

# Alignment of the System's Chief Nursing Officer Staff or Direct Line Structure?

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The role of the system chief nursing officer nationally and internationally has been traditionally structured as a staff model, a direct line model, or a hybrid that includes parts of each model. The choice of structure should be made after a thorough investigation of what outcomes the system wants this position to accomplish, developing the appropriate structure to achieve these outcomes, and then engaging a chief nursing officer with the skills indicated by the type of structure chosen. This article describes these 3 structures and the support infrastructure necessary for each model.

**Key words:** *staff vs direct line structures, system chief nursing officer*

**I**N THE NOT TOO DISTANT PAST, health care was organized within the purview of single, stand-alone structures that did not necessarily connect with others. As the patient moved through these structures, they experienced very different cultures and standards of practices. There was virtually no way of effectively communicating between sites for the information that is needed about the patient. With the movement to health systems, now it is very unusual to find independent hospitals that are not affiliated with a larger health care system and ambulatory site facilities, such as rehab, and home health not aligned in some way. Initially, health care systems consolidated the support functions such as finance, logistics, and human resources. More recently, quality data have been required to be disclosed to the public and payment is becoming dependent on patient care outcomes;

organizing the clinical functions across disparate sites and geographies to achieve consistent outcomes has become a priority. Frequently now, the positions of chief nursing officer (CNO) and chief medical officer are seen at the executive level of large health care systems.

If you look across health care nationally and internationally, there are 2 ways of structuring the work of the system CNO in a health care system: (1) staff relationship structures or (2) direct line structures with many variations of these options. There is no right or wrong way to organize this role in a system. What should happen are 3 things. First, the desired outcome of the role should be clearly agreed upon and articulated well. Stakeholders must buy into a shared vision of what this role is and is not. If this is not done, stakeholders will have their own independent vision for this role and will be either very happy or very disappointed with the way the position performs. A lack of a shared vision will create serious issues for the person in the position. Second, the underlying structures and resources must be agreed upon so that this role can successfully meet the shared expectations for the role. Third, a CNO must be chosen who is a good fit for the specific structure chosen. The

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success of this role is greatly dependent on developing a shared vision and shared expectations for the person in the role. This article discusses the various structures that systems have implemented to support the system CNO role.

### WHY HAVE A SYSTEM CNO?

Not all systems have a system CNO. However, there is an accelerating trend to create the position for a variety of reasons. Some early adopters of the system CNO have kept the position and helped it to evolve, whereas a small minority discontinued the position, believing that the position was premature for the system. It cannot be emphasized enough that a clear vision of this role must be developed and evolved over time to be successful. As a place to start, Hader<sup>1</sup> describes 8 roles for the CNO of a system: provide vision, establish a nursing governance structure, ensure quality, provide strategic nursing management, foster staff development, regulate nurse credentialing, foster open communication and collaboration, and provide financial oversight. Englebright and Perlin<sup>2</sup> believe that the role is focusing on supporting system goals through improving clinical performance. Caroselli<sup>3</sup> writes that the CNO is the chief vision officer who must formulate a vision for patient care across many sites. Other more operational considerations can be as follows:

- Integration of disparate nursing philosophies and practices across the system into a unified practice.
- Integrating the work of the hospitals with ambulatory, home health, wellness, and other activities of the system to decrease duplication, cost, and improve outcomes.
- Strategically develop recruitment/retention strategies, educational strategies, and nursing models (such as the Magnet Program) to drive the nursing organization.
- Standardization of nursing practices according to evidence and best practice

to create outstanding outcomes both for patients and for nurses across the system.

- Integration of nursing information technology (IT) systems across the system.
- Analyzing financial outcomes throughout the system to create efficiencies and implement best practices throughout.
- Determining the patient care capital needs across the system and fairly allocating scarce resources.
- Determine how to pool and spread valuable and scarce human resources over the system (such as clinical nurse specialist/educators/researchers) that will create the best clinical and financial outcomes.
- Develop a partner for the chief medical officer and other leaders of the clinical enterprise to ensure that effective intraprofessional teamwork occurs throughout the system.
- Create a nursing presence at the executive and board levels to provide input/reports and to represent patient care at that level.
- Represent the system at the state and national levels where nursing and patient care input is needed.

The list can be expanded, but the front-end analysis of what structure and type of person will work for that system is very important for the success of the role. For example, the position could be structured as a strictly strategic position with an external focus that relates to state and national issues with little internal operational accountability. Another decision could be that the need for operational efficiency across the system is imperative, and support structures and direct reporting accountabilities must be developed to meet the goal of operational efficiency. Therefore, the ultimate accountability for and direct reporting role of all of the CNOs in the system would be to this position with a goal to quickly standardize practices, elevate the role and performance of the CNOs in the system, and to accelerate the attainment of quality and financial outcomes. Other considerations to consider are geography and the ability of the CNO to

be influential over a broad geographical area, or the need to regionalize practices with regional CNOs who can be closer to the action reporting to the system CNO and/or regional structures. The variations of this role are enormous, but clear thinking and organization are necessary to make the role successful.

This article discusses the various models and the support structures needed to ensure that successful outcomes are achieved on the basis of the organizations stated objectives.

### **STAFF RESPONSIBILITIES FOR THE CNO**

After an analysis of potential structures is made by the system, it might be determined that the system is not ready internally for a system CNO. Positioning the role as a staff position could be the role that will culturally fit with the organization at this time. Some systems are structured in independent units and the system operates more as holding companies than as a system. In this model, the CNO is positioned in a consultative role and is accountable for developing strategy needed to operate across several independent-like settings. Expected outcomes could be both to develop an infrastructure of CNO councils to share information and to develop strategic plans for the system. Other potential responsibilities could evolve around consulting and coaching about quality and patient safety outcomes and professional development of nursing for the system. The relationship to the chief medical officer and other peers within the organization would need to be defined. This kind of structure also can be found in large geographically dispersed systems where it is impossible for the CNO to be in close touch with all of the entities. It could also be appropriate in newly formed systems as they determine their best structure for the future.

Support structures for this role would depend on the expected outcomes. If consulting about quality or professional development of the nursing staff were an expectation, the CNO would need access to quality data and the resources to consolidate the data into

meaningful information and resources to educate and monitor for effectiveness.

There are many good reasons for a structure like this. The person in this position must be an expert at managing by influence and not authority. The skills of communication, negotiation, and visioning would be essential.<sup>4</sup> This position needs to be skillful at governing by consensus and ensuring that the stakeholders (CNOs, chief executive officers [CEOs]) who will be affected are clear about how this role is defined. This structure can be frustrating if the expectation of the organization or the CNO is a fast, rapid change.

### **DIRECT LINE RESPONSIBILITY FOR THE CNO**

A health care system that has identified a goal for the attainment of significant "systemness" or standardization requires a direct line reporting structure where local hospital CNOs report directly to the system CNO. If there is a goal for care to be identical across all hospitals marketed under the same logo, then significant standardization must occur across all clinical areas such as emergency departments, labor and delivery, postpartum, and critical care. There is a fine balance in this model, with direct line reporting, whereby standardization is promoted and adhered to without squelching innovation at local sites. Basic standards and expectations must be clearly articulated and agreed upon across all facilities so that once these expectations are met, facilities can then continue to innovate and outperform the agreed-upon standards, which, in turn, raise the bar for all facilities. In the work of Brafman and Beckstrom,<sup>5</sup> *The Starfish and the Spider*, this type of organization is viewed as a hybrid model with expectations for outcomes clearly spelled out and measured, yet staff closest to the work are able to innovate and incubate creative ideas that create breakthrough results. In a tight-knit circle of local CNOs who collaborate and share best practices, the ability to accelerate adoption of change is markedly increased when

outcomes have been clearly articulated and routinely measured.

The direct line responsibility model has several distinct advantages over the staff model. The first and perhaps most significant advantage is that the vision for nursing is articulated with one voice and one message; however, the realization of the vision is driven by the masses who have adopted the vision as their own. A clear, concise, yet strategic, vision for nursing that advances the health care system's vision and improves patient outcomes and efficiency also advances the nursing profession as a valuable asset to attainment of organizational goals.

The direct line model also promotes more frequent and intense dialogue among nursing leaders, with the goal of agreement on goals, strategy, and tactics. This model does not allow for "one-offs," where unique entities can opt out of agreed-upon work. The system CNO and his or her supervisor's (most often the system chief operating officer or CEO) message and vision must be congruent and delivered in an integrated method so that local hospital leaderships are on board with the required strategies needed to meet system goals. Alignment of this work is crucial to gain consensus on the strategies and tactics the hospital CNOs are charged with across the system. The relationship then between the system CNO and hospital CEOs is one of mutual respect and agreement around tactics to meet system goals. This model of reporting supports greater consistency across nursing and facilitates greater change management opportunities and enhances the speed of change.

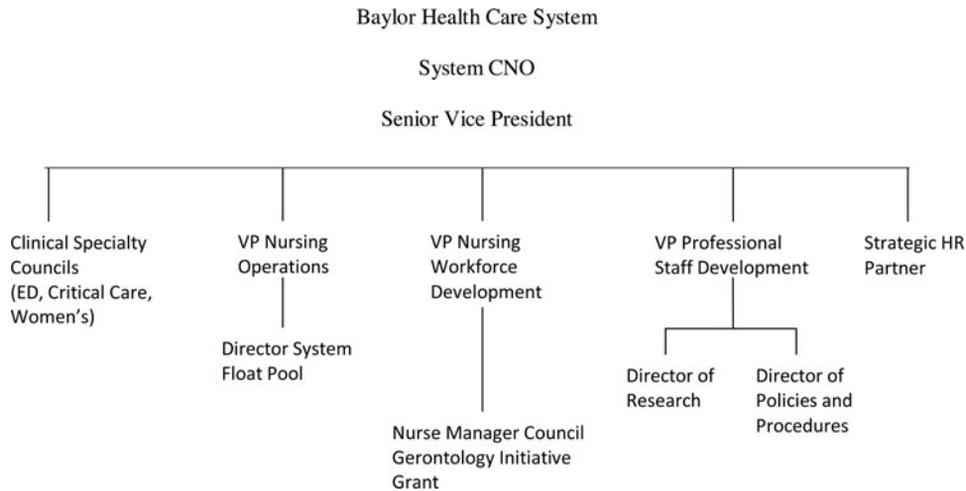
#### SYSTEM SUPPORT STRUCTURE DIRECT

The ability to effectively and efficiently impact patient care and costs is influenced by people, processes, and technology. The system CNO must have an infrastructure that promotes strategic initiatives and drives implementation across multiple settings and a large and diverse workforce. The Baylor Health Care System model of the Office

of the CNO was created to facilitate rapid change across 14 diverse facilities (ranging from 50 to 1000 beds) located in urban, suburban, and rural settings. The model consists of individuals with expertise in operations, workforce development, human resources, professional staff development, quality, research/evidence-based practice, and standardization of policies and procedures, as well as a council structure to drive improvement in specific clinical areas as required such as women's services, critical care, and emergency services (Figure).

The roles portrayed in the Figure support local CNOs and nursing leaders in developing, standardizing, and implementing best evidence-based nursing practices, education, research, and workforce and leadership development. All system leaders share the responsibility with hospital CNOs both to support Baylor hospitals in their journey toward Magnet designation and to increase the visibility of Baylor nursing nationally and internationally. A description of these support roles is provided in the subsequent discussion.

The role of the *vice president of operations* is focused primarily on finance and implementation of new technologies. This role provides education and mentoring for nurse leaders to enhance their financial acumen and business skills, including macro- and microeconomics. The *vice president of operations* oversees the systemwide staffing and scheduling system, monitors labor costs including premium pay programs, and is responsible for an internal agency for organized distribution of RN staff among facilities. This role provides a great deal of analysis that supports financial decision making for nursing across the system while also serving on several multidisciplinary systemwide initiatives focused on operations improvement strategies. Analyses of new technologies such as intravenous pumps, staffing and scheduling systems, patient flow systems, and computer workstations are also the responsibility of this role. The person who serves in this role is also an ideal candidate to serve as an interim CNO if the need should arrive.



**Figure.** Baylor Health Care System. CNO indicates chief nursing officer; ED, emergency department; HR, human resource; VP, vice president.

The role of *vice president for nursing workforce and leadership development* is a crucial role that is responsible for workforce analytics and development of strategic and tactical plans to ensure the availability of a well-qualified workforce for the future. Consensus among the hospital CNOs is crucial to the successful implementation of these plans. This role at Baylor has been instrumental in the development of a Nurse Executive Fellowship program focused on high-potential managers and directors who have the potential to assume greater responsibility in the future. This program consists of a 13-month curriculum that is provided by faculty from a local university and system leaders. Each student has a capstone project that must be completed with demonstrated systemwide impact, and a return on investment must be demonstrated that is verified by the participants' chief financial officers.

The *vice president for nursing workforce and leadership development* is also responsible for the curriculum development of a boot camp for new leaders that focuses on leadership, human resources, patient safety and quality, risk management, and the professional practice model. Magnet standards are reviewed in boot camp as well as being

embedded in job descriptions and performance standards. Classes are also offered to shared governance council chairs to enhance their effectiveness in leading council initiatives for their units, hospitals, and systemwide councils. This role is a crucial role in education and development of staff as future leaders and thus is pivotal in work to achieve the Institute of Medicine's<sup>6</sup> recommendations on the Future of Nursing (2010).

A significant focus at the Baylor Health-care System is to ensure that the community can always expect the same high level of care at all of the facilities that demands equivalent competencies of staff across the system. On the basis of this need, the *vice president of professional development* at Baylor Health Care System serves as the executive sponsor of the systemwide Education Council where standards for orientation and competency testing are set. Orientation is standardized across the system and specialty internships such as critical care and obstetrics. Rather than each hospital developing its own programs, a best practice is identified and refined across the system, therefore enhancing efficiency and effectiveness such as the creation of one standardized program and competency validation method on something

as repetitive as electrocardiographic interpretation. Innovative teaching strategies based on understanding generational differences are used to reduce teaching/learning time and enhance retention of information. The Education Council performs needs assessments routinely and develops programs as indicated for the entire system. Programs focus not only on clinical competencies but also on professional competencies such as conflict resolution and peer feedback techniques. The *vice president of professional development* also oversees the clinical ladder program, which promotes professional practice via the application of evidence-based practice and performance improvement strategies. Many of the clinical ladder initiatives have resulted in adoption of best practices across the system and the opportunity for direct care nurses to present their good work locally, nationally, and even internationally. Within the Baylor Health Care System, this role is also responsible for the *directors of nursing research and policy and procedure*.

The *director of nursing research* promotes the scholarly pursuit of research for all levels of nursing (clinical, education, and administrative) as well as interdisciplinary research studies at 1 site or across multiple sites. This leader creates excitement among staff members regarding research and provides them with the education and support needed to ensure that research methodology is valid and studies are expedited and completed. There is great benefit to multisite studies that can be accomplished across a large system, as sample size is significant that contributes to the power of the study and the ability to generalize results. This role serves on the systemwide institutional review board and also collaborates with local universities for significant funding opportunities. The *director of policy and procedure* position was created to facilitate standardization of policies and procedures across the system where possible and to maintain a centralized repository for these documents. This work is facilitated through numerous clinical and shared governance councils.

Within Baylor Health Care System, the role of the *strategic human resources partner* was created to support the system CNO in the development of human capital. This role is instrumental in performance management strategies, talent and succession planning including 360-degree feedback assessments, coaching, organizational structure and design, and compensation strategies. This centralized role assists the system CNO to ensure that the right individuals are in the right roles. In Baylor Health Care System, this person serves as a member of the system CNO Council and works closely with the system CNO as well as the *vice president for nursing workforce and leadership development*. This role has facilitated rapid organizational change in the area of enhanced performance expectations and has rallied our human resource and organizational development experts across the entire system to drive toward a unified goal of nursing excellence.

#### COMBINATION STRUCTURES FOR THE CNO AND MATRIX STRUCTURES

Combination or hybrid structures are made up of direct and staff responsibilities. Depending on the initial analysis, it could be determined that a financial function should be carved out to support the work of the CNO if the creation of consistent financial outcomes across the system is a weakness. The same conclusion could be drawn for the quality outcomes and other functions. The human resource functions of recruiting and retention could be determined to stay within the human resource department, but the nursing IT strategy and implementation would be centralized under the CNO. The danger of transferring reporting structures to the CNO from traditional departments such as IT and human resource is that they can become as isolated reporting to the CNO, as they sometimes are reporting to the centralized departments. In the ideal situation, a matrix is developed that clearly keeps persons both in their home department and under the direction of the CNO for certain aspects of their position.

The reporting structure of the site CNOs can be developed in many ways that range from sole reporting to the site CEO to sole reporting to the CNO of the system, with gradients in between. In the middle range, one could find the site CNO reporting to the CNO for professional practice such as progress toward Magnet, retention, and effectiveness of shared governance systems. The site CEO would have the oversight of the budget, as well as other functions. The structuring of this mixed hybrid model must be carefully analyzed, with clear roles and responsibilities thought out to minimize confusion and conflict.

## SUMMARY

Thoughtful dialogue and discussion about the strengths and weakness of the system and how this role can improve the deficits are imperative to the success of this role. The maturity of the leadership team and characteristics around control versus influence must be analyzed to determine the right model for the system CNO to be successful. When there is shared consensus about the expectations of the role, the structure can follow to support the role of the CNO and the CNO with the appropriate leadership skills for the particular model can be chosen.

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