Leading Change

The Nurse Executive’s Role in Implementing New Care Delivery Models

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Implementation of innovative patient care delivery models provides an opportunity to examine how effective nurse leaders are leading change in the healthcare system. The trends and pressures that make change imperative, not optional, are discussed in other articles in this issue. The focus of this article is on how chief nursing officers improve patient safety and increase care quality while managing the complexities of the nursing workforce and controlling costs. The authors examine the leader’s role in the change process, in particular, the role of nursing leaders. The care delivery model is considered an instrument for change, and the chief nursing officer is a change agent.

This article grew out of initial research done by the research team at Health Workforce Solutions LLC on innovative new care delivery models (CDMs). At the conclusion of the first phase of research, a number of new CDMs were identified as representative of the most innovative and promising models for long-term impact and replication. This article draws on that research and is supplemented by interviews with chief nursing officers (CNOs) who successfully led a new CDM implementation.

The summary of findings serves to promote an understanding of the CNO’s role as change agent. The initial research focused on such questions as: “What new innovative CDMs are being tested across the US that have the potential to change or reinvent care delivery?” and “Are they cost-effective?” However, we were also interested in the story behind the story, that is, the nursing leader’s role in driving a complex change process. Figure 1 provides examples of interview questions asked of hospital CNOs who participated in these interviews. In each case, regardless of the components of the model such as improving care for a specific patient population, designing new roles for nurses or integrating new technology, each CNO’s story began with a complex leadership challenge. These CNOs describe former first lady Rosalynn Carter’s eloquent description of great leaders. She said, “A leader takes people where they want to be. A great leader takes people not necessarily where they want to be but ought to be” (http://www.quoteworld.org/quotes/2467). The CNOs contacted for this article agreed that their implementation of new CDMs began with the daunting task of leading a diverse cast of internal and external resistors, skeptics, and other potential challengers toward a common goal.

Key Leadership Challenges

What are the key leadership challenges for CNOs in leading a change process? The CNOs surveyed for this article discussed 4 challenges in leading a significant change process, such as the implementation of a new CDM. The authors examine the
importance of making a strong business case for change, effective internal and external communication, and organizational agility. The authors illustrate each of these leadership challenges using examples from the implementation of new CDMs.

The Business Case for Change

The first leadership challenge cited was the importance of making a strong business case for the implementation of the new model of care. It is ill advised to implement a new CDM without undertaking a rigorous, formal business planning process. At a minimum, this planning should include the formulation and analysis of key assumptions, strategy, operating plan and tactics, resource requirements, financial plan/analysis, evaluation/measurement plan, and contingency plans. Whether the proposed intervention is budget-neutral or not, nurse leaders are expected to make a sensible business case for a new practice model, which includes quantitative analysis of cost and benefits along with revenue and expense calculations. One nurse executive explained that it was through the creation of a business plan that she was able to quantify potential cost savings through reduction in workers’ compensation cost. In the implementation of another model, The Primary Care Team Model, Seton Family of Hospitals, Austin, Texas, one of the outcome metrics documented in the business plan was a reduction in staff turnover. Subsequently, a year after the implementation of the new CDM, the CNO was able to document a 64% reduction in registered nurse staff turnover. In another CDM, the Transitional Care Model, developed at the University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania, the research and design team made the case that they could achieve improvements in readmission rates, inpatient costs, patient and physician satisfaction, as well as rates of medical complications and mortality.

In addition to producing measurable results, all the CNOs understood that the implementation of a new CDM would have to contribute to advancing institutional objectives or goals. While one of the goals for The 12-Bed Hospital Model, Baptist Hospital, Miami, Florida, was to create the “feel of a small hospital within a large one,” the CNO simultaneously articulated how the new model was consistent with system-wide organizational objectives, particularly restoring the hospital’s reputation in the community as the “Mecca for quality.” These anecdotes confirm that, without exception, successful nurse executives are making a strong business case to drive change.

Communication Effectiveness

Another pressing leadership challenge for the CNO revealed by the new CDM case studies was the importance of communicating effectively, internally and externally, about the change process. What are the effective communication strategies displayed by the CNOs in this study? Communication effectiveness includes many dimensions, such as informing people about the change, which include factors such as providing information people need to know to do their jobs and providing information in a timely manner so individuals can make accurate decisions. Another dimension is CNO approachability, which is being easy to approach and talk to, building rapport, and spending extra time to put others at ease. The most important dimension is listening, which means having the patience to hear people out and being able to accurately restate the opinions of others even when he or she disagrees.

Internal Communication

For an example of effective internal communication, the authors cite a comment made by the CNO involved in the implementation of The Primary Care Team Model. She said, “I was very intentional about when I brought certain information forward.” The intentionality of this communication strategy was applied across the board with internal stakeholders, beginning with the members of the care team, then more deeply across the nursing enterprise and with physicians, other senior executives in the organization, and even board members. The same CNO later said, “I thought of this as a
This comment also illustrates the way in which the CNO shaped the message about the CDM itself. By grounding the new model in principles such as “every patient deserves an experienced registered nurse” and “every patient deserves the opportunity to participate in the planning of his or her own care,” the CNO was delivering a strong message not just about the values of the nursing team but also the values of the entire organization. Internally, interactive communication, especially at the outset, was identified as a critical success factor to directly involve staff nurses, charge nurses, nurse managers, and nursing directors in the design and implementation of new CDMs. There are 2 main components of the internal communications strategy: first, the message about the need for change, that is, the objectives of a new CDM, and second, the message about the change process. The need for change was one of the most challenging messages for CNOs to deliver. Several CNOs spoke of making the case for change as one of their top leadership challenges. One CNO found it particularly difficult to persuade the experienced nurses in the organization to accept the change because many nurses just did not see the need for change. Another important element of the internal message regarding the change process has to do with the importance of communicating expectations around the change process. Several CNOs described “resistance to change” as the greatest obstacle in achieving their leadership agenda and recognized in hindsight that perhaps some of the resistance should have been dealt with directly and much earlier in the process.

In addition, CNOs were very selective in their use of language when speaking about the implementation of a new CDM. For example, 1 CNO reported, “I always spoke about it as a journey,” illustrating the importance of the change process itself as compared with the expected outcomes of the new model of care. Similarly, another CNO said “the data create a strong, compelling message for the march forward.”

**External Communication**

The counterpart to effective communication with internal stakeholders is telling the story about the new CDM to important external stakeholders, such as CNOs at other hospitals, the broader nursing profession, relevant professional associations, policy makers, consumers, and other community leaders. This leadership challenge is most relevant for the CNOs at those organizations, where new CDMs have been successfully implemented across multiple units and have generated positive measurable outcomes. Several of the CNOs spoke of the activities that they and their nursing colleagues have undertaken to disseminate the findings of new CDMs. Examples include hosting site visits (1 organization hosted 11 site visits in 7 months), writing for publication in peer-reviewed journals, making presentations at national conferences and meetings, and educational webcasts. One CNO spoke of her efforts to expose nursing students—perhaps one of the most critical constituencies given their potential to impact long-term use and replication of the new CDM—to the pilot units in her hospital where the new CDMs were being tested.

**Organizational Agility**

Organizational agility exemplifies knowing and understanding how the organization works; knowing how to get things done both through formal channels and informal networks; understanding the origin and reasoning behind key policies, practices, and procedures; and especially critical, understanding the organizational culture. Without exception, the implementation of the new CDMs studied required nursing leaders with exceptional organizational agility.

Before the implementation of The 12-Bed Hospital Model at Baptist Hospital in Miami, the CNO, in collaboration with the chief executive officer, guided the organization through a 2-year strategic decision-making process in which “full-time equivalent (FTE) increases were sacrificed by other departments, not just nursing.” This budgetary outcome reflected the understanding and acceptance across the entire organization that Baptist was embarking on an entirely new model of care delivery as opposed to simply creating a new role for nurses.

In this model, the patient care facilitator was the cornerstone of an innovative new model of care that changed how all clinicians worked together to provide patient care. Therefore, it was imperative that physicians recognized and valued the patient care facilitator’s clinical knowledge, viewed them as strong players on the interdisciplinary team, and shared the patient care facilitator’s goal of using evidence-based practice at the point of care. Leading the physician staff through this change process was a lengthy and complex challenge but ultimately one with a successful outcome. The CNO told the authors, “There isn’t a physician who practices
regularly in the hospital who doesn’t seek out these folks [patient care facilitators]."

The implementation strategies for other CDMs provide examples of how nurse leaders use all available organizational resources to lead change. In the Acuity Adaptable Beds Model, Methodist Hospital of Clarian Health Partners, Indianapolis, Indiana, the CNO described the importance of building partnerships with other internal and external collaborators to ensure that the change effort was not solely nursing driven. Depending on the specific model being implemented, internal collaborators cited included architects, engineers, statisticians, information services staff, and pharmacists. One CNO recalled that “the engineers and architects who have worked with us for years now think differently and commonly introduce plans that were formerly viewed as radical departures from the ordinary to each new project within the system.” Nursing leaders who successfully leverage available organizational resources and human capital demonstrate the organizational agility needed to drive change and innovation in the implementation of new CDMs.

In other examples, the CNO strategically leveraged the value and expertise of national experts and thought leaders to energize the internal change process. In the Self-organized Agile Team Model implemented at Prairie Lakes Healthcare System, an 81-bed nonprofit community hospital in Watertown, South Dakota, the CNO persuaded her organization to join an Institute for Healthcare Improvement Workforce Collaborative to support the innovations she was testing around care delivery systems. Through the activities of the Collaborative, this CNO connected with other healthcare leaders around the country who shared her interest in health system improvement and in creating new patient CDMs.

A positive outcome of this Collaborative participation was Prairie Lake’s participation in a grant program, Transforming Care at the Bedside, a national demonstration project supported by the Robert Wood Johnson Foundation. The CNO demonstrated considerable organizational agility in several ways. First, she persuaded the chief executive officer to agree to participate in the Institute for Healthcare Improvement Workforce Collaborative, a recommendation he initially did not favor. Secondly, she transformed the chief executive officer and chief financial officer into key champions of a new CDM and the change process, building on the executives’ shared commitment in improving clinical outcomes, work intensity, and patient flow.

Organizational agility includes the ability to understand the culture and strategize about what will work best for employees at all levels of the organization. In the previous example, the CNO used her leadership position and expertise to persuade the chief executive officer to approve an important strategic step for the organization, to join the Institute for Healthcare Improvement Workforce Collaborative. During subsequent stages of the change process, the CNO demonstrated sensitivity to the nursing staff’s ongoing frustrations with the work environment and invited their input to identify important changes.

For example, the CNO asked the nursing director of medical and surgical services to identify obstacles that prevented her from spending more time with her staff on the unit and propose solutions that might simplify some of her responsibilities. Although the nursing director believed in the importance of providing feedback to her nursing staff, she felt that the existing system of providing feedback to 65 direct reports was exceptionally inefficient. When the nursing director proposed the unconventional solution of eliminating traditional annual reviews, the CNO supported a new approach in evaluating performance and fostering frontline leadership, which improved the situation. While the new performance evaluation system does not entirely eliminate annual reviews, nursing directors now routinely focus on observing nurses performing their tasks but only document substandard performance. Finally, because the nursing directors are spending more time on the unit, performance deficiencies are identified and corrected immediately, resulting in improved patient care.

In addition, all the CNOs surveyed emphasized the importance of having at least 1 nursing champion to energize the nursing staff to embrace the change. While in many cases, the champion was the CNO, in other new CDMs, the champion was in a nursing director role. Regardless of the champion’s official title, this individual had to have considerable credibility and respect among colleagues at various levels throughout the organization. The champion had to develop and maintain relationships with many stakeholders for whom she or he did not necessarily have managerial oversight. In cases where the CNO was the champion of the change effort, it was important to make sure that others were able to contribute to the process in a meaningful way. One CNO said, “I knew what I wanted, but some things were negotiable,” a comment that illustrates how important it is to involve others in the change process. In the examples
cited throughout this article, the champion was responsible for articulating a strong case for change, for being able to identify sources of energy and creativity internally and externally to support the change, for recognizing and embracing the vision of the new model, and finally, for being able to withstand the pressure and intensity as colleagues inevitably chaffed against the process.

**Leadership Lessons Learned**

Descriptions of the implementation process of new CDMs are filled with important leadership lessons that apply to other leadership challenges facing nursing leaders. In particular, 5 leadership lessons stand out.

**Position the New CDM as Part of a Broader System Redesign Strategy**

Many CNOs spoke of the importance of framing the implementation of a new CDM as part of a broader organizational strategy. Linking these new models to health system-wide redesign of care delivery to improve patient safety, reduce medical errors, and increase patient and provider satisfaction helped to stifle resistance among staff members who labeled the new model as “just the senior management’s flavor-of-the-month strategic initiative.”

**Nursing Champion Critical to Success**

The importance of a nursing champion, whether the CNO or a designated champion, was a common theme among the participants in the research conducted. While in many cases, the CNO was the real champion in the effort, in other cases, nursing directors played a strong leadership role. In addition, for successful implementations and outcomes, it was imperative that the nursing champion was a leader with strong organizational agility and personal presence. Simply stated, the champion possessed the skills to be able to navigate—with patience and tremendous flexibility—the complexity and politics of his or her organization. The nursing champion also understood that the implementation and success of the new CDM would not happen without the support of other colleagues outside the nursing enterprise—the effort had to be endorsed by stakeholders including C-suite leadership, physicians, and other members of the care team, information services, and human resources.

**Engage New Internal Allies**

The research also suggested that internal supporters of new CDMs might not come in the form of the usual suspects, namely, human resources and other clinical professions. Many CNOs found themselves working with people in other disciplines such as finance, architecture, information systems, and engineering in new ways. These new partnerships also generated considerable energy and creativity for the difficult tasks and roadblocks ahead.

**Create New Opportunities for Service-Academic Partnerships**

While a handful of the new CDMs examined began as service-academic partnerships from the outset as in the Transitional Care Model in Philadelphia, Pennsylvania, several CNOs related the added benefit of using the implementation of a new CDM to establish new partnerships with their academic counterparts. One CNO talked enthusiastically about using nursing graduate student interns to collect and analyze outcome data. In another example, the CNO established a close collaboration with nursing school faculty on the development of the clinical nurse leader role, which was one of the new roles for nurses used in The 12-Bed Hospital Model.

**The More Significant the Change, the More the Resistance**

If a change does not produce notable resistance, then the change is probably not big enough. When leaders of an organization ask their employees to perform their jobs differently than before, the result is often fear and trepidation, which presents as resistance and opposition. Many CNOs acknowledged that they began to appreciate the significance of the new CDM by gauging the level of resistance to change across different stakeholders. Many CNOs stressed the importance of 2-way communication throughout the change process, allowing plenty of time for colleagues to voice their concerns and fears.

**Conclusion**

The CNO’s leadership challenges are complex, varied in nature, and vast in scope. However, the emergence and implementation of new CDMs offer a window through which to examine the CNO as change agent in the transformation of the inpatient care delivery environment. For those CNOs who successfully build a strong business case for change and communicate effectively with key internal and external stakeholders while maneuvering complex organizational structures, the rewards are exceedingly positive. The power of change is inspirational not only for their staff, patients, and the broader nursing profession colleagues but also for the many
and various stakeholders of the healthcare system. The implementation of new CDMs, which generate positive outcomes for patients and providers, showcases the true potential of nurse leaders to influence the transformation of the healthcare system of the future.

References