System CNE White Paper:

The Effective System Nurse Executive in Contemporary Health Systems: Emerging Competencies.

Contents

Summary

As the U.S. health care environment continues to evolve in response to calls for lower cost, higher quality and an improved patient experience, health care organizations are undergoing fundamental change. This in turn requires the system Chief Nurse Executive (CNE) to adjust and embrace new competencies. These include improving population health, increasing quality, expanding provider coverage and managing increasingly complex health information technology systems. System nursing leaders must take on these issues while at the same time ensuring safety across the continuum of care and keeping financial viability in mind. The system CNE must also remain prepared to respond to evolving changes in ownership or partnership of their health care organization.

AONE has responded to the changing role of nurse executives by providing research and strategic thinking. The organization recognized the need to provide insight into the role of system CNEs in helping to lead the transition of the U.S. health care system from a focus on acute care to the entire continuum of care. The contributors to this white paper reviewed literature predicting future changes in the health care system and identified three areas of competency that will be particularly important for system CNEs to obtain and maintain:

1. Supporting the health care system's ongoing transition from acute care to continuum of care
2. Participating in an interdisciplinary team approach through shared leadership
3. Enlarging the role of the advanced practice registered nurse (APRN) in relation to the integration and synthesis of clinical services

Focus area 1: Adjusting to new models of care

As the health care system moves to paying for value rather than volume, system CNEs will be under pressure to help ensure that their organizations are coordinating care across the continuum. The system CNE is well positioned organizationally to lead or partner with other clinical executives to prepare system environments for this change. Regional or system-level executive teams will be responsible for integrating settings. The system CNE will often take responsibility for deciding how practice variability will be managed, which involves assessment of each care delivery site. This will likely also include determining where to allow variability in nursing practice, taking into account a number of factors, including the potential impact on patient/family-centered outcomes

The system CNE can also play a key role in partnerships with academia to prepare the nursing workforce of the future in the provision of care across the continuum. These partnerships can take place in various structures, including appointments to academic boards of governance. As case management and care coordination expand to cover more sites of care, curricula must keep pace. Colleges and universities must incorporate concepts of team-based care in their curricula. Curricula should also reflect complexity and microsystems that are likely to become more prevalent in the health care system. And educational

models that respond to these system changes should be evaluated by outcomes measures based on the Triple Aim: population health, experience of care, per capita cost (IHI, 2016).

Research also needs to support the evolution of nursing education and nursing leadership as the system changes. Research and education should be coordinated so they support one another. Specific research projects that could address these issues include the most effective use of telemedicine, remote patient monitoring techniques, and methods of providing discharge information to patients.

Some mature health care organizations have already begun moving into the new payment and care delivery paradigms and provide best practices that can be of use to other organizations. Exemplars include Advocate Healthcare and Advocate Physician Partners, which have aligned a strong physician base with a health care system to create a "super PHO" to drive population health and clinical integration. The University of Pennsylvania uses advanced practice RNs (APRNs) in the inpatient setting to evaluate patients who may be at risk for readmission and schedule home care follow-up visits, reducing readmissions among high-risk patients. And Texas Health Resources has set up 12- to 16-patient microsystems that are coordinated by CNLs in collaboration with care transition management staff, resulting in improved outcomes and lengths of stay, and reduced readmissions.

Focus area 2: Shared leadership to improve interdisciplinary teams

Team care is becoming the new delivery model in the U.S. health care system. Just as other clinical specialties are evolving to take this model into account, clinical management must change from the hierarchical, discipline-oriented models of the past. Leaders with separate clinical affiliations, skills, education and experience should lead together to manage multi-professional teams. Co-leaders of the system's clinical enterprise should include both the system chief nursing officer and chief medical officer.

Co-leadership can sometimes be challenging and gender and professional cultures may make it difficult for co-leaders to overcome traditional management structures. However, these partnerships can be successful and transformational to their organizations when partners are willing and able to grow, change and learn together.

Through shared leadership the economic shift for paying for value instead of volume will have its greatest impact. These partnerships will make it possible to carry out models such as bundled payment systems. Results will be demonstrated through excellence in quality measures and patient engagement. The system CNE will be an influential source in assuring patient- and family-centeredness throughout the continuum.

Focus area 3: Role of the Advanced Practice Registered Nurse (APRN)

The future will also require greater use of advanced practice providers. The advanced-practice RN plays a key role in transforming health care systems to provide more integrated care. The system CNE helps to

establish professional standards and align nursing practice across all sites of care within the system to achieve organizational goals. Top-of-license practice requires several essential actions. Most importantly, APRNs must provide leadership within the organization to make sure there is broad understanding and acceptance of their scope of practice. This requires the CNE to establish a mechanism for professional governance for advanced practice and assure that APRNs serve in leadership roles. Governance processes for credentialed and employed APRNs should be standardized across a health care system. These processes should define credentialing and privileging, including peer review, and require APRN involvement.

The CNE is positioned to establish strategic health care system structures that document outcomes of the care of individuals and communities and monitor efficacy of the methods of care delivery. There are two primary elements in this area. The electronic health record provides the foundation for recording care and measuring the impact of care provided. Also, data systems support outcome measurement and research to demonstrate efficacy of teams, including the role of the APRN.

The NCSBN consensus model should be used by the system CNE to establish core structures and processes for APRNs. Not all states have implemented the consensus model, so it would be the CNE's responsibility to learn more about the relevant states' scope-of-practice regulations and status in relation to the consensus model. Often the System CNE will be responsible for establishing and nurturing a professional home for APRNs across the health system. The clinical dyad of the CMO and the system CNE is often responsible for leadership in establishing APRN practice governance; the duo also may need to define and measure the contribution of APRNs to the organization's goals.

The reforming health care system demands the system CNE, as a transformational leader, identifies new roles for APRNs in care delivery systems. Nurses at all levels must be responsible for the clinical and financial impact they bring to patients, consumers, and health care systems. APRNs allow improved access to care and enhanced caregiver team effectiveness to achieve these outcomes. The system CNE is in a strategic position to advance important structures and processes and demonstrate outcomes of APRN team practice.

Conclusion

The system CNE must be prepared for rapid changes in the health care industry. The three areas of competency identified in this report may not be comprehensive but are meant to build a foundation for this topic and provide the opportunity for system CNEs to contemplate the skills they will need to do their jobs effectively in the future. The committee recommends that system CNEs carry out a self-assessment that takes into account the areas of focus identified in this paper and the environmental, economic, technologic and provider role shifts expected for the future. Managing this change will require high-performing interdisciplinary teams and effective co-leadership. And the insights of system change will need to be translated to the educational system to ensure nurses in training are prepared to become the system nurse leaders of tomorrow.

Introduction

The U.S. health care environment is dynamic and health care organizations regularly adjust themselves in response to its changing requirements. As a result, the system Chief Nurse Executive (CNE) must also adjust to adopt new, wide-ranging competencies; the system CNE must also adapt to changes in the position's role within the organization. The array of system CNE competencies is broad and deep: it includes improving population health, increasing quality, expanding provider coverage and managing increasingly complex health information technology systems. These and other goals must be kept in mind while ensuring safety across the continuum of care — and remaining fiscally viable. The system CNE must also be prepared to respond to any mergers or acquisitions as health care organizations carry out Affordable Care Act strategies. All of this requires a carefully orchestrated set of strategic, interdisciplinary and purposeful initiatives.

O'Grady (2015) defines the leadership skills needed in a time of great change as "predictive" and "adaptive." Plsek (2010) defines predictive capacity as the set of skills associated with imagining the future from the perspective of the present. A solid comprehensive understanding of the topography of the world that surrounds the organization is essential for the successful system CNE. Leaders must understand the broad view of health care and predict how national trends will impact the organization. Adaptive leadership capacity is the other element critical for the system CNE. The leader must have the ability to translate innovation and change into a paradigm that the organization understands to promote the culture and life of the organization.

The purpose of this white paper is to identify the areas necessary for understanding and functioning as a system CNE in the future healthcare environment. The three areas are:

1. Supporting the health care system's ongoing transition from acute care to continuum of care
2. Participating in an interdisciplinary team approach to leadership through shared leadership
3. The role of the advanced practice registered nurse (APRN) in relation to the integration and synthesis of clinical services

Background

AONE convened a group of system CNEs in fall 2010 to develop core competencies for the system CNE role. The resulting document was made available on the AONE website. Since that time several national presentations and publications have been available for system nurse executives. The committee was charged in 2015 to identify the role of nurse leaders in leading societal change in the transition from an acute care-focused health care system to one oriented to the complete continuum of care. The group

reviewed literature concerning predictions for the future of the health care environment and identified three areas of competency that the group believes will be particularly important for system CNEs to obtain and maintain.

Focus area 1: Leading new models of care across the continuum

Systems within health care are becoming increasing complex in the move to shift to paying for value rather than volume. These changes require system CNEs and their teams to ensure that care is coordinated across the continuum, from the acute care environment to the ambulatory environment and beyond. Because the reimbursement system will increasingly be based on health of the populations hospitals serve, populations must be managed and appropriately transitioned and monitored throughout the continuum. The model is shifting toward well-being and health promotion, which means a corresponding move of culture from sick care to health care. The system CNE is well poised organizationally to lead or partner with other clinical executives to prepare system environments for this change. The system CNE will design and implement models of care that support the needs of patients not just in the acute care setting but, just as importantly, in the post-acute and ambulatory settings as well. At the system level, regional or system-level executive teams will be responsible for integrating all these settings, working in collaboration with clinical and operational partners.

The system CNE plays a vital role in technology by partnering with the CIO and CNIO to develop, implement, and evaluate their system functions. Technologies such as telemedicine, patient portals and clinical applications allow virtual interaction with patients, providing more timely and personalized clinical support. System CNEs are also positioned to provide oversight to post-acute settings such as rehabilitation and skilled care facilities. Linking quality metrics across the continuum provides consistency for the patient population.

Often the CNE in a health system is faced with deciding when, where and how practice variability should be managed. Assessment of each care delivery site is an important process to understand standard work at each site, understanding current evidence-based practice foundations and then determining how/when to create a standardized approach to nursing practice. Even more importantly, the system CNE is often in a position to determine where to allow variability in nursing practice, taking into account the practice venue and the potential impact on patient/family centered outcomes. A risk/benefit model of evaluation should be considered and carefully applied during the assessment phase with inclusion of key stakeholders along the decision making process. Partnering with academic leaders is another way to advancing the practice of nursing in this context.

The system CNE can play a key role in partnerships with academia to prepare the nursing workforce of the future in the provision of care across the full continuum, given that this new style of work will require different skills, situational awareness and critical thinking. The System CNE should also partner with academic leaders to ensure the clinical practice environment is conducive to the student

experience; this could involve leveraging the partnership to more effectively recruit new nursing graduates to a care venue where they can be successful, and accelerating orientation as the new graduate begins to craft and mature their professional practice. Partnering can occur in varied structures; examples include system CNE appointment to the university or college board of governance, joint appointments with service/academia, and creative curriculum components that integrate key practice principles important to nurse trainees.

Curriculum changes go along with system change

Historically, models of case management and care coordination in hospitals have focused mainly on utilization management/review, discharge planning needs, denials and appeals. This usually limited the scope of planning to the immediacy of the patient leaving the acute care setting and transitioning to the next setting. The next level of care was not addressed with every patient. Case management structures were often set up to address Medicare/Medicaid patients, or those with long lengths of stay or multiple social service needs. This left other patients to the nursing staff, who would prepare patients for the next level and then discharge them with instructions about how to self-manage their post-hospital stay.

While health systems are retooling their models for caring for these populations, colleges and universities educating clinicians must incorporate concepts of team-based care in their curricula to include the concepts and processes of the collaborative practice model. Health systems are also increasingly complex and must adapt constantly to a changing set of circumstances. Curricula that focus on complexity and microsystems will more effectively prepare teams for managing in these systems. A broad understanding of financial and payment concepts is needed in addition to the science-based knowledge required to provide clinical care to patients. Finally, curricula need to include an understanding of concepts surrounding community resources and systems to prepare future team members for population health initiatives that focus on wellness, prevention and community engagement.

System CNEs must influence the development of education curriculum and core competencies so that all nurses including APRNs can truly drive evidence-based practice and consistent outcomes. The system CNE must advocate for the educational system to develop curricula and master's and doctoral degree programs to advance the clinical nurse, care transition staff and care coordinators. For systems to survive and thrive in a value-based environment, education systems must retool curricula to address the skills needed for the shift to value and population health management. System CNEs must be in the forefront of this transformation and work closely in academic service partnerships to assure that nurses in these population-based roles are educated to understand the new ways of thinking about health care.

As education models evolve to respond to changes in the field, they should be evaluated by outcomes measures based on the Triple Aim:
1. Improve patient experiences (quality, satisfaction)

2. Improve health of populations
3. Reduce the per-capita cost of health care

The Triple Aim is simple in concept but very complex in practice. Outcome metrics should be designed so they can provide future insight into the success of new educational models in preparing caregivers to support the goals of the Triple Aim.

Research

Research should play a key role in the design of evidence-based practice changes necessary to transition from the inpatient to the ambulatory environment. Research guides appropriate practice change and provides guidance for the measurement of safety, effectiveness and outcomes of emerging best practices. Research and education must be coordinated, so that curricula and research support one another. Examples of potential research projects that can be aligned with education models include:

- Use of remote monitoring techniques (disease-specific) for high-risk patients, and the impact of remote monitoring on outcomes and cost of care.
- The expansion of telemedicine to support transactions of care and enhance compliance.
- Nurses as teachers: Are nurses prepared to teach patients effectively in non-traditional environments? How do patients learn best?
- Methods of delivering discharge information to patients/caregivers: effectiveness of patient education portals, emails and texts.
- Evaluate collaboration with other providers to better coordinate patient transitions to avoid readmission while improving patient compliance and outcomes and lowering costs.

Exemplars

Several mature organizations provide exemplars in succeeding and thriving in a transforming health care environment. These organizations boldly transformed well ahead of the curve and now have mature structures, processes and outcomes to provide cutting-edge best practices.

Advocate Healthcare and Advocate Physician Partners have aligned a strong physician base with a health care system to create a “super PHO” to drive results across their organization (overview Advocate Physician Partners & Clinical Integration Process September 13, 14, 2010). This model manages Advocate’s transition to population health management. Advocate Physician Partners provide consulting services to develop clinically integrated networks, physician leadership, infrastructure development and other key objectives. (www.appadvisorsonline.com/aboutus). Other systems such as Kaiser Permanente and Intermountain Health have also addressed population health and clinical integration using unique models.

System CNEs, in addition to leading within clinically integrated networks, have also begun to reengineer the inpatient cultures to focus more to the right and left of the hospital. Evolving models of transitional care management include a notable example at the University of Pennsylvania. Its model uses advanced-practice RNs (APRNs) in the inpatient setting to evaluate patients who may be at risk for readmission and schedule home care follow-up visits, reducing readmissions among high-risk patients. APRNs are also on the rise as nocturnists, service line-based expediters and caregivers for chronically ill, high-risk patients in clinic settings.

Texas Health Resources has assigned CNLs to coordinate the care of 12- to 16-patient microsystems in collaboration with care transition manager staff (RNs and LCSWs), resulting in improved outcomes and lengths of stay, and reduced readmissions of hospitalized patients. Service line-based CNLs at Maine Medical Center focus on high-risk inpatient populations and collaborate closely with the care team to improve outcomes and reduce readmissions.

Focus area 2: Shared leadership to improve interdisciplinary teams

Team care is becoming the new delivery model in the U.S. health care system. Multiple and diverse team members contribute their expertise to the well-being and healing of individuals and communities. Just as other clinical specialties are evolving, clinical management (a specialty as much as any other specialty) must change from the hierarchical, silo-oriented models of the past.

As health care evolves, leaders with separate clinical affiliations, skills, education and experience should lead together to manage multi-professional teams. These partners will have different but complementary job descriptions. Their combined talents complete a set of management competencies needed for accomplishing goals of the organization. Co-leaders of the system's clinical enterprise (most often configured as dyads or triads) should include both the system chief nursing officer and chief medical officer. Each brings unique, diverse, and distinct expertise and experience to their joint leadership roles.

Co-leadership can be challenging for individuals who lack experience with empowered team work, shared governance, two-way communication and the humility to recognize they "do not know what they do not know." Individual cultures, especially gender and professional cultures, may make it difficult for co-leaders to overcome hierarchal clinical and management structures of the past. However, when partners are willing and able to grow and change, have a high degree of emotional intelligence, and understand their own strengths and weaknesses, they can learn together to co-lead in a powerful and influential model that supports the organization's vision and goals. Successful co-leaders are transformational. They add value to their organizations through a shared ability to develop and grow synergistic teams, where every voice is encouraged and heard.

Through shared leadership the economic shift for paying for value not volume will have its greatest impact. System CNEs working with system CEOs, COOs, CIOs, CNIO and CMOs will execute measures for success in bundled payment systems. Results will be demonstrated through excellence in quality measures and patient engagement. The system CNE will be an influential source in assuring retention of patient- and family-centeredness throughout the continuum.

Examples include incorporation of strategies in clinical strategic plans across the system and defining process and outcome measures. Goal alignment with the key clinical leadership dyad allows for cascading of quality, safety, experience and efficiency goals throughout the organization. Through the goal alignment process, interdisciplinary teams can reach peak performance and drive value processes deep into the organizational interstitium. Alignment with the CIO on technological components such as telemedicine, clinical applications that support extemporaneous decision making, and patient portals will be essential for the model to succeed. Various bundled payment collaborations led by the system CNE with inclusion of multiple disciplines with timeline/goals will provide positive patient outcomes.

Focus area 3: Role of the Advanced Practice Registered Nurse (APRN)

The future will also require greater use of advanced practice providers. This includes not only the system CNE role in oversight for acute care but also for the continuum such as outpatient clinics, primary care, skilled care, etc.

The advanced-practice RN plays a key role in transforming health care systems to provide more integrated care. The system CNE helps to establish professional standards and align nursing practice across all sites of care within the system to achieve organizational goals. The following are key areas of alignment for the system when executing the role of the APRN: The Center for Advancing Provider Practices (CAP2) is a helpful resource to CNEs.

- Establish health care system structures to enable APRNs to practice at the top of their capabilities.
- Create governance processes for credentialed and employed APRNs.
- Assure data systems support outcome measurement and research to demonstrate efficacy of teams and APRNs.
- Follow the National Council of State Boards of Nursing consensus model; make an inventory of relevant state scope-of-practice regulations; and influence local policy where needed.
- Support standardized professional development and residency programs.

Top-of-license practice requires several essential actions. Most importantly, APRNs must provide leadership within the organization to make sure there is broad understanding and acceptance of their scope of practice. This requires the CNE to establish a mechanism for professional governance for advanced practice and assure that APRNs serve in leadership roles. From this structure, standard job descriptions must be developed that address core criteria for APRN practice and serve as a foundation

for the additional criteria for specialty APRN job descriptions and associated practice. The system operating structure must also include compensation, benefit and productivity models for APRNs that are commensurate with other providers such as physicians and other licensed independent practitioners. This compensation and productivity structure should include both the base model as well as performance incentives when those are present for physicians.

Governance processes for credentialed and employed APRNs should be standardized across a health care system. These processes should define credentialing and privileging, including peer review, and require APRN involvement. There should be APRN involvement in appropriate clinical practice development and operations, such as strategic decision making around accountable care organization development, monitoring processes for APRN practice across settings of care, and evaluation of APRN and multidisciplinary team clinical and financial performance.

The CNE is positioned to establish strategic health care system structures that document outcomes of the care of individuals and communities and monitor efficacy of the methods of care delivery. There are two primary elements in this area. The electronic health record provides the foundation for recording care and measuring the impact of care provided. Also, data systems support outcome measurement and research to demonstrate efficacy of teams, including the role of the APRN. Documenting the positive impact of on patient outcomes is essential; this evidence has already led to adding APRNs to multidisciplinary teams (Newhouse, et. al., 2011). It is also important for these teams, including advanced practice nurses, to advance health of communities as part of meeting the goals of reform (Porter & Lee, 2013). Nurses at all levels must look beyond their own work to help demonstrate the impact of nursing care on patient and community outcomes.

The NCSBN consensus model should be used by the system CNE to establish core structures and processes for APRNs. The elements of the consensus model include the following definitions and requirements (Cahill, Alexander, and Gross, 2014):

Licensure: APRNs hold both an RN and APRN license.

Education: Graduate education is required for APRNs regardless of role.

Certification: Every APRN is required to meet advanced certification requirements.

Independent practice: APRNs shall be granted full authority to practice independently without physician oversight or a written collaborative agreement.

Full prescriptive authority: The APRN shall be granted full prescriptive authority without physician oversight or written collaborative agreement.

Not all states have implemented the consensus model, so it would be the CNE's responsibility to learn more about the relevant states' scope-of-practice regulations and status in relation to the consensus model. In some cases, the CNE may provide leadership with state policy makers to align state rules and regulations with the consensus model. As of 2014, only 17 states have independent scope-of-practice

and prescriptive authority without a requirement or attestation for physician collaboration, consultation, delegation or supervision (Phillips, 2014).

System CNE accountabilities include professional nursing practice at all levels. Health care system professional practice includes practice of APRNs. The various roles filled by APRNs commonly have developed over time without specific regard to scope of practice or best evidence for APRN requirements. The CNE is in the best position to engage APRNs in the development of programs that address onboarding and mentoring as well as professional development for practicing APRNs. These structures should be standardized and evidence-based.

Often the System CNE will be responsible for establishing and nurturing a professional home for APRNs across the health system. The clinical dyad of the CMO and the system CNE is often responsible for leadership in establishing APRN practice governance; the duo also may need to define and measure the contribution of APRNs to the organization's goals.

The reforming health care system demands the system CNE integrate APRNs into care delivery systems. Nurses at all levels must be responsible for the clinical and financial impact they bring to patients, consumers, and health care systems. APRNs allow improved access to care and enhanced caregiver team effectiveness to achieve these outcomes. The system CNE is in a strategic position to advance important structures and processes and demonstrate outcomes of APRN team practice.

Conclusion

The healthcare industry is changing rapidly and requires skill and knowledge to respond effectively and build a sense of urgency. While the three areas of focus discussed in this paper are not comprehensive, they do create a foundation for building competencies for the future; they may also provide an opportunity for self-reflection for new and experienced system-level chief nurses. The committee recommends that system CNEs perform a self-assessment to align the areas of focus identified here with environmental shifts and predictions of change in a variety of roles: sociopolitical, economic, technological and provider. Co-leadership models are critical for managing across the care continuum and certainly in managing care transitions. Integration of evidence-based practice in the contemporary care environment can be challenging given the complexity and acceleration of care transitions. The system CNE is a vital role for the future; at the same time there is an urgent need to create and nurture a culture of co-leadership and promotion of high-performing interdisciplinary teams in order to accelerate a health systems value creation. The system CNE can be positioned to transform the health delivery systems of tomorrow.

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