and education, is qualified to navigate the complexities of the health care environment and make effective decisions. For several years, some hospitals and health systems have been adding outside experts to their boards. These boards are either a hybrid of internal subject matter experts combined with externally hired experts or are populated entirely with outside experts with the competencies most needed to support the leadership team in executing on key organizational strategies.

Board committees limited to the system board level.

Eliminating redundancies and governance layers is often in part accomplished by having one set of board committees for oversight of governance, executive compensation, finance, strategy, audit and compliance, and quality and safety. This single set of committees is populated by community members from across the service area or by experts with needed competencies and allows committee work to be focused in a standard way system-wide. Having these types of committees for each subsidiary board is becoming increasingly rare.

Executives throughout the system report to the system CEO (not subsidiary boards).

Increasingly, chief executives of entities across a health care system

report to the system CEO rather than the individual subsidiary boards. The parent board, or its compensation committee, makes executive compensation decisions organization-wide in a systematic and consistent manner.

Conclusion

There is no question that health care organizations must be connected to the communities they serve. Increasingly, they are evaluating whether community boards for each business unit or even each community are the best means to provide that connection. New avenues for community connectivity, needs assessment, and providing the voice of the customer are being implemented to bring more significant value across a broader spectrum of communities served.

Streamlining governance to the fewest layers possible has always been a fundamental governance principle. While that used to mean consolidating corporations and still does for many, innovative alternatives that maximize resources and board talent may be the new optimal.

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7 Rules of Board Engagement

by Dottie Schindlinger

For a hospital board to be effective, it must first be engaged. Specifically, board members must actively and productively participate in the work of governing. This is absolutely vital in today's health care environment, which is full of volatility, uncertainty, complexity and ambiguity. Within this setting, boards have a harder job than ever before. When trustee performance expectations are higher and the most desirable board candidates have the least time, engagement is crucial.

But what does true board engagement look like, and how do boards know when

they achieve it? Board engagement is part art and part science. Board engagement never ends. Rather, it is a fluid process, but with discrete components and steps. This article offers frameworks and guidance ("7 Rules") to aid board administrators, executives and directors in their efforts toward the elusive goal of engaging and elevating the effectiveness of hospital boards.

1. Identifying the Cycle

The work of boards is complex, demanding and high-stakes. It is also cyclical in nature. Boards convene on a regular meeting cycle, deliver on a recurring set

of annual responsibilities, and continuously work in a development cycle to refresh and strengthen themselves as strategic assets to the organizations they serve. This board development cycle includes three distinct areas of focus, including: (a) planning and recruitment, (b) orientation and onboarding, and (c) evaluation and retention. There is a great deal of emphasis placed on the recruitment and election of new members, but less so on the other areas. Also, contrary to popular opinion, these are not episodic initiatives. Rather, board development never ends, with trustee engagement naturally and intrinsically woven

into every part of that cycle. Today, the responsibility for setting and keeping that cycle in motion rests with the board's governance committee.

2. Rethinking the Nominating Committee

Once a staple among a majority of boards, the “nominating committee” is increasingly becoming passé. In its place, fully-fledged “governance” or “board development” committees have emerged. The governance committee is an updated, expanded, and empowered next-generation of the nominating committee. The governance committee is charged with overseeing the ongoing development and engagement of board members, ensuring that governance is happening effectively, and taking steps to remediate gaps. Irrespective of its name, every health care organization needs a committee that concentrates exclusively on that overarching purpose, asking such questions as:

- Given our strategic plan, do the by-laws still make sense? Will they support or hinder achieving our goals?
- What does the board see as its primary purpose, and is that purpose explicitly being adhered to by trustees?
- What are the board's opportunities and constraints? What education or information should be provided to help the board take advantage of the opportunities and minimize the constraints?
- Who are the right players to make the right things happen and provide the right guidance to the CEO? How can we ensure the right mixture of talents, experience, demographics and personalities on our board?

3. Recruiting for Engagement

The governance committee is charged with determining what types of board members need to be at the table over the next three to five years, and with deciding which candidates can best address the most important issues the organization will face. To optimize downstream member engagement, boards need to be specific about the talents they seek. They should first ask “What is our primary purpose, and what do we need to ac-

complish?” and then communicate those needs, as would be the case for any other job. For example, trustees who have expertise in community health could be invaluable in helping the board oversee how the hospital meets its community benefit obligations.

The governance committee should create specific profiles for the trustees it seeks (as well as for current trustees) to make it easy for the right candidates to emerge. Understanding the mixture of skill sets, experiences and mindsets of current and potential trustees is critical to creating the right board “team.” And, as new trustees' skills are matched with the organization's most pressing needs, deeper engagement among all board members will likely follow.

4. Orient for the Journey

New trustees should be provided with a thorough orientation program – one that allows board members to engage in as much self-directed discovery as possible, and steadily come up-to-speed with the board's work and the specific ways they can add value. Additionally, assign each newcomer a “board buddy” or mentor with whom questions and advice about how to fit into the board can be discussed. That mentor does not necessarily need to be a current board member. Having a trustee who may have just rotated off the board serve as a mentor, with support from the organization's staff, not only helps a new trustee gain comfort in the role, but retains the past trustee's engagement as well.

As new trustees complete their orientation and take on more responsibilities, effective engagement also depends on not overwhelming them with too much information at once. If the hospital has an online board portal, proposed meeting topics can be posted there before each meeting, along with a survey asking trustees which topics they consider the highest priority for discussion and which ones could be covered by a written report. Asking board members what they want to talk about engages the entire board in thinking about the content for the meeting, and helps reduce the potential for board members to mentally “check out” during meetings. Engaging the board in planning the content for the meeting also increases the likelihood that

Board Member Job “Ads”

To find the best slate of candidates for your next board cycle, follow a similar approach to sourcing the best talent to join your staff – create a clear job description and advertise the position broadly.

What to include in your ad:

1. Background – your health care organization's name, description, mission, a little about your history and current operations.
2. Board Member Job Description – size of the board, listing of officer positions, frequency of meetings, length of terms, term limit information, and your expectations of board members (such as participation on committees, attending events, making donations, etc.).
3. Qualifications – what specific talents, skills, expertise, and/or experiences do you seek from qualified candidates? What is your policy on board diversity?
4. Application Procedures – how do interested candidates become nominated and/or elected?
5. Contact Information – organization's website and contact information for interested candidates.

trustees will review the full agenda and all reports in advance, and will be better prepared to have meaningful discussions.

5. Partnering for Success

A strong partnership between the CEO and the board chair is vital to the entire board's engagement. Regular conversations and candid communication establish mutual trust, helping both leaders support and get to know each other as individuals. Their relationship sets the stage for a shared governance model, the most effective way to achieve full board engagement.

It's also important for board members to personally connect—in effect, build a relationship—with the organization in the context of their work. Setting aside a few minutes at each board meeting for

Simplifying Board Self-Assessment

Samples of board self-assessment surveys abound, with many being so lengthy and complex that they nearly ensure a low level of participation from busy trustees. This does not need to be the case. Provided you have set clear expectations for trustee performance, and have a written set of the board's priorities for the year, your assessment can be reduced to five simple questions:

1. Rate (from 1-to-10, with 10 being highest) how well you feel the board as a whole met the priorities we set at last year's retreat.
2. Rate (from 1-to-10, with 10 being highest) how well you feel you as an individual met the expectations set in last year's board member agreement.
3. What do you think the board should do differently for next year?
4. What do you want to do differently for next year?
5. How likely (from 1-to-10, with 10 being highest) are you to recommend serving on this board to a friend or colleague?

Question 5 is the "net promoter score" – allowing you to determine the overall health of the board by determining whether you have more "promoters" (those that rate the board as a 9 or a 10), "neutrals" (those that rate the board as a 7 or an 8), or "detractors" (those that rate the board 1 through 6). Subtracting the number of detractors from the number of promoters equals your "net promoter score" – which, hopefully, will increase each year as you focus on building board engagement.

trustee-led "mission moments" – where a board member shares a story or example of one way the hospital or health care system is meeting its mission – is one way to build these connections. For example, the board might invite trustees to look into a topic or attend an event outside their area of expertise. A banker trustee might go on hospital rounds, while a physician trustee might attend a community event. Each would then relate what they have learned about the hospital's mission and relevance through the experience, tapping into a shared passion and enthusiasm for the hospital's work that become contagious. Such activities engage all board members in both building relationships and thinking about what the organization's mission really means – to them individually, to the board collectively, and to the broader community.

6. Sharing for Balance

Sharing perspectives that come from varied backgrounds and experiences also speaks to the importance of board diversity, another factor that fosters greater trustee engagement. In a more diverse group, people behave differently. They tend to dive deeper into topics, which

often leads to better conversations and decision-making on behalf of the organization's varied stakeholders.

It is also important for boards to have a balance of personality types among their members. They cannot all be visionaries. Boards need some who say, "Let's get it done" and others who say, "Let's deliberate;" those who want to start something new, and those who want to vote and move on. Boards need all types, but at the end of the day, they need people who are working really hard to make good decisions, for whom "easy" is not good enough.

7. Codifying for Accountability

To ensure everyone is clear on where and how to focus their efforts, boards might consider having each member sign an annual agreement with a written set of expectations and goals—a "contract" that speaks to the individual trustee's expertise and passions, as well as the organization's needs. An annual contract provides clarity and guidance for trustees and the organization alike, allowing everyone to openly ask, "Are we getting what we want from each other and our work?" The clearer board members are

about what they want from the board and what the board needs from them, the more fully engaged members can be.

To ensure a high level of engagement an annual board assessment is required. The governance committee should own the task of helping the board evaluate its purpose and priorities annually, along with facilitating each trustee's self-evaluation of individual performance. The results – analyzed in summary and compared to the standards set by the strategic plan, board development plan, and trustee annual "contracts" – can help identify the board's development opportunities for the following year. An annual board retreat is the ideal time for board members to discuss the results of both evaluations, determining what has been completed, what goals and activities are still important, areas for performance improvement, and what new initiatives the board wants to tackle.

For boards whose members are truly engaged, evaluation and retention should be their easiest job. If retention is a problem, it is often a symptom of another issue or concern. The board then must determine what is broken and how to fix it, so that governance remains work to which all members can give their fully engaged commitment.

Conclusion

Boards must rise to the challenge and develop creative, innovative approaches to helping their members become engaged, even before their first meeting, and stay engaged throughout their board service. Boards can no longer afford to have members follow a traditional board development timeline: a term to learn, a term to do, a term to lead. Trustees need to make a contribution on Day 1, but to do that they need to understand what is expected of them and be given lots of opportunities for engagement in board work. These 7 Rules will help you navigate the fluid, yet rigorously demanding, landscape of engaging your board toward effective leadership.

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The Physician's Impact on Patient Satisfaction

by Derik K. King, M.D.

Patient satisfaction scores are important metrics; they draw attention to the subjective experience of patients who received care from a hospital. The Centers for Medicare & Medicaid Services (CMS) consider patient satisfaction to be a key value marker in evaluating hospital performance and includes those scores when calculating individual hospital reimbursement.

To better understand patient satisfaction and performance on quality, cost-effectiveness and other key factors critical to value-focused care delivery, hospitals—and the boards that guide them—must look beyond the numbers to consider the factors that influence them. For example, while enhancing patient satisfaction is immensely important in today's value-based health care environment, understanding the impact that physician satisfaction and well-being can have on patient satisfaction scores can help hospitals and systems guide improvements in several areas simultaneously. Because physicians are an integral and increasingly important part of the overall enterprise, especially in this age of clinical integration, their satisfaction will help drive success on a number of metrics, including patient satisfaction.

Fundamental corporate wisdom holds that the level of contentment or satisfaction of the person delivering a service is integral to the satisfaction of the person receiving the service. The board, with its ability to orient organizational strategy and ask questions executives listen to, is the place to foster this rational approach. How should trustees begin? By expanding the patient satisfaction conversation to include the linchpin of a positive patient experience: the physician.

Trustees invested in patient satisfaction can guide the focus back to basics: the physician and the care team. Broadening the conversation to include factors like the care team's practice environment is a smart way to achieve, and more importantly sustain, strong scores from patients.

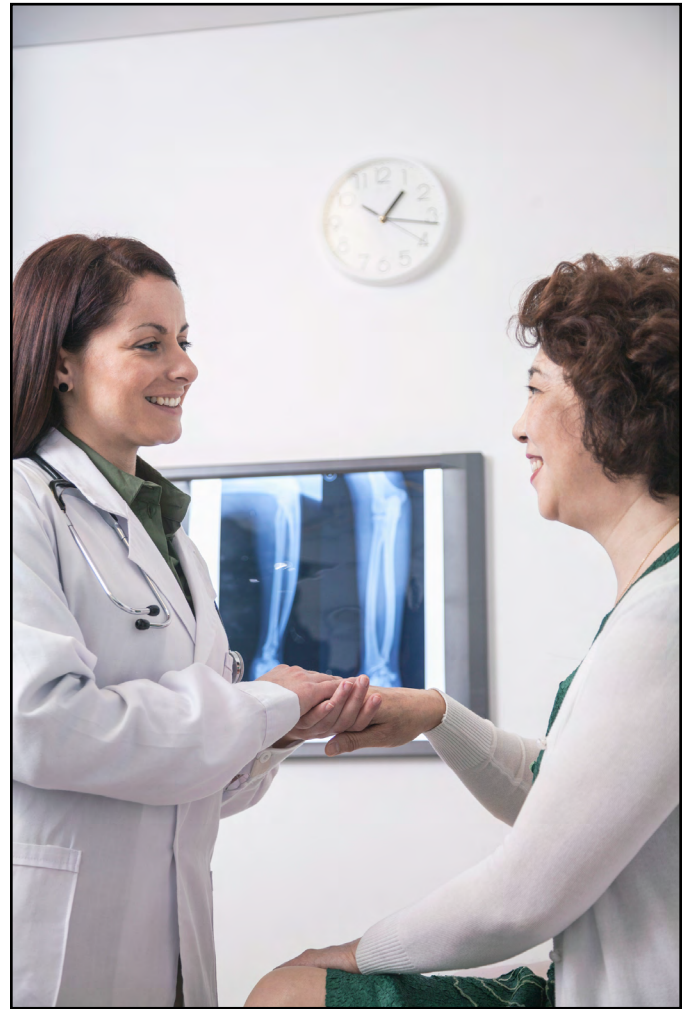
The Six Questions

Here are six questions hospital boards and leaders should consider in assessing physician satisfaction.

Can physicians maintain a manageable work/life balance?

Physician burnout is a cause for concern in health care today. A 2015 study from the Medscape Physician Lifestyle Report noted that 46 percent of all physicians responded that they experienced burnout, up from 40 percent just two years prior. The causes of burnout are complex, but the Medscape study found that bureaucratic tasks, long work hours, insufficient income, and increasing computerization of a practice are the top causes.

In his recent article, "Reducing Physician Burnout Through Engagement" (*Journal of Healthcare Management*, March/April 2016), John W. Henson, M.D., chief of oncology services at Piedmont Healthcare in Atlanta, takes another point of view. He cites studies that indicate the antidote for physician burnout might be engagement through strong physician leadership. He reviews data from a 2014 Physicians Foundation survey that indicates physicians reported better professional morale and more positive views about the medical profession than did respondents to the organization's 2012 survey. He also discussed results of a 2015 Mayo Clinic study, which found that the quality of physician leadership appears to affect the well-being and satisfaction of physicians working in health care organizations. These findings,



he says, indicate that physician leaders should be carefully selected and should focus on the professional needs of the physicians they lead. He also recommends that it may be useful to redefine the issue of high burnout as one of low engagement and that physician leaders can help address this issue.

With this context in mind, the questions board members should ask are: Can the hospital's physicians expect reasonable scheduling and manageable work-life balance? How are physician leaders selected and what role are they playing to address physician satisfaction? Hospital and physician leadership can work together to help provide physicians a more satisfying work experience by avoiding situations such as quick shift turnarounds or extending work hours longer than is reasonable, which can in turn drive down

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patient satisfaction. Conversely, creating an environment where physicians feel supported, including adequate staff and supplies, will not only help the physician, but also improve patient satisfaction.

What is the staffing mix? Does the hospital have a stable, locally based clinical staff?

In rural or overwhelmed care settings with a small labor pool, hospitals may rely on *locum tenens* physicians to fill out their roster. As temporary hires working to cover a set span of time or number of shifts, they rarely get the chance to establish the same kind of connections that permanent employees can.

A stable clinical team with physicians who live in the same area they serve likely will be able to influence the culture more effectively than temporary staff. Besides the accountability and personal investment that come from living where you work, long-term staff will have the time to assess and internalize the culture of the facility. Understanding the culture of various groups—from the medical staff and office employees to the nursing staff—will improve interactions and aid teamwork. Physicians need to know the culture intimately before they can ask the right questions and make positive suggestions. Only when they understand the lay of the land can they find ways to remove stumbling blocks and deliver more efficient service to patients.

Asking about the staff mix can also help trustees zero in on one of the aspects of care referenced most frequently in patient satisfaction surveys: treatment from nurses. *Locum tenens* physicians may not have the time to build the meaningful relationships that permanent physicians can develop with the nursing staff. Nurses have to be able to recognize

and triage illness efficiently, and need to have the communication skills and trust to get physicians to the patient's bedside quickly. Turnover in nursing staff directly influences patient care and work flow. Because medicine is a team sport, the way team members treat each other is both an indicator of how they take care of patients and a quality measure assessed by satisfaction surveys.

Confident, stable staff also will be able to inform management when work levels become overly burdensome; part-time staff is less likely to be able to make positive change.

Is the medical leadership trained to lead and manage, and supported in those efforts?

It is unheard of for a hospital medical leader to be a mediocre or subpar clinician. But it is also a truism that excellent clinical skills do not necessarily translate into excellent management. There are no classes on effective leadership in medical school, and no board exams on running efficient meetings or responsibly and equitably addressing team conflict.

Effective meeting management is an interesting case, and one that trustees understand. Meeting leaders convey respect for participants when they lay out expectations in advance, address digressions before they derail discussion, and ensure that all have an opportunity to speak. Anyone in an upper management or C-suite position likely will have endured a disorganized, uneven medical executive committee meeting run by a medical director without experience in leading meetings. While lack of this leadership skill does not detract from the physician's clinical acumen or capacity for leadership, it is nonetheless vital, from a patient satisfaction perspective, to im-

prove the medical leader's management skills. If a team is feeling disgruntled about their leader, it is a distinct likelihood that such a sentiment will become visible to their patients.

Training medical leaders in general leadership and management techniques, such as conflict resolution, negotiating skills, and team empowerment, will help them build a stronger, more positive practice environment that satisfies both physicians and patients. Likewise, training in documentation management, quality and risk management program implementation, and LEAN methodologies will help medical directors run departments that are stronger operationally and financially.

Boards may find it useful to assess the support the organization provides to its clinical leaders. Do they have access to all the data and metrics necessary to monitor and measure department and medical staff performance? Do they receive ongoing guidance from a mentor who has both clinical and management experience in their specialty? Are hospital-based medical directors responsible for all aspects of running their departments, or can they shift some duties, such as physician recruitment or scheduling, to a trusted person or group? Just as a community should have high expectations of its hospital, a hospital should have high expectations of its medical leaders. Without adequate support and training, medical leaders will not be equipped to motivate and lead their departmental teams proactively.

Do physicians have a say in decision-making?

Guiding patient flow, setting performance goals, assigning patients: all of these tasks require a complicated choreography determined in advance. Because physicians are daily affected by this choreography, they should have a voice in its creation or modification. With clinical matters in particular, hospital leadership should solicit and value physician insight. Inviting physicians to help determine and develop triage protocols, disaster plans, and criteria governing admissions and fast-tracking patients will help establish best practices, and also will make it more likely that physicians will embrace and incorporate those practices.

“The primary job of a great board is not to execute a plan for improvement but, rather, to ask the important questions that encourage all involved to assess, create and sustain a setting of support and care—for their staff as well as their patients.”

Do physicians receive competitive pay, benefits and retirement?

This is one question that most people would put at the top of the list. However, experience indicates that pay and benefits are not, in fact, the most important differentiators of employment (which is more often than not a choice based on the location of family or friend networks). As long as the pay is competitive and the benefits and retirement options good, committed physicians join a hospital and stay there because of quality of life, a stable team environment, strong leadership, and an equal voice in shaping their practice environment.

What should the board do if the organization is losing physicians? After confirming that physicians' compensation is competitive, drilling down further is vital: Is there a nursing issue? Are there too few specialists supporting primary care physicians' needs? Do physicians feel unsupported by the medical director, the hospital staff, other medical staff, or attending physicians? Trustees don't have

the time or the purview to micromanage such matters, but they have the capacity to spark the right conversations.

Are physicians furnished with the education, training and opportunity to advance?

Certifications and licensure renewals depend on continuing medical education. Hospitals can have a positive impact on physician satisfaction by making it easier for physicians to meet these requirements, and providing physicians with easy access to continuing medical education.

Some education providers are accredited by continuing medical education groups so that programs can be brought to busy physicians easily; other groups offer personal scheduling services. Education is necessary, but the obstacles that go along with it can dilute its power. Doing away with such impediments can help physicians stay up-to-date with the latest techniques and evidence-based medicine without overburdening them with

the small stuff (scheduling, etc.). Showing that the hospital is invested in their professional growth and recognizes that their time is valuable will improve physicians' skills and demonstrate how much the hospital values them.

Conclusion

Trustees may not be medical experts, but their leadership and wisdom in other realms can certainly help hospitals take a broader perspective in the push for better patient satisfaction. The primary job of a great board is not to execute a plan for improvement but, rather, to ask the important questions that encourage all involved to assess, create and sustain a setting of support and care—for their staff as well as their patients.

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