The Orthopaedist's Role in Healthcare System Governance

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Abstract

Background Historically, physicians as participants in healthcare governance were shunned because of perceived potential for conflict of interest. This maxim is being revisited as health systems begin to appreciate the value presented by physician leaders.

Questions/purposes This overview of the orthopaedist's role in healthcare governance will be addressed in three sections: first to identify the need for change in American healthcare, second to examine the role that physicians should play in governing over this inevitable change, and third to outline strategies for effective participation for those physicians wishing to play a role in healthcare governance.

Methods The PubMed data set was queried applying the search commands “governance AND (healthcare OR hospital) AND (doctor OR physician OR surgeon)” for the time period 1969 to 2012. In addition, the bibliographies of relevant articles were reviewed. This search strategy returned 404 titles. Abstract and article review identified 19 relevant to the topic. Bibliographic review identified five more articles of relevance forming the foundation for this review.

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Results The delivery of American health care will require change to face current economic realities. Organizations that embrace this change guided by the insight of physician governors are well positioned to recognize the simultaneous improvement in value and quality. Although few physicians are formally trained for these roles, multiple paths to becoming effective governors are available.

Conclusions In this environment of rapid change in healthcare delivery, the medical insight of physician leadership will prove invaluable. Governing bodies should reach out to talented physicians and administratively talented physicians should rise to this challenge.

Introduction

Toby Cosgrove of the Cleveland Clinic, Glen Steele of the Geisinger Health system, Charles Sorenson of Intermountain Health, and Wright Pinson of the Vanderbilt Health System are all surgeons who have gone on to serve in chief executive officer roles at some of the most prestigious and influential healthcare organizations in the country. Although it would be improbable for a large percentage of those reading this article to assume such roles, there are innumerable ways in which the practicing orthopaedic surgeon can contribute to the improvements in health care through increased participation in the governance of their local hospital or health system.

This overview addresses the issue of physician governance of health systems from three perspectives. First, it is important to elucidate the current shortcomings of the American health system that mandate change; this starting point will define the challenges to be met by contemporary health system governors and hopefully pique the interest of

orthopaedist wanting to become involved in contributing to solutions. The second part of this article examines the role that physicians should play in governing over this change. Finally, for those seeking direction in assuming an expanded role in system governance, strategies for growing into effective participation are outlined.

Search Strategy and Criteria

The PubMed data set was queried applying the search commands “governance AND (healthcare OR hospital) AND (doctor OR physician OR surgeon)” for the time period 1969 to 2012. This resulted in a total of 404 citations. After reviewing abstracts and content, a total of 19 citations were included in this review. The bibliographies of relevant governance articles were reviewed generating an additional five references for the governance section. The references supporting the sections on healthcare economics and physician education were identified through targeted queries using standard search engines.

Several points are important in defining the scope of this review. The first is the use of the term “healthcare governance” in contrast to “hospital governance.” It is becoming increasingly evident that focus on acute episodes of care will be deemphasized in future models of health care with increasing attention being paid to community health and the avoidance of hospitalization. In this context, hospitals will increasingly be thought of as components of a system alongside preventive programs, chronic disease surveillance, and postacute care facilities. The second important defining point is the distinction between the role of management and the role of governance. Although both activities are critical to the operations of a healthcare system, the roles and responsibilities of governors and managers are quite different. Managers in an organization are responsible for the daily operations. In contrast, those in governance envision the future, create strategies, respond to shifting markets, and design systems that improve the health of communities. Everyone who has run a private practice has experience in management. This is a complex and challenging topic but will not be the focus of this review. Lastly, although the focus of this review is on how the orthopaedist may become involved in hospital governance, many of the concepts apply to the broader group of physicians. This differentiation is highlighted in the article by using the general or specific descriptor as appropriate.

The Need for Change in American Health Care

The first topic to be considered is “why now?” Modern hospitals have run for decades with nonphysician

administrators providing environments for orthopaedists to perform surgeries and admit patients. Although this is what we know, powerful forces are at play that portend drastic changes in our current delivery model. The first of these enigmas is inconsistent quality. In the Institute of Medicine's 1999 report [27], “To Err Is Human,” it was pointed out that tens of thousands of Americans incur avoidable deaths each year from errors inside our hospital system. As an orthopaedic example, despite attempts to improve the reported rate of appropriate bone density therapy in patients sustaining proximal femoral fracture, there continue to be large numbers of undertreated patients [34]. Both patients and payers are appropriately making demands for health systems to improve their transparency and performance with regard to these measures [6].

The second driver of change is the economy. The US public debt continues to rise and is now in excess of USD 16.4 trillion [44]. Federal healthcare spending for Medicare and Medicaid make up 29% of this total and are forecasted to rise [23]. In total, healthcare spending in the United States currently consumes one-sixth of the entire economy [43] with the demographics of an aging population promising further escalation [40]. The Patient Protection and Affordable Care Act of 2010 expanded coverage of the uninsured and increased regulations on the health insurance industry but is projected to increase rather than decrease overall costs [7, 11, 25]. The trend of continuous cost escalation in health care cannot be borne by any combination of employers, patients, and government.

In the midst of this environment of certain change, three choices are available to the orthopaedist: resisting change as long as possible, passively accepting the changes that are dictated by others, or proactively defining models of quality musculoskeletal care. The first option is imprudent, because it clings to a failed model. The second runs the risk of orthopaedics being sidelined in critical debates that would threaten quality musculoskeletal care and its role as an integral and valued part of the healthcare system. The clear and compelling, appropriate response would be for members of the orthopaedic profession to become actively engaged in the third option.

If one accepts the challenge of becoming a positive influence in the design of healthcare's future, there are several avenues in which this can be pursued. One of these avenues would be involvement in the political process. Orthopaedists enjoy one of the largest medical political action committees in the United States and are benefitted by a highly effective, professional society in the American Academy of Orthopaedic Surgeons (AAOS). Although this avenue is critically important and deserves our attention, the US Congress cannot be relied on to solve this problem because of the partisan gridlock that has characterized their activities in recent years. Increasingly, health systems are

turning to their governors as architects of the necessary transformation [9, 16].

The Role for Physicians in Governance

Evidence of this change can already be found in the hospital employment of physicians [24]. Currently, more than half of the physicians in the United States are employed by integrated systems or hospitals [27]. Members of the AAOS have doubled the percentage of their ranks that are hospital-employed from 4% in 2000 to 8% in 2010 [31]; this trend appears to be continuing. A September 2010 survey of hospital administrators revealed that 74% planned to increase physician employment within the next 12 to 36 months [10]. Healthcare policy and reimbursement trends are driving this alignment. The advent of accountable care organizations, the demonstration projects involving bundled payments, and the inclusion of quality, safety, and satisfaction-performance metrics into reimbursement rates are all attempting to promote increasing degrees of physician-hospital cooperation [5, 30]. As the migration toward system employment continues, the profession must be proactive in avoiding the role of employed labor and actively seek positions of shared governance. Although the lure of salary stabilization and relief of regulatory burden are real, they must be balanced against the potential adverse consequences of lost autonomy if the role of system governance is left completely relegated to others [15, 37].

Throughout history, unfettered growth with reliance on a central government has failed the constituency. The Roman, British, and Soviet empires all succumbed to poor decision-making that stemmed from overreliance on a removed central government. Similar lessons can be learned from the physician practice acquisitions of the 1990s [17]. These predominantly failed because of the lack of shared goals and values [13]. A classic example of them was exemplified by St Johns Clinic in southwest Missouri [17]. By 1995 the Regional Hospital System had employed 280 physicians. Despite being highly successful at this employment strategy, financial performance, patient satisfaction, and physician morale remained at unacceptably low levels. In 1999, a plan for drastic reorganization was created focusing largely on system integration and physician governance. Once this structural change had taken place, production, salaries, and quality metrics all showed substantial rise. Most notably the St Johns Clinic showed a rapid and dramatic improvement in patient satisfaction being ranked as having the highest rating of clinics with over 100 providers by the Press Ganey Corporation in 2004 [1]. The lessons learned from such turnarounds suggest that physicians do not maximally contribute to health system

goals in the absence of explicit alignment models [4, 22, 32, 36]. As the employed model makes a resurgence, a number of strategies are being pursued that attempt to strike this balance. These include comanagement of orthopaedic service lines, joint ventures, clinical integration, and bundled payment agreements [33]. Each of these new relationship structures can be effective in aligning the mission of hospitals and orthopaedic providers. Depending on contract structure and incentives, these models have proven effective in increasing the awareness and engagement of physicians in important hospital metrics including cost and quality [4, 15, 16, 20]. The move to value-based reimbursements, payment denials for complications, and readmission-reduction initiatives have prompted a change in focus within organizations that previously thought exclusively about volume with little focus on quality. In aggregate, these proposed penalties would total 10% of Medicare payments to hospitals by 2016 [12]. Given the narrow margins typical of hospital business units, this loss cannot be absorbed, meaning that all hospitals that wish to remain open will require a focus on quality. Although orthopaedic hospital partnerships such as these provide the orthopaedist with valuable exposure to hospital operations, the essential elements of governance such as visioning and strategy are typically restricted to the musculoskeletal service line. This may lead to a program of orthopaedic excellence; however, from a hospital's perspective, this creates a patchwork of alignment strategies, model designs, and differing incentives. More importantly, the narrowed focus on orthopaedic programs limits opportunity for interdepartmental innovation [36]. Some examples of lost opportunities would include developing fracture care guidelines in conjunction with primary care, comanagement programs for osteoporotic fractures, treatment algorithms for arthritis management, and the opportunity to offer bundled payment contracts. Although the aforementioned models do have the potential to achieve these goals within orthopaedics, they miss the opportunity to integrate quality orthopaedic care into the global healthcare system.

The Joint Commission on Accreditation of Healthcare Organizations also recognizes the patient benefit derived from a system governance structure that extends beyond individual departments. They distinguish three distinct entities that contribute to the governance of a hospital: the governing body, the senior managers, and the medical staff. By Joint Commission regulation, an accredited hospital's governance plan must articulate the specific role played by each of these entities [2]. When looking beyond the confines of orthopaedics, active participation within the medical staff group, or more likely, its executive committee is a readily available venue to begin participation. The Joint Commission further specifies that the medical staff is comprised solely of independent licensed

practitioners, is self-governing, and is responsible for the “quality of care, treatment and services” provided by the medical staff [38]. It is in these settings where orthopaedic leaders often gain their first insight into the complexities of hospital operations [21]. Topics such as quality, safety, regulatory compliance, and human resources require thought well beyond the confines of orthopaedics and provide the unique perspective of problem solving within groups of diverse background and experience. Specific examples of common topics addressed by medical staff committees would include performance metrics on core measures, HCAHPS scores (Hospital Consumer Assessment of Healthcare Providers and Systems; www.hcahpsonline.org/), and the development of policy and procedures specific to the medical staff.

The second leadership group defined by Joint Commission is the executive team. Conceivably, an orthopaedist could gain access to this leadership group through appointment as the chief medical officer. This position by requirement is an independent licensed provider who is responsible for medical practice. Depending on the size and complexity of the organization, this position may be filled by a physician with substantial administrative education and experience. A more focused and detailed problem-solving administrative experience can be found within the multiple committees that support these objectives and include quality and safety, peer review, ethics, utilization review, and credentialing. Because these present stepping stones toward an increased role in governance, they will be more fully described in the subsequent section.

Sitting atop the administrative branch of hospital governance is the chief executive officer. Despite the theoretic advantage of physicians serving in this role, this is decidedly uncommon. Of the 6500 hospitals in the United States, only 235 are led by physicians [20]. Despite its rarity, there is some evidence that hospitals with physicians as CEO receive higher quality rankings. Using the methodology of the *US News & World Report*, Goodall compared the top 100 hospitals in cancer, digestive disorders, and cardiac disease [18]. She highlighted statistically higher rankings of those hospitals with physicians as CEO when compared with those with nonphysician CEOs. Although a cause-and-effect association was not proven, it does introduce a concept worthy of further study.

The pinnacle of health system governance comes through participation in the governing body. The role of physicians on healthcare system boards has long been an enigma. On the positive side, the medical training and expertise of a physician brings obvious value to board discussions. The concern over physician participation has been the potential for conflict of interest [4, 26, 32]. Physicians have often been involved in competing interests

such as other hospitals, surgery centers, or imaging sites. Even when these direct financial conflicts did not exist, the potential to bring undue influence in executive compensation, project approval, or capital allocation presents challenges [19]. A common example of this potential conflict would be the governing body's responsibility to hire and determine compensation for the CEO. Distinct potential for conflict of interest exists when the CEO can benefit a physician board member through program investment and the board member can benefit the CEO through compensation. Conflicts of these types must be identified through comprehensive reporting of potential conflicts and conflict management [4]. In this particular case, CEO salary determination should be delegated to a compensation committee comprised of individuals absent of such conflicts.

Despite these potential drawbacks, incorporating the insight of fully aligned physicians into a board's portfolio of expertise is imperative if healthcare redesign is to be successful. The Joint Commission actually encourages medical staff representation on hospital boards by calling for the “opportunity to participate in governance” and “to be represented at governing body meetings by one or more of its members” [2]. Although voting membership is not required, hospital systems are responding and increasingly expanding the expertise of their boards by inclusion of carefully selected physician board members [19]. As physician and physician group employment models proliferate, one specific example where physician input can be valuable is in the construction of physician compensation models. Historically, these models were simply production-based. As health care appropriately evolves toward increasing focus on quality and population health, with a commensurate decrease in the emphasis on production, these objectives should be thoughtfully incorporated into compensation models. The work inherent to being on-call, serving as medical directors, and practicing evidenced based quality care can only be fully appreciated by those in the profession. This insight makes physicians a critical participant in the complex determination of the compensation packages of fellow physicians. Being a part of the board of directors of a healthcare system is an exciting opportunity to take acquired medical insights, developed in practice, and sagely uses available resources to serve the public need. It is an opportunity to exponentially expand spheres of influence in the quest to serve patients. Stimulating aspects of board service is the breadth of responsibility. This stretches from the development of an explicit strategic plan, procuring the necessary financial resources to execute this plan, providing oversight in financial and medical performance, and providing for the ongoing development of the next generation of physician leadership.

Physician Strategies for Growing into Healthcare Governance

Although it is becoming increasingly clear that physicians bring value to the governance of health systems, it is difficult for a physician to make the decision to direct his or her time and effort toward such a pursuit. The disturbing paradox is that those physicians who have much to contribute to system design, cultural cultivation, and strategic planning are also the physicians recognized by their peers as the consummate providers of clinical service. As a starting point, a productive physician has to assure him- or herself that participation in a governance role is a high enough priority to make the necessary investment of time and sacrifices to clinical medicine. The next check is to take an honest assessment of one's skills and assure that they are compatible with a successful role in governance. Given the complexity of the task, the successful physician governor has to possess a strong record of teamwork, communication, budgeting, and strategic planning [8]. If both the commitment and talent exist, then governance goals can be laid out and pursued.

Within a large healthcare system, it is unlikely that an orthopaedist will find him- or herself elected as chairman of a hospital board or in a position of financial responsibility without "paying the dues," working up through the "farm league" of hospital governance. Traditionally, a common pathway to interaction has been for the leader of an orthopaedic group to serve as the negotiator for a hospital affiliation contract. Although often involving incentive creation and substantial amounts of cash flow, these contracts fall more heavily into the arena of management with emphasis on the skills of accounting, productivity expectations, and compensation. Gaining respect and authority as a governor must be earned from both those that grant it as well as from those over whom the governing is exercised. Building of this trust typically begins with successful hospital committee participation. Hospitals have regulatory requirements for a number of committees that are frequently recruiting engaged physicians for their perspectives and contributions. Committees such as the credentialing, risk management, infection control, utilization review, academic affairs, and quality committees are opportunities through which one may apply his or her interests and skills in hospital governance while demonstrating mission-focused, system leadership thinking. Given the relative rarity of physicians who demonstrate these system focused attributes, expressing them will be quickly noticed placing those that demonstrate them on the short list for increasing levels of responsibility. Because these are important stepping stones in the path toward system governance, the opportunities for physicians within three important committees—credentialing, risk management, and quality—will be briefly discussed.

The purpose of the credentials and privileges committee is to review the credentials of providers applying for initial appointments or reappointments to the medical staff. This committee is typically an excellent opportunity to work collaboratively with physicians of other specialties and to cultivate a medical staff of well-trained physicians. The public, without medical knowledge, counts on this committee to restrict privileges to those who have demonstrated competency. Beyond the verification of training that accompanies initial appointment, this committee also brings an opportunity to create a culture of professional behavior by actively reviewing any concerns for unprofessional behavior in the recredentialing process [14]. The reputation of a hospital is the sum of the professional behavior of its staff. Defining the acceptable standards and having the fortitude to remove those that fall short is the most efficient path to excellence.

Regardless of the level of quality performance, all healthcare systems will find themselves as defendants of malpractice claims. Responsible healthcare systems will use all suits, claims, sentinel events, and instances of potential harm to review policies and procedures with the ultimate goal of continuously improving patient safety. Realizing this goal requires active participation by physicians from diverse backgrounds to provide insight expertise and recommendations. As a specific example of this process driving effective change, a case of wrong site surgery was recently investigated at our institution. Root cause analysis revealed that in this spinal operation involving multiple surgeons, an appropriate "time-out" procedure was performed with the initiating surgeon but was not repeated as a subsequent surgeon assumed responsibility. This analysis led to the process improvement of requiring repeat "time-out" during such transitions of care, which will hopefully prevent future similar errors. An additional benefit of committee participation is the ongoing education in hospital law, which will provide valuable experience in any future governance endeavor.

Since the revelations of the 1999 Institute of Medicine report on hospital safety [27], there has been no sector of activity within hospital systems that has grown faster than the quality and safety initiatives. This is driven by physician response to data showing opportunity for improvement in addition to regulators and payers making a dramatic shift toward paying for metric performance. In a followup publication, "Crossing the Quality Chasm" [6], the Institute of Medicine provided a blueprint for improving the processes that have the potential to lead to consistent quality in care delivery. It is clear that achieving the goals of superior outcomes with high levels of safety will require cultural change. This change cannot be realized without physicians in roles who define quality and establish quality metrics. This shift will require increasing reliance on

teams, checklists, and enforcement of standard evidence-based order sets; these are all initiatives that will require strong leadership for successful implementation [35].

Given the breadth of committee opportunities that exists in hospital systems, it should not be difficult to become involved in one of these committees. Given the proactive mindset of most orthopaedists, it should also not be difficult to bring influence, creativity, and energy to these groups and demonstrate effectiveness in creating a better healthcare system. It should be emphasized that performance in a system governance role is not defined by what benefit comes to the orthopaedic department but rather the value of contribution to the system. Although an individual's value to a governance body includes their specialty content knowledge, governors must possess the ability to separate advocacy for their specialties to a mindset of system benefit. Successful organizations are adept at identifying governance talent and providing opportunities for continued growth and development. Depending on local governance structure and bylaws, this may take the form of committee chairmanship, placement on important ad hoc projects, or, ultimately, election to the system's board of directors.

Classic medical education does little to prepare one for the work of governance. Physicians are taught to be individuals who interact with single patients in the diagnoses and treatments of diseases. The required skills of effective governors include drawing conclusions from ambiguous data points and working within broad teams and coalitions to create and disseminate strategies. These are skills that some come by naturally, and many physician governors are phenomenally successful in their roles without additional formal training [28]. In the vast majority of governance environments, contributions will be those of one who brings the insight and perspective of a care provider. Other professionals will be available with their skills in strategy, finance, revenue cycle, and law to provide necessary content knowledge.

With that proviso, a surgeon's value to a committee or board can be enhanced with focused educational effort directed at improving business acumen. The shortest path to expanded knowledge might be the reading of business primers such as "The Ten Day MBA" [39] or "The Physician's Essential MBA" [41]. Although lacking the depth of explanation that more formal educations would provide, both of these texts provide useful definitions and concepts.

More detailed, topic-specific learning can conveniently be obtained through web-based courses offered by The American College of Physician Executives [3]. Specifically designed for physicians wanting to deepen their knowledge in focused areas, this resource offers a convenient way to fill in perceived gaps in virtually all areas of interest to a physician governor. If a focused path of education is

chosen, the subjects within a Master's in Business Administration (MBA) curriculum that have the most relevance to a physician board member would be marketing, ethics, organizational behavior, economics, and strategy. For those deeply interested in expanding their business knowledge, consideration may be given to pursuing an MBA. There are many variations of this degree, several offering a healthcare focus with varying degrees of site and/or distance learning.

Options are many when an MBA is pursued. The most extensive option would be the traditional 2-year program, offered by most universities requiring full-time commitments. Short of that, most schools also offer executive MBA options with classes in the evening, weekends, or through distance learning. Even more condensed, many university business schools have a 9-month "Executive Management" program that usually meets once a week for 3 hours and covers the essentials.

Unlike our nonphysician colleagues, it is unlikely that the addition of CPE or MBA initials behind your name is likely to increase your salary. There are clearly business skills that can be acquired, lexicons that can be mastered, and valuable contacts that can be made, particularly if pursuing a full transition from clinical medicine to administration. In the end, however, professional reputation and organizational value stem from one's contributions, and not one's certificates.

Discussion

Historically, physicians have not been fully involved in healthcare governance either because of perceived potential for conflict of interest or focus on patient care. These concerns are being revisited as health systems begin to appreciate the value presented by physician leaders. This review addresses three major issues related to the orthopaedist's role in healthcare governance: the first is to identify the need for change in American health care, the second to examine the role that physicians should play in governing over this inevitable change, and the third to outline strategies for effective participation for those physicians wishing to play a role in healthcare governance.

Although the preponderance of contemporary writing suggests physicians have a large role to play in the governance of health systems, there are potential limitations of this review. The principal one is that the body of literature recommending physician involvement is derived primarily from anecdotal experience and subjective opinion. Evidence-based management science from within health care is sorely lacking. Second, the leadership structure between hospitals varies dramatically between organizations. With the inconsistencies in the relative power and influence of

the governing body, executives, and medical staff, direct translation of practical recommendations from institution to institution is subject to error.

Notwithstanding these limitations, it appears physicians should become increasingly involved in the governance of health systems. Economic realities dictate that we are fast approaching an era in which resources available to apply to health care are becoming scarce. On this background of limited means, we must introduce innovation that improves the quality and safety of our care. Creating this innovation and making accurate judgment about the allocation of scarce resources can only be made with the collaborative involvement of physicians in governance teams.

With nearly half of Americans over the age of 18 years being affected with a musculoskeletal condition [42], it would be prudent for healthcare systems looking to expand the involvement of physicians in their governance structure to include orthopaedists. Incumbent on those seeking physician guidance and leadership is the facilitation of a path toward meaningful involvement. Formal and informal development programs for physician leaders will lead to greater engagement, more consistent communication, and, ultimately, healthcare systems that function in a much more integrated fashion [29].

For the orthopaedist with interest and talent, contributions toward governance can be as limited as participation in a peer review committee to as consuming as assuming the role of chief executive officer. To be successful at any point along this continuum, the participating orthopaedist has to not only bring his content knowledge of musculoskeletal conditions, but make governance decisions with the best interest of patients and a sustainable healthcare system in mind. For the sake of protecting quality musculoskeletal care, it is imperative that some American orthopaedists actively participate by moving beyond the parochial concerns of bone and joint care and lend their expertise to the larger task of designing healthcare systems through a commitment to increasing one's experience and skill as a governor.

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