Interview With Linda J. Knodel, FACHE, Senior Vice President and Chief Nursing Officer at Mercy

Linda J. Knodel, FACHE, is senior vice president and chief nursing officer (CNO) at Mercy, based in Chesterfield, Missouri. Composed of 45 hospitals, 40,000 employees, and more than 2,000 Mercy Clinic physicians, Mercy is the seventh largest Catholic healthcare system in the United States and serves residents in a four-state region.

Ms. Knodel was previously vice president and CNO of Mercy Springfield Communities in Springfield, Missouri, and senior vice president and CNO at St. Alexius Medical Center in Bismarck, North Dakota. She has served in various local, regional, and national governance capacities, most recently as president of the American Organization of Nurse Executives (AONE). Ms. Knodel has served on the ACHE Board of Governors, Regents Advisory Council, and Finance Committee. She participated on AONE's strategic planning, membership, bylaws, and annual meeting committees and has served as a regional policy board member for the American Hospital Association. Ms. Knodel currently serves on the Health Professions Program Council with Western Governors University in Salt Lake City, Utah. She has written a book titled *Nurse to Nurse: Nursing Management* and in 2011 was recognized by the *Springfield Business Journal* as one of the "12 People You Need to Know."

Ms. Knodel is the 2016 recipient of ACHE's Gold Medal Award in the category of healthcare delivery organization. The Gold Medal Award is the highest honor bestowed by ACHE on outstanding leaders who have made significant contributions to the healthcare profession.

Dr. Kash: *As a nurse leader, how have you worked effectively with both administrators (on the business side) and physicians (on the clinical side) in a large not-for-profit health system?*

Ms. Knodel: Two years after finishing nursing school, I was a young nurse working in the dialysis unit of a hospital, and the federal government had put together the End-Stage Renal Disease program, under which Medicare funded treatment for end-stage renal disease. In the mid-1970s, our dialysis unit received $120 per dialysis treatment to care for this patient population. I soon became the department leader and wondered how we could manage the care of these patients for $120 per treatment. We had to come up with a care model under which we provided care for that amount or even less, depending on our ability to negotiate contracts for artificial kidneys, lines, medications, and so forth. That process really intrigued me. I loved the finance side, and the position allowed me to work with our medical director from a practice standpoint to ensure quality patient outcomes, as well as

with administration and finance to make sure we were meeting our budget requirements. I thought this was such a healthy model, and that is how I began to grow in the profession.

Shortly afterward, our CEO asked me to take over a division that included the quality department, infection control, utilization review, a home care department, and medical records. We were looking at diagnosis-related groups, which was a foreign language to me. That experience prompted me to obtain a bachelor's degree in health administration and then a master's degree in health administration at the University of Minnesota. The education enabled me to bridge my knowledge with administrative and clinical skills.

At the same time, the hospital was on the Magnet journey (a designation of the American Nurses Credentialing Center). Just before we submitted our application, the credentialing requirements changed and CNOs needed to have a bachelor's or master's degree in nursing, and I had neither. The local college, which was run by the same order of sisters that owned the hospital, put together a program that allowed 23 other nurse managers and me to receive a master's degree in nursing. About a year and a half later, the hospital achieved Magnet status, the first hospital in North Dakota to do so.

Administrators and physicians have to want to work together. On the hospital's Magnet journey, I witnessed individuals who really believed in the team and the various talents we all brought to the table. I also encourage students to reach out to those of us in the field. We are there for them and want to help them. As they become members of ACHE, I encourage them to reach out and use us as mentors. For instance, a young man who is finishing his healthcare accounting degree sends me an update on how he is doing every 6 months. He asks if I have any ideas or suggestions for him. As we have all been given that gift through our lives, it is our responsibility to give back.

Dr. Kash: *Share your thoughts about the future of the nursing profession in the United States.*

Ms. Knodel: This is probably the most exciting time in the history of nursing, and we are on the cusp of some really great innovations. The "heads in beds" model required one kind of nurse, but the new model stresses value, access, and quality. The nurse of the future will need to have clinical expertise and change management skills, along with an even deeper level of business and interpersonal acumen. Because of the rapid acceleration of change, nurse leaders—particularly current and aspiring nurse leaders—need to place an even greater priority on continuing education.

As today's healthcare model is changing, so too must our nursing model. Nurses perform the majority of all care functions for patients, but unlike other healthcare professionals, they do so for multiple patients simultaneously. Most other providers perform their duties sequentially and on a one-to-one basis with patients. A bedside nurse, on the other hand, may be assigned to five patients, four discharges, and four admissions during one shift. This is one reason we need a new model. Another

reason is the forecast for a different type of nurse within the next 5 to 10 years. Many current responsibilities of nurses will be completely automated by 2025, and others will be performed by nonnurses.

Today, 68% of nurses work in the acute care setting, but a dramatic transition to ambulatory and community-based systems will take place during the next 3 to 5 years. However, this does not mean that the registered nurse's position is in jeopardy. On the contrary, according to the U.S. Bureau of Labor Statistics, we will need about half a million additional nurses by 2020, and with more than 600,000 nurses expected to retire in the next several years, more than 1.1 million nurses will be needed to fill the gap. So twenty-first-century nurses will not only be in high demand, they also will have many new opportunities to pursue.

We anticipate that nurses will serve primarily as educators and care coordinators, roles that are critical in the new care model. The nurse will be the professional who provides clarity around the complexities of healthcare and manages the patient's journey through the system. But with greater privilege comes greater responsibility, and I am convinced that nurses must play an even more active role in the new model of care.

Dr. Kash: *You have an extensive background in leadership development and physician training. What are your thoughts on the type of leadership training needed for healthcare administrators and physician leaders?*

Ms. Knodel: Becoming a leader does not happen overnight or by happenstance. I was fortunate to have leaders who saw potential in me and gave me numerous opportunities to grow and develop. The same scenario holds true today because we, as leaders, have a responsibility to identify and mentor those who desire a similar path. Leadership development is continuous learning; it means living what you learn, becoming a role model, and engaging with others. The turning point for me occurred when I had the opportunity to be a faculty member at AONE, which sponsors an Emerging Nurse Leader Institute. When we began this program more than 10 years ago, we taught a 3-day leadership course across the United States, and aspiring and new nurse leaders attended this course. These individuals were so hungry to learn that at times they broke down and said they had never been taught this material before, yet were expected to perform at a certain level. That experience really taught me about the enormous opportunity for education and training in our field.

I was fortunate that several healthcare administrators—all Regents or Governors of ACHE—served as my mentors. They encouraged me to become active, join a committee, and consider running for Regent. Then-CEO Tom Dolan reached out to me, and we had discussions about growth and opportunity. What really makes a difference is that special individual who identifies talents in others, mentors them, and allows them to grow. You become lifelong friends and professional colleagues.

In one of my previous jobs, I was responsible for medical staff services; that was before the advent of chief medical officers. When the organization brought on new medical staff leaders, I took them to boot camps or physician leader orientations

across the United States. These clinicians were highly trained in their specialties and subspecialties, but they were learning an entirely new skill set and developing as leaders. My most memorable takeaway from these boot camps and orientations was observing the physicians learning together. A group of six to eight attended the 3-day classes about leadership development and the role of medical staff leaders. They learned from each other or called on each other when an issue arose. The experience was inspiring and affirmed the importance of team training opportunities.

As part of the operating room (OR) leadership, I had the opportunity to attend an OR boot camp with service line leaders, nursing leaders, and the head of anesthesiology. They went to team meetings and became immersed in leadership development. When you see positive outcomes, collaboration, and individuals setting and achieving goals together, you realize that this is the right thing to do and the right team to make things happen.

Dr. Kash: *Describe the top challenges facing not-for-profit health systems today and in the next 5 years.*

Ms. Knodel: I think finances are going to be a real challenge as we manage patient care and other demands. Not-for-profit organizations have a responsibility to show the impact they are having on our communities. We have to be more collaborative in using our resources to improve the health of our neighbors. We will be working to manage our patients' health to keep them out of the hospital and, in our roles as nurses or community healthcare providers, giving them the best care at the lowest cost. I also believe that finding and retaining talented staff members is going to be another significant challenge. Roles will emerge that we don't even know about today. When one thinks about the role of a data scientist, that role did not exist a few years ago. Now, these experts help us look at and interpret data so we can determine what has worked best in treating patients with a certain condition.

Dr. Kash: *How have you accomplished so much as a nurse leader and an executive and balanced work with family?*

Ms. Knodel: Most important is being surrounded by people who want you to be successful, and the first person I think of is my husband. When we began this career journey, our children were aged 3, 5, and 8. When I told my husband that I needed to go back to school, he was fully supportive and told me to do whatever I needed to do. So for the next 11 years, I attended school and studied at night with the kids at the dining room table. My husband took the children to the park on weekends so I had time to study.

I also think it is important to surround yourself with mentors in the workplace who want to help you grow. There were summers when I took classes at the University of Minnesota, and my CEO told me to take off as much time as I needed. While writing my thesis, I asked to take every Friday off for 2 months, and he always said yes. But my greatest strength and support came from my family.