Strengthening the CNO/CEO Relationship: *A Model of Collaboration*

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Healthcare in the United States is in a tumultuous state of reformation. The Affordable Care Act (ACA) of 2010 was designed to restructure a system of healthcare in America that is both fragmented and financially unsustainable. The foundational components of this new legislation require healthcare leaders to refocus on the patient. Strategies to facilitate patient-centered care include: volume to value-based economics, models of accountable-care organizations, interdisciplinary team decisions, and patient/family/user-driven technologies.[1]

Senior leaders of acute care medical centers, specifically the chief executive officer (CEO) and chief nursing officer (CNO) are responsible for leading their teams to achieve these new goals. CNOs have primarily held the responsibility for patient-centered care.[2] CEOs have been responsible for the overall financial performance of the organization.[3] Current and future healthcare reform will require that leaders in both roles meld their responsibilities, endorse the same mission, and redesign acute care delivery systems into relevant, sustainable entities beneficial to patients, employees, and community stakeholders. This article examines the similarities and differences in education, competencies, and the roles and responsibilities of the CEO and the CNO. A model is presented that advances their mutual impact on the development of a different culture with an emphasis on safety, quality, and caring that is necessary in today's environment of healthcare reform.

BACKGROUND

Historically, healthcare reimbursement has been based on a volume versus value model. With healthcare reform, this dynamic is rapidly changing to a performance metric model. Healthcare executives are being challenged by both public and private organizations, not to only address patient-centered quality and safety initiatives, but also to be accountable for all patient outcomes during any given length of stay and up to 30 days post-discharge. In 2009, the Centers for Medicare & Medicaid (CMS) outlined its rationale for value-based purchasing: reimbursing medical centers based on a combination of evidenced-based core measure compliance and patient satisfaction results.[4] Performance is made public to assure accountability.

The Joint Commission (TJC) accredits acute care medical centers and directs over 283 standards specific to the healthcare leader's role in assuring patient safety and quality care outcomes.[5] In 2009, TJC reinforced the importance of this responsibility by releasing a sentinel event alert entitled *Leadership Committed to Safety.* The sentinel alert is linked to accreditation and requires proactive, not reactive, leadership. The *leadership* defined as responsible includes the CEO, CNO, senior leaders of the clinical staff, as well as physicians, and the governing body.[6] To address this alert successfully, a commitment to developing a culture of high-quality, safe healthcare is required.

Concurrently, the National Patient Safety Foundation, the National Patient Safety Forum, and the Leapfrog Organization are examples of consumer advocacy groups partnering with providers of healthcare to promote agendas of responsible safe care.[7,8] These nonregulatory agencies oblige medical centers to publish data that highlight the systems' accomplishments on a number of criteria congruent with quality and safe outcomes and then apply grades. Leapfrog "grades" establish a competitive edge to performance and provide the impedance to declare victory when an "A" is reported on a public scorecard.

The pressure from consumers of healthcare, accreditation bodies, and payers are mounting. A review of healthcare executive leadership literature by the author indicated that there is limited information regarding CEO/CNO relationships and the importance of collaboration.

EDUCATION AND COMPETENCIES

Education

Although it is more common today to see CNOs advance into CEO roles, foundational differences in the educational preparation of the CEO and CNO exist in most settings. Increasingly, there are major similarities in the healthcare leadership competencies that both groups must address and obtain to be effective leaders. A review of the demographic data indicates that differences between the CEO and CNO are reflected in gender, educational preparation, licensure, and experience. A 2008 American College of Healthcare Executive (ACHE) healthcare management summary report of CEOs revealed 56% of CEOs were white men with a median age of 52 years. Comparatively, 37% Hispanic women and 31% white women held top-level positions.[9] In a more recent study, 90% of CNOs were women with a mean age of 52 years. Ninety-six percent reported their race as white.[10] The American Organization of Nurse Executives (AONE) recently released a position statement regarding the educational preparation of nurse leaders.[11] The organization recommends that nurse leaders be minimally prepared with a bachelor's degree or master's degree in nursing. It is recommended that nurse executive leaders obtain doctoral education[11] TJC outlines in its nursing chapter a standard requiring the CNO to be licensed and registered and possess a postgraduate degree.[5]

The educational preparation of CEOs in healthcare varies. Bachelor's degrees and master's degrees in the areas of business/healthcare administration, finance, or a clinical specialty are common. The American College of Healthcare Executives' reference manual is indistinct as to specifying healthcare management degrees, but suggest a post-bachelor's degree and 2 years healthcare management before certification as a healthcare executive may be obtained.[12]

Competencies

Both the ACHE and the AONE frame executive leadership competencies utilizing the same 5 domains. These are communication and relationship management, professionalism, knowledge of the healthcare environment, business skills, and leadership.[13,14] Many of the skills necessary for the top executive leadership positions within healthcare are the same. Delving into the specific competencies within these 5 domains provides further awareness of the centrality of mission: patient-centered care with an emphasis on safety and quality. Table 1 identifies similarities of initiatives focusing on culture necessary for success in this era of healthcare reform. Acknowledging this shared skill set clarifies and serves to link the CEO/CNO.

CEO–CNO RELATIONS

A strong CEO–CNO relationship is widely accepted as important to building an effective executive team, but there is little research in this area. Some relational information is

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