Go to the HIMSS book on IT governance,1 we interviewed chief medical information officers (CMIOs) and chief medical officers (CMOs) to understand what they saw as their role in the IT governance process. In this article, we present their responses along with insights from interviews with other physician leaders.

**THE UNWRITTEN ROLE OF PHYSICIAN LEADERS IN IT GOVERNANCE**

In addition to their formal roles, physician leaders have roles that aren’t written down anywhere.

Erik Steele, CMO of Eastern Maine Health Systems (Brewer, ME) believes the role of the CMO is to “make it work.” “You are the utility infielder and your job is to make it work, whatever that takes,” he said. He suggested talking directly to physicians. “Push through a process for tracking concerns and getting them resolved. Good governance isn’t a random event.”

According to Christopher Barrilleaux, CMIO at East Jefferson General Hospital (Metairie, LA), the CMIO needs to be a leader, cheerleader and salesperson. The CMIO needs to use the system, which means practicing medicine, and be willing to say when the system needs improvement. The CMIO also must be willing to tell project sponsors what reality is. “The CMIO has to be ready to say ‘We can’t do it because it’s not for the greater good, or we can’t do it because of budgetary reasons.’”

**COMMUNICATION**

The physician leaders stressed the importance of communication with other physicians in the success of IT governance. Back to Steele who believes that to keep physicians engaged you need to provide multiple modes of communication. CMIO and Meaningful Use reports were formally on the agenda of medical staff meetings. Reminders were built into the electronic medical record (EMR). “You may need to call physicians, as well as send materials to emphasize the importance of what they should be reading,” he says. “If they miss a meeting, a staff member needs to follow up with them and tell them what happened to issues they care about. Their performance needs to be monitored. If they are not showing up for meetings or repeatedly approving changes that their group later objects to, they need to be approached and asked to change behavior or be replaced.”

C.T. Lin, CMIO of University of Colorado Health, stresses listening and repeating what is heard. “Sometimes just verbally repeating a frustrated physician’s concerns can re-start a stuck conversation. The CMIO has to be seen as a physician advocate, but also a steady hand and voice of reason.” Lin added “Help establish and hold to the guiding principles of the project when situations get muddy. Sometimes a physician’s voice stating both sides of an argument and returning to general principles can help clarify difficulties.”

**STRUCTURES TO FACILATE PHYSICIAN INVOLVEMENT AND SUPPORT**

The role, authority and influence of physicians need to be considered in determining a committee structure. Many physicians are interested in attending a meeting where a project of personal importance is being discussed, but participants in the governance process need to commit to working on a whole range of projects. Multiple perspectives are needed to make good decisions. All three organizations had a high-level committee to make decisions that were then forwarded to the CEO and board, as well as to advisory committees. Decisions had been made on whether the CMO or CMIO would serve on each committee.

The CMO at St. Luke’s Health System (Kansas City, MO), a member of the man-
agreement committee, chairs the clinical applications prioritization group and is also a member of the business applications prioritization group. The system's management committee had delegated the function of assessing and prioritizing clinical applications to the clinical applications prioritization group.

Dirks, as discussed earlier, co-chairs the Information Technology User Group and is a member of both the clinical applications and business services prioritization groups but is not a member of the system management committee. This provides the CMO and CMIO the opportunity to discuss and vote on both types of applications before they are sent to the management committee. Dirks noted that most applications, with a few exceptions such as revenue cycle management, affect clinical care.

Because so much money is being spent on clinical systems, many hospitals and health systems have established specific structures and processes for clinical IT governance. The need for clinical IT governance is made even more important because of the key role that physicians play in the governance and success of health organizations.

East Jefferson General Hospital (EJGH) has a clinical operations committee (COC) chaired by the CMIO and includes the chief nursing executive, the medical director, the chief of staff, nursing vice presidents, other physicians and IT staff. Under the COC are three subcommittees. The first is the physicians advisory committee, chaired by the CMIO. The second is the meaningful use steering committee. The third is the COMPASS advisory committee (COMPASS is EJGH's EHR system), which is composed of nurses.

Eastern Maine Health Systems (EMHS) has a clinical coordinating committee composed of the CMO, chief nursing officer (CNO) and the president of the medical staff of each member organization. There is a subcommittee of the clinical coordinating committee, the clinical systems steering committee, delegated to make design decisions about the EMR. There is also a decision support work group composed of physicians that makes decisions on order sets and clinical pathways.

**KEYS TO SUCCESSFUL PHYSICIAN ENGAGEMENT**

We asked physician leaders to describe the important factors in engaging physicians in the governance process. As noted earlier, they stressed the importance of their active engagement and constant communication.

In addition, they suggested:

**Keep Governance Simple and Transparent:**

“Physicians want to know how decisions are made. They want some processes embedded in policy. Physicians and nurses can go online and raise an issue about the EMR and that issue will be tracked until it's resolved. Others will go to the CMIO and CMO and raise the concern directly.”

-- Erik Steele, CMO, Eastern Maine Healthcare Systems, Brewer, ME

**Physicians and CNO input into prioritization and configuration of applications:**

“Physicians need to feel they are just as important as the business side. If there are templates, physicians need to know what they are, agree that they will be functional and have significant input on configuration.”

-- George Pagels, CMO, St. Luke's Health System and chief executive officer (CEO) of Saint Luke's East, Kansas City, MO

**Personal Involvement of Physician Leaders:**

“The personal investment of the CMO in the process is key. The CMO has to understand how decisions are made. CMOs have to make sure that issues get tracked and resolved. The loop has to be closed back to the initiating physician. The CMIO and the CMO have to be partners. The CMO needs to be involved in key discussions to make sure that the physician perspective is represented. You have to make sure the physician’s voice is effective in decision making.”

-- Erik Steele, CMO, Eastern Maine Healthcare Systems

**Engaging the Critics:**

“Remember that the people who don’t agree with you are not your enemy. Bring the people who are the loudest critics into the process.”

-- Christopher Barrilleaux, CMIO, East Jefferson General Hospital, Metairie, LA

**THE FORMAL ROLE OF THE CMIO IS CHANGING**

Hospitals have frequently sought out members of their medical staff who would be willing to take on a part-time CMIO role. They would serve as advisors and work with the medical staff. Sheryl Bushman, CMIO at New York University Langone Medical Center in New York, believes the HITECH Act and the timeline for complying with meaningful use requirements is increasing the need for full-time CMIO involvement. CMIOs are moving into implementation and supervisory roles they did not have before. Bushman now has three full-time physicians working for her and works full-time as CMIO. She believes that the importance of experience in implementation is making CMIOs more mobile. Hospitals and health systems are seeking experienced physicians regardless of whether they have been part of the medical staff.

**CONCLUSION**

We agree with Lin that the physician leader “... has to be seen as a physician advocate, but also a steady hand and voice of reason.” Effective governance requires careful thinking and discussion regarding the role of physicians and physician leaders. That dialog should result in structures and processes that encourage physician involvement and support. As our interviews suggest, not all organizations will make the same choices, but the final objective remains an engaged and supportive physician community.