

Cover Story

The Case for a Nurse Trustee

09.08.14 by Charlotte Huff

Boards need to make room at the table for the voice of patient care.

Snapshot

Without a nurse trustee, boards lack an authority on the patient experience, quality and safety, and the largest part of the hospital workforce.

Connie Curran, R.N., was a relatively new board member for a 100-bed community hospital when the administrator proposed several cost-cutting measures to offset a decline in patient revenue, including shutting down the inpatient pharmacy during the weekends.

It was the end of the meeting and people were gathering up their belongings, Curran recounts. "I raised my hand and I said, 'Who will get the medications for patients on the weekends?'"

When she was told that the medication orders could be filled in advance on Fridays, Curran followed up. What about the newly admitted patients, or the postsurgical patient who suddenly spikes a fever? "I was the only person on that board who understood how a hospital, honest to God, operates on nights and weekends," she says.

"The physicians [on the board] weren't being negligent. They never had to think about how a new medication gets executed on the weekend. They didn't have to worry about that."

That episode, which resulted in the board's opting not to close weekend access, occurred roughly a decade ago. But Curran, who has served on some 20 boards through the years, including some for hospitals, believes that boards need nurse members. She's part of a growing clamor of voices arguing that an anemic nurse governance role undercuts a hospital's effectiveness, especially in its efforts to reduce patient harm and unnecessary readmissions. Several groups, including the American Organization of Nurse Executives and the Robert Wood Johnson Foundation, are taking steps to fill the gap, including identifying and training talented nurse trustee prospects.

Doctors fill 20 percent of the board seats and nurses comprise 6 percent, according to the most recent American Hospital Association governance survey, published in 2011. And that 6 percent figure might be on the high side. A *Nurse Leader* article published this summer, which cited a cross section of studies, found that between 2 and 6 percent of today's voting members are nurses. "It's an untapped resource," says Lawrence Prybil, a co-author and the Norton Professor of Health Care Leadership at the University of Kentucky College of Public Health in Lexington.

Nurses don't provide a better perspective than doctors, proponents say, but instead a missing organizational and clinical sensibility. Physicians' talents are vital to focusing on treating the illness or injury at hand, says Melanie Dreher, R.N., who chairs the board of directors at CHE Trinity Health, Livonia, Mich. "But the nurses are the keepers of the house," says Dreher, who served as dean of the Rush University College of Nursing in Chicago until early this year.

"They run the show. They live there. The physicians visit there. So [nurses] know that housekeeping is part of the patient experience. They know that food service is part of the patient experience," she says. "And nurses are tied into family-centered care. Nurses really do own the patient experience."

Why So Scarce?

To make the case for adding nurse trustees, Curran offers a list of data points. Nurses, by far, represent the biggest chunk of the hospital workforce, she points out, and thus the greatest budgetary expense. In terms of customer contact, they also reign supreme, regardless of whether hospital leaders view their primary customers as the patients themselves, their families or the doctors who admit and treat patients at the facility.

Hospitals are in a courting phase right now, trying to recruit the most talented physicians as they build integrated health networks, Curran says. When doctors are asked what they look for, they frequently cite the quality of the nursing staff, as well as satisfied patients, which are inextricably linked, she says. Moreover, failure to meet patient safety goals increasingly will hit physicians' income in the wake of the Affordable Care Act and other federal initiatives. She also points to the heightened focus on preventive care and population health initiatives moving forward.

"It's just so distorted that nurses aren't there [on the board]," Curran says. "It's absolutely incredible when you think of it in light of the impact that nurses have on the organization."

This isn't a new issue. In its 2011 report, "The Future of Nursing," the Institute of Medicine included among its recommendations that nurse representation be incorporated at the board level as well as in executive leadership positions. Along with their clinical experiences, nurse executives have honed top-level

organizational skills, says Pamela Thompson, R.N., chief executive officer of AONE, the American Organization of Nurse Executives, a subsidiary of the American Hospital Association. "If you look at what they are managing, they are small, multimillion-dollar companies in some respects," she says.

Frequently, these responsibilities start at a relatively young age, says Laura Wood, R.N., senior vice president of patient care services and chief nursing officer at Boston Children's Hospital, where she also serves on the 20-member board. Wood, who has worked as a nurse manager at several hospitals during her career, notes that by age 26, there were 50 people reporting to her and she oversaw everything from staffing to care quality. By age 30, she held the equivalent of an associate chief nursing officer position and was responsible for more than 1,000 employees, she says.

As they recruit to fill vacant seats on the board, lawyers, bankers and other nonclinicians sometimes don't grasp the breadth of nursing skills and knowledge, Prybil notes. "They have tended to view nurses as mid-level technicians."

That perception likely is due in part to confusion around the multiple levels of nurse education and credentials that range from licensed practical nurse to doctor of nursing practice, he says. It also should be noted, Prybil says, that nurses are overwhelmingly female, and women historically have been underrepresented across all boards and professions. In 2013, 22 percent of Fortune 1500 companies lacked any female board members, according to an analysis by Ernst & Young. An additional 36 percent had only one female member.

There are no signs of improvement in academic medical centers either. University HealthSystem Consortium recently analyzed responses from 58 AMCs in late 2013 and early 2014 and found that just 2 percent of the total 1,142 voting members across all those institutions were nurses, says Marilyn Szekendi, R.N., director of quality research at the Chicago-based association.

Szekendi, who also partnered with Prybil in incorporating best practices data into the analysis, found a correlation between the number of nurse trustees and better performance. Of the low-performing hospitals, 11 percent had at least one voting nurse member, Szekendi says. For high performers, 44 percent had at least one nurse, she says.

Leading Strategically

While a nurse executive, such as a chief nursing officer, can provide a lot of input in an advisory role, having a voting seat at the table does make a difference, says Therese Fitzpatrick, R.N., who chairs the governing council at Advocate Good Samaritan Hospital in Downers Grove, Ill. Fitzpatrick, who was a CNO previously in her career, said she had presented reports in that role, but described it as more of a one-way conversation.

"That's very different from being a voting member on the board," she says. "[As a voting member,] I can lead those conversations. It is a different level of holding those executives accountable for the strategy of the organization as well as the operations."

For example, the board for the 333-bed nonprofit hospital recently brought in architects to present their design for the facility's planned \$76 million patient care tower, Fitzpatrick says. "I asked the question, 'Show me and talk to us about how you are making it safe for caregivers. We all understand, with an aging nursing workforce, the importance of ergonomics. So tell me about how you're doing that.'"

That led to discussions about workflow, room design and even how many steps the nurses would have to take within the patient room itself, she says.

David Fox, the hospital's president, says that Fitzpatrick's perspective as the only voting nurse on the board provides key clinical context. Just as importantly, he cites her consulting experience and related travels for providing insight into nursing practices around the country. Additionally, Fitzpatrick serves as a sounding board for the hospital's CNO, who attends the meetings as well, and "brings lots of knowledge to the table," Fox says. "[Fitzpatrick] fully appreciates the distinction between governance and operations, which is great."

Nurses, who are accustomed to living and breathing hospital operations, need to learn to adopt a broader strategic mindset and governance perspective, Fitzpatrick says. "You have to be ready to move from a position in which the CEO is doing your evaluation — to doing his," she quips.

She recalls a story she heard about a nurse trustee in another state, who has been rounding with the hospital's CNO. "To help the CNO manage her area of responsibility is not the job of the nurse on the board," she says. "It's staying strategic." For example, that nurse could channel her clinical expertise into looking at the quality data presented to the board, Fitzpatrick says.

Identifying, Developing Talent

One challenge, in terms of boosting nurse participation, is that boards are in transition right now and are focused on getting more community representation, Thompson says. There also is some hesitancy to recruit a staff nurse, who also is a hospital employee, she adds. "Your nursing leaders in the [local] area could very well be already employed at the hospital, or could be members of the competition."

An alternative is to consider other local nurse leaders, such as those teaching at the nearby nursing school, Thompson says, or a retired nurse executive might possess both the skills and the time to invest in the board.

To develop more governance-savvy candidates around the country, Thompson's organization is working with AHA's Center for Healthcare Governance to adapt their program for trustee education and development to nurses. The goal is to offer it to AONE members by early 2015, she says.

AONE leaders also have collaborated with the Healthcare Financial Management Association to create a certificate in health care finance for nurse executives. Over time, the organization plans to build a list of talented nurses for hospitals around the country who can't find a well-suited candidate closer to home, Thompson says.

Good governance training matters, she says. "It's more concerning to me if we put nurses on boards, and they aren't prepared," she says. "That's not achieving what we are looking for."

But any implication that the bar, even one of perception, is somehow set higher for nurses makes Curran sputter with frustration. Can a hospital system achieve better results with a voting nurse sitting in the room? "It's absolutely true: We do not have proof," she says. "On the other hand, we don't have proof that having a realtor on the board makes a difference, or a banker or a doctor."

To further build the case for change, Curran and others call on today's midcareer nurses to start preparing themselves now. Network with individuals who already serve on boards, take advantage of available courses and perhaps brush up on presentation skills and other confidence-building exercises, says Wood of Boston Children's.

"I think nurses have to put themselves in the game a bit more than they have, and be more assertive and raise their hands," she says. "This is no time to be bashful. People need to say, 'I have something to contribute.'"

Charlotte Huff is a health and business writer in Fort Worth, Texas.

Case Study: Patient Safety through a Different Lens at CHE Trinity Health

When Melanie Dreher, R.N., first chaired the quality and safety committee at Livonia, Mich.-based Trinity Health in 2008, she wanted data about patient falls, infections and other reportable events to be more visceral than a dry reading of statistics could convey.

So, as part of the committee's presentation to the board, Dreher worked with other clinicians to present cases of patients who had died or suffered a serious injury that could have been prevented, and analyzed why each happened to be able to identify improvements. The cases ranged from debilitating sepsis to falls that caused injury to compromised childbirth.

Board members were surprised and troubled, Dreher says. "They had no idea." And they became quite engaged in discussing and tackling patient safety, she says. The quality-related discussions, typically budgeted for 30 minutes at most were now given 45 minutes, and would sometimes consume an hour and a half.

As specific circumstances were discussed, some of the factors involved nurse interactions with doctors or residents with attending physicians, or patients worried about offending a nurse or a doctor, she says. It was important for the board to know that "very few medical errors are solely based on absence of medical knowledge," Dreher says. "It really has to do with the social context of care."

Dreher now chairs the board for CHE Trinity Health, created when Trinity Health and Catholic Health East merged in 2013. She estimates that the clinical-related portion of the meetings consumes as much as 45 percent of the board's time compared with approximately 10 percent when she first started.

One of the measures Dreher also helped to implement is a requirement that any serious clinical event be reported within 48 hours and discussed, not in writing, but verbally among the key clinicians involved, as well as the CNO, the chief medical officer and the hospital's chief executive officer.

As Dreher has worked with other trustees and hospital leaders to highlight clinical concerns, she's made sure not to lose sight of the financial implications. For example, the committee identified the cost related to an extended stay if a patient suffered a fall or developed a pressure ulcer. "If you can reframe quality and safety in terms of cost, either saved or spent, it's a very good thing," Dreher says.

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