The Representation of Health Professionals on Governing Boards of Health Care Organizations in New York City

Diana J. Mason, David Keepnews,
Jessica Holmberg, and Ellen Murray

ABSTRACT *The Representation of Health Professionals on Governing Boards of Health Care Organizations in New York City. The heightened importance of processes and outcomes of care—including their impact on health care organizations' (HCOs) financial health—translate into greater accountability for clinical performance on the part of HCO leaders, including their boards, during an era of health care reform. Quality and safety of care are now fiduciary responsibilities of HCO board members. The participation of health professionals on HCO governing bodies may be an asset to HCO governing boards because of their deep knowledge of clinical problems, best practices, quality indicators, and other issues related to the safety and quality of care. And yet, the sparse data that exist indicate that physicians comprise more than 20 % of the governing board members of hospitals while less than 5 % are nurses and no data exist on other health professionals. The purpose of this two-phased study is to examine health professionals' representations on HCOs—specifically hospitals, home care agencies, nursing homes, and federally qualified health centers—in New York City. Through a survey of these organizations, phase 1 of the study found that 93 % of hospitals had physicians on their governing boards, compared with 26 % with nurses, 7 % with dentists, and 4 % with social workers or psychologists. The overrepresentation of physicians declined with the other HCOs. Only 38 % of home care agencies had physicians on their governing boards, 29 % had nurses, and 24 % had social workers. Phase 2 focused on the barriers to the appointment of health professionals to governing boards of HCOs and the strategies to address these barriers. Sixteen health care leaders in the region were interviewed in this qualitative study. Barriers included invisibility of health professionals other than physicians; concerns about “special interests”; lack of financial resources for donations to the organization; and lack of knowledge and skills with regard to board governance, especially financial matters. Strategies included developing an infrastructure for preparing and getting appointed various health professionals, mentoring, and developing a personal plan of action for appointments.*

KEYWORDS *Governing boards, Health care organizations, Health professionals, New York City, Physicians, Nurses*

Mason is with the Center for Health Media and Policy, Hunter College, City University of New York, New York, NY 10010, USA; Keepnews is with the Hunter College and City University of New York Graduate Center, New York, NY 10010, USA; Holmberg is with the New York University Langone Medical Center, New York, NY 10010, USA; Murray is with the Roosevelt House Public Policy Institute, Hunter College, New York, NY 10010, USA.

Correspondence: Diana J. Mason, Center for Health Media and Policy, Hunter College, City University of New York, 425 E. 25th Street, Box 837, New York, NY 10010, USA. (E-mail: diana.mason@hunter.cuny.edu)

Hospitals and other health care organizations (HCOs) face a broad range of challenges in meeting heightened expectations for quality care while also negotiating rapidly changing fiscal environments. Implementation of the Affordable Care Act (ACA) has solidified trends toward public disclosure of quality performance data and linking clinical performance to reimbursement.¹ The ACA has also accelerated the adoption of models that depend on interprofessional approaches to providing care, especially for patients with chronic conditions.²

Hospital governing bodies are invested with ultimate accountability for the safety and quality of care.^{3,4} Federally qualified health centers (FQHCs) and FQHC “Look-Alikes”^{*} must be governed by a board of directors that includes a majority of active, registered clients of the center who are representative of the populations it serves (42 U.S. Code § 254b). Not-for-profit nursing homes and home care agencies are also overseen by boards of directors.[†]

The heightened importance of processes and outcomes of care—including their impact on HCO’s financial health—translate into greater accountability for clinical performance on the part of HCO leaders, including their boards. In fact, as Callender et al.⁵ argue, quality and safety of care are now fiduciary responsibilities of HCO board members.

Accordingly, the participation of health professionals on HCO governing bodies has drawn some attention in recent years. These bodies may be well served by members who bring knowledge of clinical problems, best practices, quality indicators, and other issues related to the safety and quality of care provided by the organization.

In 2007, a Blue Ribbon Panel on Health Care Governance convened by the American Hospital Association’s 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.”⁶

Available data indicate that many hospital boards include physicians while many fewer include nurses. In a study of 123 nonprofit community health systems (defined as nonprofit healthcare organizations that operate two or more hospitals in a geographic area under a single, system-level board of directors), Prybil et al.⁷ found that physicians accounted for 22.6 % of these systems’ board members while 2.3 % of board members were nurses. This study and others have not addressed the presence of other health professionals.

Prybil et al.⁸ made a case for including nurses on boards: “Engaging leaders in the nursing profession on hospital and health system boards has not yet become the norm, nor has it been accepted as a benchmark of good governance. However, given the importance of nursing in the provision of patient care, it seems likely that the idea of engaging nurses on boards and board committees will receive growing consideration in the future.” The authors went on to quote health care quality pioneer Donald Berwick: “It is key that nurses be as involved as physicians, and I think boards should understand that the performance of the organization depends as much on the well-being, engagement, and capabilities of nursing and nurse leaders, as it does on physicians.”

Others have also advocated for including nurses on HCO governing bodies. The Institute of Medicine, in its 2011 report on *The Future of Nursing: Leading Change*,

^{*} An FQHC Look-Alike is a center that meets the eligibility requirements for an FQHC but does not receive grant funding under Section 330 of the Public Health Service Act. Nonetheless, it can receive the same federal benefits as FQHCs, such as cost-based reimbursement by Medicare.

[†] HCO governing bodies may be known as boards of trustees, boards of directors, or by other names. For purposes of this article, they will be referred to simply as “boards.”

Advancing Health, called for nurses to be represented at all decision-making tables.⁹ The IOM report noted: “The growing attention of hospital boards to quality and safety issues reflects the increased visibility of these issues in recent years ... This is one area ... in which nurse board members can have a significant impact.”

Much emphasis has been placed on increasing the numbers of nurses on HCO boards, but arguments could be made that other non-physician health professionals (including social workers, dentists, nutritionists, psychologists, and pharmacists) may provide important clinical perspectives in specific areas that can enhance HCOs’ efforts to improve quality and safety.

INTRODUCTION

Most of the literature on health professionals’ participation on HCO boards focuses on national-level issues and data. In the present study, we focus specifically on New York City (NYC). We believe that a lack of local- or regional-level studies of health professionals on HCO boards is an important gap. Health care markets differ considerably from one another in terms of populations served, mix of not-for-profit and for-profit organizations, bed-to-population ratios, numbers and influence of academic medical centers, and many other factors.

NYC is a national center for health care education and practice. It includes a diverse mix of health care institutions and systems, including world-renowned academic medical centers and the nation’s largest network of municipal hospitals and clinics, known as the NYC Health and Hospitals Corporation (HHC). There are no for-profit acute-care hospitals in NYC, but both non-profit and for-profit home care agencies and nursing homes operate in the city, along with FQHCs and “Look-Alikes.”

The city’s health systems are faced with a multitude of health, social and economic challenges. In recent years, several local hospitals have closed. Some of these closures were planned—reflecting recommendations by the state’s Commission on Health Care Facilities in the twenty-first century, popularly known as the Berger Commission¹⁰—while several others were unplanned, resulting largely from ongoing financial problems. Some hospitals have been absorbed by larger health systems. In 2010, for example, Lenox Hill Hospital on Manhattan’s Upper East Side—which had functioned as an independent hospital for over a century—became part of the North Shore-LIJ Health System. The city’s HCOs—particularly HHC hospitals—serve large numbers of uninsured, many of whom are undocumented immigrants who will remain uninsured even after the implementation of the ACA. All of NYC’s HCOs will be affected by the state’s evolving plans to redesign its Medicaid program with the aim of reducing costs.

In examining the participation of health professionals on governing bodies of HCOs in NYC, we posed the following questions:

1. Are health care professionals represented on governing bodies of HCOs (hospitals, nursing homes, home care agencies, and FQHCs) in NYC?
2. What are the barriers to health professionals’ being appointed to these bodies?
3. What are strategies that can address these barriers?

METHODS

This study was conducted in two phases. In “Phase 1,” we surveyed HCOs in NYC to determine which, if any, health care professionals were represented on governing

boards. “Phase 2” entailed interviews of local health care leaders to identify barriers that exist to appointment of nurses and other health care professionals and what strategies could be used to reduce those barriers.

The study was developed in collaboration with the New York Academy of Medicine (NYAM), a multidisciplinary organization with a history of leadership in health care and public health with a particular focus on urban health and NYC. (NYAM’s membership includes over 2,000 Fellows from a range of health care disciplines; two of this paper’s authors, DM and DK, are Fellows; a third author, JH, is a NYAM member). The study protocol was approved by the Institutional Review Boards of both Hunter College and NYAM.

Phase 1

As described below, we used a variety of methods—Web searches, electronic and mailed surveys, telephone calls, and secondary analysis of available data—to ascertain the composition of governing boards of HCOs in NYC.

Hospitals. At the time of the study, the New York State (NYS) Hospital Profile website maintained by the Department of Health (DOH) (<http://hospitals.nyhealth.gov/>) listed 60 hospitals in NYC. When one board oversaw two or more hospitals, it was included in our study only once. We also excluded hospitals on the list that had closed or that were small specialty hospitals. A total of 32 hospital/health system boards were included in the final sample.

Information on board composition was initially obtained from hospital and health system websites. These sites identified physicians with the “MD” credential but often failed to include credentials for other members who were health professionals. We contacted each hospital or system’s executive administrative office by phone and e-mail to verify information on their websites and/or to request missing information about board members.

Nursing Home and Care Centers. A list of Nursing Home and Care Centers was obtained from the NYS DOH Nursing Home Profile website (<http://nursinghomes.nyhealth.gov/>). From a list of 159, every fourth (selected from a table of random numbers) nursing home was selected until 50 were identified for phone interviews. However, personnel at many of these nursing homes declined to provide information, so we mailed each nursing home survey along with a cover letter and a stamped, return envelope. One was “returned-to-sender” and 24 responded, for a 49 % response rate.

FQHCs. A list of FQHC’s and Look-Alikes was obtained through the Community Health Care Association of NYS. After eliminating out-of-date entries and those located outside of NYC, 35 FQHCs and Look-Alikes remained and were mailed a survey and cover letter; 7 were “returned-to-sender” and 15 responded, producing a 54 % response rate.

Home Care Agencies. We conducted a secondary analysis of data that had been obtained by the Home Care Association of NYS (HCANYS) through an electronic survey of the state’s home care agencies. HCANYS has 191 member agencies, 58 of whom are located in one of the five NYC boroughs. Twenty-two of the NYC agencies responded to the survey, for a 38 % response rate.

Phase 2

We sought to understand the perceptions of health care leaders in NYC regarding the participation of health professionals on HCO boards. In collaboration with NYAM’s president, we created a matrix of potential participants to ensure that we were getting perspectives from leaders of local health-related foundations; health professional and industry groups; CEOs, CNOs, and board members of local HCOs; and government officials. We interviewed a total of 16 participants, at which point we determined that we had reached saturation of the data.¹¹

Potential participants were invited via an e-mail that explained the purpose and nature of the study. Participants completed and returned an informed consent form that included consent to be audio-recorded and transcribed without their names included.

The transcribed interviews were analyzed using conventional content analysis techniques.¹² Each member of the research team read each interview transcript twice; on the second reading, they highlighted words and phrases that they believed captured key concepts. Team members recorded their impressions, thoughts, and initial analyses, including any labels that emerged as suitable for categories when clustering words and phrases. The team then met to share these analyses, identify commonalities and divergences, and reach consensus on key themes, concepts, and phrases. An independent researcher reviewed the transcripts to validate the themes and concepts identified by the team.

RESULTS

Phase 1

Hospitals. Of the 32 hospitals with distinct boards, 29 (91 %) included at least one MD. Table 1 shows that 24 included two or more MDs and one included 12; 25 % included one or two RNs. Few included other health professionals.

Nursing Homes. Of the 24 respondents, 7 (29 %) were affiliated with a medical center or hospital system, and 20 (83 %) reported having a board of directors or advisors. Of these 20 with boards, 15 (75 %) indicated that they were not for profit. As shown in Table 2, 11 (55 %) of the 20 respondents reported having a physician on their board. Seven (64 %) of these 11 had two MDs on their board. Six (30 %) reported having a nurse on their board; one nonprofit nursing home had two. Five (25 %) had a social worker; one had a psychologist; and one had a dentist. Seven

TABLE 1 Health professionals on governing boards of hospitals in NYC (n=27)

	Physician	Nurse	Social worker	Psychologist	Dentist	Other ^a
Maximum number on 1 board	12	2	1	1	1	0
Total number of boards with representation (n (%))	25 (93 %)	7 (26 %)	1 (4 %)	1 (4 %)	2 (7 %)	0

^aBecause the survey of hospitals included phone calls to verify the type of health professionals included on their boards, the category of “other” was not included. No pharmacists were included on these boards

TABLE 2 Health professionals on governing boards of nursing homes in NYC (n=20)^a

	Physician	Nurse	Social worker	Psychologist	Dentist	Other ^b
Maximum number on 1 board	2	2	2	1	1	4
Total number of boards with representation (n (%))	11 (55 %)	6 (30 %)	5 (25 %)	1 (5 %)	1 (5 %)	7 (35 %)

^aTable includes only the 20 of the 24 responding nursing homes that have a board of directors or advisers
^bExamples of “Other” included: radiologist, nursing home administrator, JD, Ph.D., and financial analysts

respondents indicated that they had other health professionals, identifying them as a radiologist, a “Ph.D.,” lawyers and “MBA.” One might assume that these last three also had a background in health care.

FQHCs. Six (40 %) of the 15 respondents confirmed affiliations with a medical center, and all but two confirmed having a board of directors or advisors (the two exceptions did not respond to this survey question). As noted in Table 3, 8 (53 %) of these 15 respondents reported having physicians on their board, with the maximum number of physicians on a single board being two. Six (40 %) had social workers; two (13 %) of these had two on their boards and four FQHCs had two. Five (33 %) had nurses on their boards; three had one RN, one had two RNs, and one had three RNs. None had psychologists and only 2 (13 %) had a dentist on their boards. Five (33 %) reported having other health professionals. These professionals ranged from community activists to a hospital senior vice president to government employees. Since 51 % of the governing boards of FQHCs must be community representatives, it is unknown how many of these health professionals are holding community seats.

Home Care Agencies. Of the 22 NYC home care agencies responding to the online survey, 14 (64 %) are nonprofit and 7 (32 %) are for profit. One respondent provided no additional information, so the percentages reported here are based upon the 21 surveys that were complete. As shown in Table 4, eight (38 %) had one or two MDs on their boards; six (29 %) had one to four RNs; five (24 %) had one, two or three social workers; three (14 %) had dentists³; and one (5 %) had a psychologist. Three agencies

TABLE 3 Health professionals on governing boards of FQHC’s and look-alikes in NYC (n=15)

	Physician	Nurse	Social worker	Psychologist	Dentist	Other ^a
Maximum number on 1 board	2	3	3	0	1	5
Total number of boards with representation (n (%))	8 (53 %)	5 (33 %)	6 (40 %)	0	2 (13 %)	5 (33 %)

^aThis includes a pharmacist. Other examples included: health administrator, hospital senior vice president, and community activist

TABLE 4 Health professionals on governing boards of home care agencies in NYC (*n*=21)

	Physician	Nurse	Social worker	Psychologist	Dentist	Other ^a
Maximum number on 1 board	2	4	3	1	1	12
Total number of boards with representation (<i>n</i> (%))	8 (38 %)	6 (29 %)	5 (24 %)	1 (5 %)	3 (14 %)	7 (33 %)

^aExamples of “Other” included: “public health” and “nonclinicians with many years of health care experience”

included “other health professionals,” identified as “public health” and “nonclinicians with many years of health care experience.” Two respondents commented that committees (e.g., Quality Improvement Committee) made up of MDs, RNs, and other clinicians made recommendations to the governing board.

Phase 2

Themes were categorized as general (1), barriers (4), or strategies to address the barriers (3).

General Theme 1: Does Including Health Professionals Make a Difference?

Participants voiced a range of opinions on the impact of having health professionals on boards. Several participants, arguing that many HCO boards are ineffective, questioned the importance of including health professionals on these boards. One participant who has served on hospital boards and examined governance issues believed that most CEOs do not want nurses or other health professionals on their boards because these CEOs “don’t want discussions of care, quality or patient safety.” “Boards don’t care about care; they care about research and money,” said another. “You need a critical mass of like-minded trustees to change this.” A few argued that most boards are “rubber stamps” for the plans of the CEO, so that who sits on a board really does not matter.

Many participants noted that board composition and focus vary widely from organization to organization. As one put it, “if you know one board, you know one board.” With one major exception (HHC hospitals, which have a statutorily mandated, system-level board), the type of board an organization had and how it functions were viewed by participants as dependent largely upon the CEO and board chair.

Others argued that the representation of non-employee health professionals on boards is essential for holding the HCO accountable for the quality and safety of care, noting that they can ask important questions and raise critical issues. One who had been a hospital board member believed that board committees are where members hear clinical perspectives. Most participants indicated that having nurses and other health professionals serving on governing boards of HCOs was essential for developing a collaborative model of governance that would help the organization to be more accountable, particularly for the quality of clinical care: “Until you have representation from the people that you’re serving and interact with, you don’t have the opportunity to have governance relating to care and the responsibilities of the institution to the community.” One argued for the inclusion of RNs:

The worldview of nursing differentiates itself from the world view of other health professionals. They're very intersecting and overlapping but the worldview of nursing is about how people live with whatever state of health they happen to be in at any one point ... Nurses meet people where they are, in the social context of where they live, and that worldview, I think, needs to be brought to the policy table because it's a little different from the "interventionist, let me cure" view of some, or the "how do you fit the social system" view of others, or the more specific views of the nutritionists, physical therapist, and so on ... And then there's a practical side of what nurses bring. Nurses—whether it's a survivor skill or taught—know something about how to make things happen. Sometimes they make do by going around things; sometimes they make it happen by doing it through the policy chain. But these sort of practical things can be very helpful on a board.

Barriers to Appointments

The following themes emerged as barriers to health professionals being appointed to governing boards of HCOs.

Barriers Theme 1. Nurses and Other Health Professionals—except for Physicians—Are Often Invisible and So Are Not Considered for Appointment As one participant noted, "I think they're just not thought about." Another believed that "the biggest barrier [to appointing health professionals other than physicians to boards] is that it hasn't historically been done ... and institutions are sort of reluctant to make radical change on such fundamental issues as governance." Several noted that most boards are self-perpetuating and likely to appoint people who are similar to existing trustees and known to them.

Several participants believed that too many people have inaccurate perceptions of contemporary nurses. One observed that "nurses are often seen as the background of the system, not necessarily as leaders." Several felt that the CNO should serve as an *ex officio* or appointed member of the board if the chief medical officer does so. One participant who is a CNO said, "The last thing you want is the principle of having the CEO and president of the medical staff keeping the board informed on the quality of nursing care going on in the institution. What the hell do they know?"

Physicians were viewed as being in another category altogether. "[NYC] is the most medical-centric place I've seen and Manhattan is the worst," noted one participant who is a nurse on the governing board of a hospital.

Barrier Theme 2. Who Is the Health Professional's Constituency? Some participants argued against the notion of boards having specific categories of provider slots to fill, cautioning that health professionals on boards need to represent the interests of the organization as a whole, not just their specific discipline: "It's not enough to just have RN after your name." The prevailing perception was that health professionals are sometimes fixated on their own special interests and may confine their arguments in support of specific positions to their own personal and professional experiences. As one participant said:

It can really kind of drag down the conversation ... it lowers the denominator of the level of the conversation, and it's embarrassing ... to bring somebody with a rather narrow clinical background into these kinds of arenas. They don't know how to behave. They don't know how to get into the conversation.

On the other hand, one participant noted that nurses are assuming leadership roles within their HCOs and this is preparing them to hold a broader view of health care. A couple of participants were concerned that physicians see themselves as speaking for all health professions and might be opposed to other professionals being appointed to governing boards. One nurse said, "It's hard to believe we have so many physician enemies. I don't know what else to call it." Nonetheless, some participants, citing a growing emphasis on interprofessional teams, suggested that boards could benefit from an interprofessional composition.

Most participants believed that it is a conflict of interest for employee health professionals other than those in high-level executive positions to serve on the board. Physicians who were employees of an affiliated medical school were viewed as an exception since they were not directly employed by the hospital. One participant suggested that including employees could bring about a radical, beneficial transformation of the role of a board.

Another participant noted that the "traditional model" of governance had been required by prior hospital accreditation standards and Medicare Conditions of Participation, which included an autonomous, organized medical staff as well as a governing body: "...[T]here really was, historically, a real dual governance model in which the board had the fundamental fiduciary responsibility for the institution. The ... organized [medical] staff ... had areas of real authority over certain aspects of what happened in the institution ... Implicitly or explicitly, there was a model of ... collaborative governance of clinical activities between the board and the medical staff ..."

Barrier Theme 3. "You Have to Give to Get" Most HCOs expect board members to make significant financial contributions. Many health professionals (including most nurses) may lack the resources to do so, which can pose a significant barrier to board membership. Most participants who identified this barrier also emphasized that the importance of having health professionals on boards is their ability to help guide the organization in improving safety and clinical performance, not in fundraising.

Closely related to this, social class arose as a potential barrier, particularly in NYC where some of the wealthiest New Yorkers serve on boards and donate substantial funds. But one nurse participant believed that health professional board members without the same financial standing as other members can build relationships that transcend class. She related her experience of helping some fellow board members by serving as an information resource when family members encountered illness and challenges in navigating the health care system.

Barrier Theme 4. Health Professionals May Lack Needed Knowledge and Skills Participants discussed what they saw as the qualifications a health professional needs in order to be an effective member of a governing board, noting that health professionals may often lack some of these. These qualifications include:

- Prior leadership experience and organizational skills, including the ability to think and plan strategically;
- The ability to be able to articulate a logical, cogent position based on a broad worldview that extends beyond the individual's professional discipline;

- A reputation of being influential and well-regarded by peers;
- A strong commitment to the organization and its mission;
- Strong social and interpersonal skills and the ability to engage with a milieu that includes individuals of higher socioeconomic status;
- A commitment to participate fully in the group's deliberations and a willingness to work (as one participant described it: "Show up and speak up").
- In some cases, affiliations and networks that align with an HCO's specific mission (e.g., for faith-based hospitals);

While most participants believed that knowledge of finances, budgeting, and the ability to examine financial documents is an important qualification, a few disagreed. They argued that some health professionals may lack this knowledge but other board members will have this expertise. The health professionals can be educated about financial and budgetary matters after they are appointed. Further, "The important thing as far as finance goes is it has to be explained to [board members] so they can understand it ... If [the chief financial officer] can't explain it to them, then something's wrong with the chief financial officer.

Some participants believed that staff nurses can provide valuable perspectives, while others insisted that nurses in leadership positions are far more likely to have the sufficient skill set and confidence to fully participate as board members. One participant expressed concern about appointing "token" nurses to boards, noting that no one nurse is likely to meet traditional board expectations, while also bringing needed clinical expertise: "Can you find everything in one nurse?" At the same time, it may be difficult to have multiple nurses appointed to a single board.

Strategies for Addressing Barriers

The participants identified strategies that focused on preparing health professionals for effective service on boards and promoting their appointment to CEOs and board members. As one noted, "It's two sets of issues with professionals. One of them is getting [them] ready to be in these groups, or having experience that allows them to add value...The other issue [is] having institutions network more broadly and consciously to add clinical people to their boards because they can provide clinical expertise, quality expertise.

Strategies Theme 1. A System Is Needed for Training and Promoting Health Professionals for Board Membership Most participants believed that developing or tapping into existing training programs for board service would help to prepare health professionals to meet performance expectations with confidence prior to joining a board. Some participants noted that high-performing boards have ongoing training to keep members current on important issues and relevant developments. A preparatory training program would include basic education in board functions, governance, policy development, and financing. Some participants suggested that health professions education programs should provide substantive content on financing, budgeting, organizational governance, and linking clinical issues to policy development. Such education is important for preparing graduates to practice in today's health care environment but would also provide a foundation for serving on governing boards.

A deliberate, organized approach to prepare nurses and other health professionals and get them appointed to boards would require an infrastructure for monitoring and pursuing such appointments. It would include identifying good candidates,

grooming them, and finding opportunities for appointments. One strategy would be reaching out to current board members with recommendations of health professionals who are qualified for a board appointment. At the same time, an organized effort would include “grooming the expectation” of appointments of nurses and other health professionals among CEOs or trustees: “Somebody has to start talking to the decision makers at the other end, teasing out and finding who are the nominating committee chairs, who is doing the potential screening of board members.” Another participant explained that “It would be great if you [had] some way of saying ‘here’s a hundred nurses who qualify to be board members. Here’s where they live, here’s where they work.’ And [then] go after every hospital board and every CEO and say, we want to get 20 of these people on boards by this year.”

One participant addressed succession planning, noting that it would be crucial for any health professional serving on a governing board to recommend other qualified members of their profession before his or her own appointment ends.

Strategies Theme 2. Mentorship Is Critical There was consensus that mentorship is an important strategy for developing new board members’ knowledge and skills in governance, as well as in paving the way for other appointments. This mentoring was viewed as starting in undergraduate and graduate programs. One participant suggested having health professional graduate students attend board meetings with a health professional who serves on the board as a first step in mentoring.

Several of the participants recommended that people seek out mentors who already serve on boards and especially a mentor who serves on the board on which the person wants an appointment. Seeking out such a mentor ahead of time can facilitate the mentor nominating the person for the appointment. Most participants agreed that nominations from other board members is extremely helpful, underscoring the self-perpetuating nature of many boards. The mentors need not be health professionals; in fact, one participant recommended that people seek out mentors who serve on HCOs’ boards as business leaders or lawyers, for example.

Strategies Theme 3. Each Potential Appointee Needs a Personal Strategy for Developing the Necessary Qualifications and Visibility One nurse participant was emphatic in arguing that nurses needed to seize opportunities to join interdisciplinary groups and community organizations. Another thought it important to be visible as community leaders: “There are certain people who really say, ‘I want to be engaged at this level’ and they start moving [in that direction].” Furthermore, if health professionals want to be viewed as leaders in health care, participants recommended that they speak publicly about governance and policy issues.

DISCUSSION

One limitation of this study is that it may have undercounted the presence of nonphysician health professionals on boards. We encountered incomplete publicly accessible information and were dependent on individuals supplying information that may not always have been reliable. In some cases, particularly with regard to nursing homes, we encountered considerable reluctance to provide this information at all. However, the data we were able to obtain were generally consistent with

national findings in that physicians were well represented, nurses less so, and other professionals were often unrepresented. Notably, nurses were present in greater numbers on boards of HCOs other than hospitals.

Prybil¹³ identified three factors that contribute to nurses' underrepresentation on governing boards of hospitals:

- Gender disparities, as nurses are predominantly women and women continue to be under-represented on governing boards.
- The slow recognition by CEOs and board leaders that nurses are skilled professionals who are central to quality patient care and patient satisfaction.
- The hesitancy of some CEOs and board leaders to appoint employees of their organization to serve on their governing boards.

Concerns about conflicts of interest—whether and when they attach to employees serving on a governing board, and how they may apply differently to physicians than to other professionals—are complex, and will not be addressed at length in this article. We note that such concerns should not be a barrier to appointment of nurse executives to *ex officio* board membership. Of course, HCOs are not limited to appointing employees.

The participants in the interviews identified additional factors, including a lack of visibility of health professionals other than physicians as leaders in health care who are known to the CEO and board leaders. In addition, as some participants noted, nurses and other health care professionals may lack some of the skills needed to be effective board members. However, Holland, Ritvo, and Kovner make the case that a high-performing hospital governing board must be developed.¹⁴ It is not sufficient to have a group of individuals with specific skill sets, and, as noted by several participants in the interviews for the present study, it is uncommon for any one trustee to have all competencies. Individual skills for serving on boards can be developed and strengthened through training programs, mentoring, and experience.

There is an understandable resistance to nurses or other health care professionals being appointed to governing boards if they are there to represent their profession rather than the organization as a whole. But it is nurses' and other professionals' expertise on quality, safety, and processes of care that make them valuable assets to boards. Many nurses hold executive positions in HCOs, lead quality improvement initiatives, are the guardians of patient safety, serve as expert clinicians and researchers across institutional and community-based health care settings, and have deep expertise in the many clinical and systems issues confronting HCOs. Perhaps, as was suggested in qualitative comments to the survey and by the participants interviewed in "Phase 2," it is sufficient to have clinicians on key committees that can make recommendations to the board. But, if so, then why should physicians be on governing boards?

How does one change the tradition and culture of these organizations? Some participants in the interviews suggested that a concerted, organized effort was needed to prepare health care professionals for board service and to get them appointed. In NYC, there are few options outside of unions for nurses to have a collective effort to advocate being at key decision-making tables related to health and health care. The local chapter of the state nurses' association for Manhattan, Bronx, and Staten Island recently closed its operations after over 100 years of existence, and the state nurses association's activities in NYC focus primarily on

representing its collective bargaining members. While specialty organizations for nurses and other health professionals do exist on the local level, they are underfunded and fragmented.

The following recommendations are derived from a synthesis of the data, the themes, and the authors' deliberations on the issues. They suggest ways to correct the imbalance of health professionals' representation on governing boards of HCOs:

1. *Aim beyond tokenism.* An assumption of this study is that health professionals can bring important expertise to the deliberations of boards and advisory bodies. It is not a matter of quotas or checklists. One nurse may bring an important safety perspective to deliberations, while another may be an expert in staff satisfaction. Similarly, a psychologist will bring a perspective that is likely to be different from that of a dentist or nurse. We need to rethink board composition in ways that will help organizations to improve the safety, efficiency and outcomes of care within fiscal constraints.
2. *Develop health professionals' knowledge and competencies in governance and health policy.* Health professional educational programs should examine the extent to which they are preparing graduates who are able to articulate the broader implications of the clinical problems and solutions they encounter. This competency is essential for appointments to governing board. For clinicians, continuing education courses can develop professionals' knowledge and skill in governance issues, legal and ethical matters, and of financial affairs.
3. *Diverse health professions should collaborate in developing a local infrastructure for identifying opportunities for appointments and a strategy for promoting various professionals for these positions.* This includes meeting with the local hospital association, CEOs of select HCOs, and leading trustees to garner their support of appointments of diverse health professionals based upon the needs of specific HCOs.
4. *Conduct a comparative analysis of governing boards with and without substantial numbers of members who are health professionals.* A fundamental theme of the interviewees and premise of the authors is that health care professionals other than physicians (who are already well represented) will strengthen the effectiveness of a governing board in improving the quality and safety of an organization without compromising its fiscal status, but this remains to be tested.

As the USA focuses on reforming its health care system to improve the quality, safety and cost of care, the governance of HCOs must be critically examined¹⁵ Including more health professionals on HCO boards may provide significant gains for the organizations the people they serve.

ACKNOWLEDGEMENTS

We are grateful to New York Academy of Medicine President Jo Ivey Boufford, MD, for her counsel on the study design; specifically, broadening the survey beyond physicians and nurses, and developing a sampling plan of key opinion leaders in health care. This study was supported by a grant from the Professional Staff Congress of City University of New York.

REFERENCES

1. Belmont E, Halton CC, Hastings DA, Homchick RG, Morris L, Taitzman J, et al. A new quality compass: hospital boards' increased role under the Affordable Care Act. *Health Aff.* 2011; 30(7): 1282–1288.
2. Cronenwett L, Dzau V. *Who will provide primary care and how will they be trained?* New York, NY: Josiah Macy Jr. Foundation; 2010. Available at: http://www.macyfoundation.org/docs/macy_pubs/JMF_PrimaryCare_Monograph.pdf. Accessed 3 July 2012.
3. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace: Joint Commission Resources, Inc; 2012.
4. Conditions of Participation for hospitals. (2010). 42 CFR. Sec 482.12 Available at: http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr482.12.pdf
5. Callender AN, Hastings DA, Hemsley MC, Morris L, Peregrine MW. *Corporate responsibility and health care quality: a resource for health care boards of directors*. Washington, DC: Office of the Inspector General, Department of Health and Human Services; 2007. Available at: <http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>. Accessed 3 July 2012.
6. Health Research and Educational Trust. *Building an Exceptional Board: Effective Practices for Health Care Governance. Report of the Blue Ribbon Panel on Health Care Governance*. Chicago: Center for Healthcare Governance; 2007; p. 13. Available at: http://www.americangovernance.com/americangovernance/BRP/files/BRP_final.pdf. Accessed 3 July 2012.
7. Prybil L, Levey S, Peterson R, Heinrich D, Brezinski P, Zamba G, et al. *Governance in high-performing community health systems: a report on Trustee and CEO views*. Chicago: Grant Thornton, LLP; 2009.
8. Prybil L, Levey S, Peterson R, Heinrich D, Brezinski P, Zamba G, et al. *Governance in high-performing community health systems: a report on Trustee and CEO views*. Chicago: Grant Thornton, LLP; 2009: 8.
9. Institute of Medicine. *The future of nursing: leading change, advancing health*. Washington, DC: The National Academies Press; 2010: 238.
10. "Berger Commission update: 1390 hospital beds never closed." *Crain's Health Pulse*. (2010, June 14). Available at: <http://www.crainsnewyork.com/article/20100614/PULSE/100619956>. Accessed 3 July 2012.
11. Huberman M, Miles M. *The qualitative researcher's companion*. New York: Sage; 2002.
12. Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.* 2005; 15(9): 1277–1288.
13. Prybil L. Engaging nurses in governing hospitals and health systems. *J Nurs Care Qual.* 2009; 24(1): 5–9.
14. Holland TP, Ritvo RA, Kovner AR. *Improving board effectiveness*. Chicago: American Hospital Publishing, Inc; 1997.
15. Joshi M, Hines S. Getting the board on board: engaging hospital boards in quality and safety. *Joint Comm J Qual Patient Saf.* 2006; 32(4): 179–187.