The Chief Nursing Officer Council

A Model to Achieve Integrated Professional Practice in Health Care Systems

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The directive to develop more nursing leaders was clear in the 2010 report from the Institute of Medicine (IOM), *The Future of Nursing: Leading Change, Advancing Health*.[1] The IOM had 4 messages for nurses: one, practice to the full extent of your education and training; two, achieve higher levels of education and training through a system that promotes unified academic progression; three, partner with physicians and other health care professionals to achieve care reform; and four, commence improved data collection and information structure to realize effective workforce planning and policy making. Research continues to show the influence of nursing leadership on patient satisfaction, patient mortality, medication errors, restraint use, and hospital-associated infections (HAIs).

BACKGROUND

In the changing health care environment of today, the roles of the chief nursing officer (CNO) continue to expand beyond simply acute inpatient care settings. Challenges such as decreasing reimbursement, recruitment and retention, succession planning, expanded education to support clinical advancement, and health care reform are now added to the original responsibilities of a CNO, which included overall quality of care, patient safety, patient satisfaction, and fiscal responsibility. In addition to the expanding role of a CNO, hospital systems

continue to expand, and standardizing care across growing health care systems is challenging. Assuming that each facility in a system has a CNO, the system will eventually have many CNOs who are leaders within their own facilities. The overriding challenges now facing expanding hospital systems are how to focus on evolving priorities, standardization of a continuum of care, and unified organizational strategy.[2]

Rochester Regional Health (RRH), a community-based hospital system, found itself facing such challenges as it quickly grew from 1 acute care hospital to 5 acute care hospitals, 6 long-term care facilities, 5 adult day care programs, assisted living, a Program for All-inclusive Care for the Elderly (PACE), more than 100 medical groups, dialysis centers, multiple ambulatory surgery centers, health care for the homeless, and a home care agency. Today, RRH has more than 2300 medical staff members and 3600 nurses, and is the leading provider of cardiac health care services in upstate New York. RRH serves a population of 1.8 million across 8000 square miles in over 7 counties. Today's increasingly competitive health care environment led RRH to consider whether a CNO council model would provide the standardization of leadership across the system that now is essential, as well as the adequate attention to clinical and operational improvement needed to maintain quality.

Historically, community hospitals and health systems have looked to a single CNO as a resource to segue between the clinical and operational domains[3]; however, the ever-expanding roles of the CNO and continuous health care system expansion demand a new model to standardize care and assure safety system-wide for nurses, patients, and the community. In 2016, a survey of 27 CNOs revealed what they believed to be their current challenges.[4] Recruitment and retention of staff were top of the list, followed by patient safety, effective teamwork, patient and family engagement, and stronger physician and nurse communication.[5] The survey also noted leadership alignment with organizational initiatives in a changing environment to be an important challenge. CNOs ensure quality and safety targets are achieved; mortality declines; care is delivered efficiently—not only within acute care setting, but in the 30 days post-discharge; readmissions are reduced; and patients are satisfied with their experience of care.[5]

Alignment of multiple, diverse health care settings and an overriding need to address the many challenges for CNOs demanded a new model. In 2014, the RRH system-wide CNOs, under the leadership of the RRH chief executive officer (CEO), formed the RRH CNO Council.

CASE STUDY

The Chief Nursing Officer Council at Rochester Regional Health

CNOs of the 5 RRH acute care hospitals met informally to discuss the goals of the new CNO council. Once the CEO formalized the establishment of the council, the goals were approved. Initially, the council comprised CNOs from the 5 acute care hospitals and 1 CNO representing all long-term care facilities. Currently, a CNO for the medical groups and a CNO for ambulatory surgery were added to ensure nurse leadership across the RRH health care system. Physicians, human resources, sustainability, purchasing, and information technology now maintain ongoing collaboration with the CNO council for guidance and discussions that may affect a nursing workforce and patient care across the RRH system.

The CNO council has made every effort to represent all entities currently comprising the RRH System.

Goals of the CNO Council

- Develop an integrated clinical nurse advancement program for implementation in various settings across the system, when appropriate.
- Establish a vision for RRH to be employer of choice for RNs in its regional area.
- Harmonize and standardize, in collaboration with human resources, pay practices among nurses across the RRH system.
- Initiate a plan to achieve Magnet® designation at all RRH acute facilities and Pathways to Excellence® designation for all long-term care facilities.
- Achieve American Association of Critical Care Nurses (ANCC) Beacon Awards.
- Create system quality goals and alignment dashboard and scorecard measures.
- Institute a shared governance decision-making model that engages the role of each council member for maximum system input and outcomes. Align each council member to sponsor key strategic imperatives.
- Launch strategic partnerships with institutions of higher education, affording education advancement and career path development to obtain a nursing degree.
- Improve the patient experience in collaboration with other system leaders.

The council goals impacted all practice environments and leveraged nursing input and expertise; therefore, the council cultivated a culture that would value evidence-based practice (EBP) and gain support from their C-suite colleagues.

A system-wide, shared governance model was established to ensure that continuation of work and identification of needs within each facility remained intact, while bringing together the RRH health care system (*Figure 1*). The model restructured individual influence over more comprehensive, organizational areas regarding information, authority, goals, and conflict.[6] Hospitals in the process of seeking Magnet designation, as RRH is, must demonstrate empowering structures and procedures that involve nurses in governance and decision-making about their practice.[7] The council looked to this type of model to achieve favorable outcomes.

Shared Governance

Implementation of the shared governance model across the RHH system was critical for the council as a way to promote cooperation, professionalism, and trust throughout the team. Under the leadership of the council, participatory management transitioned to a full-shared governance model.

At the center, patients and the interdisciplinary team are represented by a foundation: navigation—the nurse's role on the