What Does It Mean to Be Part of a System?

The Role of the Chief Nurse Executive and Shared Governance

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As the healthcare system landscape continues to evolve toward more integrated care, a trend of consolidating hospitals into larger systems continues. The systems are more than the traditional hospital-centric structures, as acute care becomes just 1 component in a larger system that includes ambulatory care, acute and post-acute care, chronic disease, end-of-life management, and all structures inbetween.[1]

To meet the healthcare system landscape changes, nursing and nurse leader roles are changing. The role of the chief nursing officer (CNO) is no exception. CNOs are no longer practicing within the walls of 1 hospital. The role is expanding to encompass leadership of multiple hospitals, system responsibility, and more importantly, to include healthcare outside the walls of the hospital. The purpose of this article is to describe how the role of the nurse leader and the shared governance structure has evolved into a divisional structure and how this structure functions in 1 healthcare system.

EVOLVING NURSE LEADERSHIP ROLES

According to Clark,[1] to provide leadership in the new healthcare system model, an increasing number of system chief nurse executives (CNEs) have been employed both to facilitate the integration of care and to align and standardize nursing practice across the continuum. The Hospital Sisters Health System (HSHS) has recently evolved their leadership roles following this model. HSHS has 14 hospitals, 6 located in Wisconsin and 8 in Illinois, which are divided by regions into 4 divisions. Three years ago, each hospital had a single CNO, and there were no CNEs. Now there are 12 CNOs (2 hospitals share 1 CNO), and 4 of the CNOs also serve as a divisional CNE (*Figure 1*).

Historically, the CNOs met only once a year for an operational meeting and did not function as a system but rather as 13 individual hospitals. With the new divisional structure in place, leaders sought to create a new leadership structure to support aligning practices across the system. The model of this new structure is similar to the chief nursing officer advisory council (CNOAC) developed at Ascension Health. Ascension Health is the largest Catholic and nonprofit healthcare system in the United States, encompassing 70 acute care hospitals, organized into 34 health ministries. The CNOAC was created by Ascension to provide strategic direction and thoughtful leadership for major system-level initiatives that affect quality, safety, operational performance, nursing leadership, and patient-care delivery.[2] Although HSHS is not as large as Ascension, the function of the CNOAC aligned with the goals of our new CNO team.

In the past few years, the CNOs have been collaborating as a team and meeting every 2 to 4 weeks virtually and every few months in person. The CNOs have developed a strategic plan for nursing across the system. The 2 key goals of this strategy are to increase the percentage of Bachelor of Science in Nursing (BSN)-employed nurses to 80% by 2020, and to develop and implement the Franciscan Inspired Care Delivery Model for patient engagement. One of the CNO team's decisions was to collaborate with our physician partners; we invited the chief medical officers to join us quarterly as we make clinical decisions. HSHS was impressed with our decision to collaborate and lead clinical decision making. The meeting of CNOs and chief medical officers has transformed into the HSHS Clinical Executive Council, where all clinical issues are discussed with a focus on clinical improvement. When those in nursing can speak with consensus-driven opinions, it translates into a powerful, influential voice at all levels in the organization.[2] We continue to meet and have been making progress on our goals; the Franciscan Inspired Care Delivery Model has been introduced to leadership across all hospitals and is being shared with all colleagues.

EVOLVING DIVISIONAL SHARED GOVERNANCE STRUCTURE

In the future, the Affordable Care Act will surely promote the implementation of divisional shared governance structures because healthcare organizations depend on empowered professionals to achieve the healthcare reform mandates of cost containment and accountability.[3] Successful implementation of shared governance as a practice model in a large healthcare system requires meticulous planning, hard work, and a strong commitment to build an empowered workforce.[4] Burkman et al[4] suggest that the system CNO can significantly influence and guide the nursing strategic direction at all the healthcare system–related facilities by utilizing a single, system-wide nursing shared governance structure. Using this structure provides a venue to maximize the influence of a transformational leader and creates efficiencies in workforce development, resource management, best practice identification, and spread of initiatives and improvements to adapt to an ever-changing healthcare landscape.[4] In the Eastern Wisconsin Division (EWD), there are 4 hospitals: 2 hospitals have a CNO, and 2 of the hospitals share a CNO, who also serves as the divisional CNE. In the EWD, the divisional CNE was able to influence and guide the evolution of a divisional shared governance council, a nursing leadership council, and a clinical education and research council. The next section describes the evolution of the shared governance council structure and lessons learned along the way.

In the EWD, nurses have successfully formed a shared governance nursing practice council representing all 4 hospitals. As the 4 hospitals came together as the EWD, there was concern from leaders about the unique cultures of each hospital and sustaining their uniqueness. When it came to nursing, there was no need for concern. The nurses came together, learned what was in place at each hospital, and developed a new shared governance council to serve nurses across the division. The divisional council took the best of each of the prior council practices and formed a new structure, changed membership and terms, and created a new name, the professional nurse practice council (PNPC). The PNPC nurses also agreed to a new vision statement: "Nurses leading the way with Passion, Quality, and Excellence." The professionalism and collaboration of the nursing colleagues was inspiring. The shared governance structure of EWD is displayed in Figure 2.

Professional Nurse Practice Council

The PNPC has 24 frontline RNs who represent each hospital, home health, and hospice. Each member serves a 3-year term. There is an application process, and members are selected by their peers. Each year in April through July, the PNPC develops a strategic plan and seeks input from nursing col-