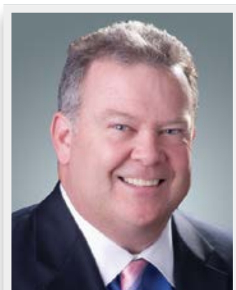
Becoming More Clinically Focused

BY JAMES A. DIEGEL, FACHE, ST. CHARLES HEALTH SYSTEM

As with any healthcare organization, the St. Charles Health System board of directors is asked to review, analyze, and make decisions related to the complicated landscape that is healthcare today.

It is an environment that includes health reform, physician integration strategies, and ongoing quality and improvement of care initiatives, including the financial and regulatory considerations that accompany each issue. The decisions we're asking our board to make require a broader and deeper set of competencies than in the past.



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Three years ago, our health system initiated a reorganization to become more clinically focused and driven. We believe physicians, nurses, and other clinicians need to play a larger role than providing bedside care; they need to be involved in directing health systems at the highest level of governance. Our belief in this premise is so strong that during this reorganization St. Charles added two senior physician executive positions to the leadership suite. One of the physicians leads the St. Charles Medical Group and all hospital-based contracts, and the other physician executive directs clinical integration activities across the system. These positions provide added clinical input and oversight at the highest levels of the organization. In addition, the board reviewed its overall governance structure and responsibilities, including a detailed examination of the skills and competencies of our mix of board members. We asked ourselves, "Do we currently have the right mix of skilled and experienced outside opinion leaders? Should the CEO and other senior executives be clinicians? If yes, what business experience and education would be required?"

Though we are still answering these and other questions, the health system is making progress. We recognize the strength of having clinicians in key leadership positions throughout the organization, including our governing board, and have taken the necessary actions to ensure this representation. For example, the board changed its corporate bylaws and now requires a minimum of one active staff physician—not employed by the hospital—from one of our hospitals to serve on the board. Of its voting members, up to 40 percent of the board can be composed of physicians from the active medical staff. The bylaw changes also require the four presidents and chiefs of staff of our four hospitals to serve in an *ex-officio* status without the right to vote.

Currently, three of our 12 board members are physicians; two are active staff physicians (not employed by the hospital) and the third is a retired physician. In addition to the three physicians, two board members are nonpracticing nurses who serve in executive leadership positions in their healthcare organizations. One is the CEO of a local, federally qualified health clinic. The other is the COO of a health system in North Carolina. Each brings a key clinical delivery perspective to the board.

In all, our board's clinical emphasis includes five voting clinical positions and four nonvoting medical staff presidents. This clinical presence allows our board to bring an increased level of attention to patient safety and quality issues. As St. Charles is a Triple Aim Improvement Community organization, our board member physicians and clinicians grasp the benefits of ongoing process improvement efforts and bring a unique perspective to the table that simply can't come from nonclinical board members.

Some physicians, however, would like to see an even stronger governance presence of clinicians. They believe unless an adequate number of physicians serve on the board it cannot fully understand the patient's experience or clinicians' needs. We believe the changes we've made at all levels of organizational leadership provide the mechanisms needed for physician and clinician involvement in all aspects of patient care planning and delivery. However, our board does continue to struggle with what the proper number of physicians/clinicians who should serve on the board is, and whether these clinicians should come from outside the region we serve to ensure independent and nonbiased perspectives.

Currently, physicians on the board cannot be employed by the organization; the only board member who can is the president and CEO of the system. As a board, we have discussed including employed physicians but believe the current system works well and avoids the awkward perception or potential dynamic of physicians influencing decisions that could directly benefit them monetarily or in some other way. An ongoing discussion involves the delicate balance and overall management of our clinical board members in a manner that is sensible, fair, objective, and in alignment with our overall governance practices.

Hearing the voice of our physicians and clinicians at the highest levels of the organization is a key piece of our ongoing health system strategies. Toward the end of 2012, the St. Charles Medical Group, which employs 122 physicians and other practitioners, formed a governance council comprised of nine physicians elected by their peers. These physicians work with the health system's physician executives in strengthening quality and competency standards. As the medical group continues to grow, we may consider adding members from the medical group to the board as nonvoting members, which will provide a broader, subclinical perspective to all decisions being made.

Our next area of focus will be increasing the role nurses have in governance and overall care delivery. Nurses currently serve in a variety of significant roles outside the hospital, including service

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in patient-centered medical homes or population health and nurse coordinator initiatives. I personally believe their skills and capabilities are not being used to their fullest potential, particularly when you look at how nurses play a key role in the coordination of care. With the limited numbers of primary care providers today and fewer projected to graduate from medical school, many hospitals don't have enough resources to provide the level of coordinated care being required through reform efforts. Moving forward, nurses and other clinicians will see their roles expanded to meet reform requirements and ongoing patient care needs. As board members, we need to strategically consider how we include nurses and other clinicians in key leadership roles and include their experienced voice at the board level. We're currently working on a plan to accomplish this goal.

There are no easy answers, but we're willing to keep asking the questions and exploring innovative ways to involve the right mix of experienced, competent business leaders, physicians, nurses, and clinicians in healthcare governance. We're willing to put in the work and the time. In the end, it will be well worth it.

The Governance Institute thanks James A. Diegel, FACHE, president and CEO of St. Charles Health System in Bend, Oregon, for contributing this article. He can be reached at jdiegel@stcharleshealthcare.org.