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THE POSITION OF THE NURSE EXECUTIVE AT THE CORPORATE LEVEL OF A MULTIHOSPITAL HEALTH CARE SYSTEM: AN EXPLORATORY DESCRIPTIVE STUDY

by

FRANCES LORRAINE GUTOWSKI, B.S.N., M.N.

DISSERTATION

Presented to the Graduate Faculty
in Partial Fulfillment
of the Requirement
for the Degree of

DOCTOR OF NURSING SCIENCE

LOUISIANA STATE UNIVERSITY MEDICAL CENTER
SCHOOL OF NURSING

New Orleans, Louisiana

August, 1995

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OF A MULTIHOSPITAL HEALTH CARE SYSTEM:

AN EXPLORATORY DESCRIPTIVE STUDY

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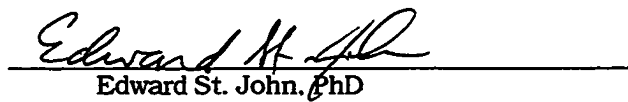
Edward St. John, PhD

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Abstract

An exploratory descriptive research design was used to describe the position of the nurse executive as it naturally exists at the corporate level of a multihospital health care system (MHHCS). A convenience sample composed of 14 corporate nurse executives (CNEs) with at least one year of experience in MHHCS located in the United States was used. Data collection methods included unstructured telephone interviews, a written open-ended questionnaire, and a demographic data form. The unstructured data were analyzed by content analysis and the structured data by quantitative methods. Three research questions guided the investigation: (1) what is the role of the CNE of a MHHCS? (2) what are the responsibilities of a CNE in a MHHCS? (3) what are the relationships of the CNE within the MHHCS? Descriptive summaries for the categories of role, responsibilities, and relationships were compiled. Following the descriptive summaries dominant themes from the categories are reported. These themes are: health care environment, collaboration, global vision, change agent, and nursing's perspective. Findings indicated that the role of the CNE is an expansion of that of the local nurse executive. The subjects identified characteristics, functions and skills needed to perform in the role of CNEs.

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DEDICATION

In Loving Memory of my Parents

Michael Isadore Gutowski
1915-1982

Father, supporter, comforter, and able provider
who loved me into living

and

Erma Lorene Hickam Gutowski, RN
1916-1994

Mother, friend, counselor, mentor and role model
who loved me into nursing

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CHAPTER I

INTRODUCTION

This study explores and describes the unfolding position of the contemporary nurse executive at the corporate level of a multihospital health care system. The nurse executive role has been in existence since Florence Nightingale went to the Crimea in 1854 and organized nursing services for the British Army (Henry, Woods, & Nagelkerk, 1990). Since that time nurse executive practice has evolved to include not only the management of individual patient care but also the management of nursing departments in a variety of health care settings.

As with the development of most new entities, little is known about what constitutes the position of the nurse executive at the corporate level in a multihospital health care system (MHHCS). This position has come into existence with the establishment of the MHHCS during the early 1970's. With the continued expansion of multihospital systems, the role of the nurse executive at the corporate level is emerging as a new phenomenon in nursing administrative practice. The investigator believes that the information obtained from this study can be useful to health care corporations, nursing administration, graduate nursing education, and further research.

Since little or no research has been conducted on the position of the CNE in a MHHCS, an explanation of this role is not based on a conceptual framework or existing theory but rather on the ingenuity of the investigator to explore and describe the topic as identified in the available literature. At the completion of this study several themes emerge to provide a nucleus for discussion of the results by the investigator (Brink & Wood, 1944, p. 101).

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Purpose

The purpose of this study is to explore and describe the position of the nurse executive as it naturally exists at the corporate level of a multihospital health care system.

Research Questions

In order to gain clarity on the position of the nurse executive at the corporate level of a MHHCS, answers to the following research questions were sought.

1. What is the role of the CNE of a MHHCS?
2. What are the responsibilities of a CNE in a MHHCS?
3. What are the relationships of the CNE within the MHHCS?

Definition of Terms

AHA--American Hospital Association.

Characteristic--a distinguishing trait.

Contract--a written agreement between the CNE and the organization, describing the terms of employment.

Corporate level--the location (corporate office) of the highest executive management position in a multihospital health care system.

Corporate Nurse Executive (CNE)--the nurse executive at the corporate level of a MHHCS with responsibility for nursing.

Function--a special duty required in work.

Health Care System--an organized way of delivering health services identified as both multihospital and diversified single hospital systems.

Local Nurse Executive (LNE)--the nurse at the executive level of management in the hospitals owned, leased, sponsored or contract managed of a MHHCS.

Multihospital Health Care System (MHHCS)--two or more hospitals owned, leased, sponsored or contract managed by a central organization for the

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purposes of shared services, purchasing, development of capital and new service areas.

Position/role--official rank or status held within the MHHCS by the CNE.

Relationship--the connection between or among persons.

Responsibilities--able to answer for one's duties and obligations.

Setting--the corporate office of a MHHCS and the hospitals that are leased, owned, sponsored or contract managed by an MHHCS.

Skills--a learned power of doing something competently; a developed aptitude or ability.

Assumptions

Assumptions for this study include the following:

1. Nurse executives are responsible for creating and maintaining the environment for the delivery of nursing services within established health care settings.

2. The role of the nurse executive at the corporate level in a multihospital health care system is an expansion of the functions, responsibilities and relationships of the local nurse executive.

3. Increased opportunities for local nurse executive advancement to the position of the corporate nurse executive will be provided by the continued growth of multihospital health care systems.

4. The position of the corporate nurse executive is equivalent to the positions of other members of the executive team at the corporate level of the multihospital health care system.

5. The rapidity of change associated with the health care delivery system and its effect upon the practice of nursing will continue to influence the role of the corporate nurse executive.

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Limitations

Limitations of the study are as follows:

1. Due to the evolving nature of the position, the number of nurse executives at the corporate level in MHHCSs is small.

2. The use of a convenience sample is necessary and therefore the results of the study are not generalized to all corporate nurse executives.

3. The use of a specific time frame for data collection narrows the ability to add new subjects as corporate level nurse executive positions increase.

4. Because of the nature of this study, no inferences are drawn from the data.

Significance of the Study

A consequence of this study is a foundational description of the role of the nurse executive at the corporate level. The present study also has the potential of contributing to the nurse executive literature. While examining the themes to answer the research questions, considerable data were collected to describe the position of the nurse executive at the corporate level. The information given by the corporate nurse executives provided a better understanding of the position. The study also provided for those corporate nurse executives, who actually hold the position and were the subjects of the investigation, a validation of their role description.

Summary

In this chapter, the problem statement, purpose of the study, the research questions, definition of terms, assumptions, limitations, and significance of the study were presented. A conceptual or theoretical framework was not presented, since little or no research has been conducted on the position of the CNE in a MHHCS. The investigator sought to identify central themes that emerged from the data collected in the course of this study. These themes provide a framework for a discussion of the results.

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CHAPTER II

REVIEW OF THE LITERATURE

The position of the nurse executive at the corporate level in MHHCSs is a relatively new entity in nursing administrative practice. In order to describe this evolving position of the nurse executive, the following areas were identified in a review of the nursing and business literature. These areas are role, responsibilities, and relationships. A review of the MHHCS literature aides in the articulation of the corporate setting of which this developing position is a part.

Multihospital Health Care Systems

The MHHCS in many instances is replacing the provision of contemporary health care by the individual hospital provider. It is predicted that by the year 2000, more than half of the hospitals in the United States would be part of a multihospital system (Harrison & Roth, 1987). The establishment of MHHCSs was the result of the enactment of Medicare and Medicaid programs in the middle 1960's. Rapid growth and development occurred in the types of services provided, buildings, construction, equipment, and the number of MHHCSs. The climate changed in the middle 1980's and multihospital systems became endangered. The implementation of a prospective payment system coupled with environmental forces such as cost containment, competition due to continued deregulation, and a choice in delivery of care systems caused MHHCSs to reorganize, dissolve, or merge (Risk, 1992). Donaho (1989) and Kaiser (1992) predict the continued growth of multihospital systems, stating their underlying purpose as the delivery of efficient, cost-effective, quality care. The MHHCS has the structure to offer a variety of health care services through regionalization to fulfill its purpose and remain viable in the 21st century.

There are two types of MHHCSs: for-profit (investor-owned/proprietary) and not-for-profit (secular, Catholic, other religious, and public) systems (Brown, 1982; Freund & Mitchell, 1985; D. Johnson, 1985; Mark, 1984; & Relman, 1980). Mark (1984)

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succinctly described investor-owned and not-for-profit hospital systems by identifying three differences: legal, financial, and organizational.

The first difference involves the legal aspect. Nonprofit systems are formed for the purposes of charitable works, education or scientific endeavors, and are operated by not-for-profit corporations governed by state corporation laws. However, investor-owned hospitals are operated either as separate proprietary businesses or as subsidiaries of larger profit-making multihospital systems, governed by the business corporation laws of the state in which they are incorporated (Mark, 1984).

The second difference, financial, designates tax exempt status. The nonprofit system is exempted from federal income tax under Section 501(3)(c) of the Internal Revenue Code. This enables nonprofit systems to have access to support provided by tax deductible activities, while investor-owned are not tax exempt but have the ability to raise funds by issuing stock (Mark, 1984).

The third difference is organizational. Both types of multihospital systems, for-profit and not-for-profit, are based on legal constraints, financial characteristics, patient care philosophy, and strategies used to meet their specific mission and goals. According to Beyers "the influence of mission of MHHCS on governance, and subsequently on the identity of the corporation, may be the essential difference between for-profit and not-for-profit corporations" (1988, p.73).

Little is known about the position of the CNE, the issues related to nursing, and nursing practice in the MHHCS. However, the development of the CNE position attests to an understanding and valuing of nursing's contributions toward the continued life of the system. Some challenges are apparent: gaining equality with other executives in developing policy about the allocation of resources in a cost-effective manner, quality control, and addressing relationships with consumers and staff from many perspectives (White & Green, 1989).

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<u>Role, Responsibilities, and Relationships</u>

The manner in which the individual performs within the organization is known as role. The CNE's perception of position and the organization's expectations meet and determine how a given role will be executed (Owens, 1987, pp. 60-65).

Stevens (1981) looks at the positions people hold from two perspectives: ascribed and achieved. The ascribed role defines expectations and actions not of the person's choice but based on such attributes as gender, ethnicity, and culture. The achieved role is based on the position held by the individual and is composed of the expectations of people in society of the person in the position; job responsibilities as delineated in position descriptions, organizational policies, and procedures; and the uniqueness of the individual in determining how the job is performed (p.19). These features help the person in a specific position to identify that role's content.

From his studies of the role of managers, Mintzberg's (1990) role classifications of interpersonal, informational, and decisional could be used to describe the functions of corporate nurse executives. These roles are overlapping and form an integrated framework from which executives perform specific job functions within the organizational structure. The interpersonal role is composed of basic human relationships and addresses the functions of figurehead, leader, and liaison. The informational role processes information gleaned from interpersonal contacts from within the organization and a network of contacts from without the organization. Decisional roles are based in executive authority and the interpretation of information necessary to plan strategically (pp.168-172).

Today executives are responsible for building relationships within corporate management by collaborating, cooperating and negotiating with other professionals; supporting staff in a variety of settings; and, responding to community groups and clients within corporate institutions. In order to meet these challenges, executives must be able to blend the responsibilities of a professional nurse and an executive.

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Some of these skills include designing work structures for professional nurses, developing and implementing care delivery systems, fostering research and publication, implementing total quality management or continuous quality improvement programs, participating in long range institutional strategic planning, team building on the corporate and institutional level, and satisfying external regulatory and accrediting agencies (Cusine, 1983; Farley & Stoner, 1989; Jacobsen-Webb, 1985; Mateo & Meeker, 1992; McCloskey, Gardner, Johnson, & Maas, 1988; Neidlinger & Miller, 1990).

Katz (1974) has developed a framework for executive role development based on conditions existing in the organization. The concepts of his framework are: (a) the remedial role for which conceptual and human skills are needed to plan and implement corrective action, (b) the maintaining role with emphasis placed on technical skills because of the need for only minor technical or strategic changes, and (c) the innovative role with its demands for competence in conceptual and human skills. The ability to place subordinates in positions to provide the technical skill needed is maintained (pp. 91-95). This framework provides the executive with a balance of skills needed to change and adapt management practices that effectively support organizational change, growth, and development.

Byrd (1987) has provided another frame of reference which might enable executives to address new management realities. This category includes various types of skills: (a) anticipatory skills, (b) visioning skills, (c) value-congruence skills, (d) empowerment skills, and (e) self-understanding skills, (pp. 34-42).

Various nursing administrative authors have identified skills and characteristics for the nurse executive. Two studies, one in university based hospitals (Freund, 1985) and the other in community based hospitals (Moore, Biordi, Holm, & McElmurry, 1988) resulted in the identification of those characteristics which led to effective LNEs.

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The first study (Freund, 1985) identified the following characteristics rank ordered by nurse executives in an opened ended questionnaire. The characteristics are: general management/health and nursing knowledge, human management skill, total organization view, chief executive officer support, medical staff relations, flexibility/negotiation/compromise, and political savvy (p. 27). Using the same characteristics identified by Freund (1985), Moore, et al (1988), asked LNEs in community based hospitals to rank order these same characteristics according to level of importance. Respondents were encouraged to include any characteristics of effectiveness that might be missing. The order of the characteristics according to this study is: human management skill, chief executive officer support, management/ health/nursing knowledge, total organizational view, flexibility/negotiation/ compromise, political savvy, and medical staff relations (p. 25). Both the university and community settings identified the same characteristics in the top four positions, though ranked differently. There is consensus within these two settings about the skills needed by LNEs to be effective in each environment (pp. 23-26).

The expectations of chief executive officers for nursing are similar to those for other health care executives: a broad organizational perspective and a vision of how nursing fits into the organizational structure as well as the possession of leadership, management, and business skills. The LNE has the responsibility of meshing nursing knowledge not only with knowledge of the health field but also must incorporate business and management techniques. Business and management skills assist LNEs in the efficient use of nursing resources in delivering cost-effective quality nursing care (Mark, Turner, & Englebardt, 1990).

In an effort to identify role characteristics of LNEs, Dunham and Fisher (1990) conducted a study of 85 local hospital nurse executives. They asked these nurses to describe the characteristics of excellent nursing leadership. Eighteen themes emerged from the taped interviews. The themes included administrative competence with

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adequate educational background, business skills, and clinical expertise combined with a global understanding of leadership principles. The second theme included the importance of creating an environment such that the professional nurse can participate at both the organizational and professional level. The third theme addressed was the ability of the LNE to integrate nursing into the overall organizational setting. The fourth theme addressed the LNE's appreciation of the difference between negotiation and compromise, and the possession of effective negotiation skills. The fifth theme involved the LNE as an ambassador for nursing with the medical staff, the board, hospital administrators, and the public. The sixth and final theme indicates that the excellent LNEs have strong value systems, are creative, have vision, are risk takers, possess flexibility, are adaptable, have good communication skills, establish vision and set direction, empower, mentor, recognize excellence in staff and others, mentor, and constantly grow and learn (pp. 1-5). The study results support leadership characteristics presented by various authors in the literature.

Fralic (1993) has identified characteristics that she considers the centerpiece for LNEs in terms of being key decision makers. "The new era LNE will be: clinically centered, competent, credentialed, credible, caring, creative, catalytic, composed, clairvoyant, and confident" (p. 8). Possession of these skills facilitates cost - containment, quality of service, and the redesign of systems that LNEs can perform effectively and efficiently in an era of professional clinical practice.

Effective executive leadership, according to Sovie (1987), calls for creating and maintaining an environment in which professional nursing can be practiced. This is accomplished by projecting visions, providing role models, establishing values that followers embrace, setting policies by which the organization is conducted, creating systems to get work done, establishing norms regarding attitudes toward customers,

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stimulating involvement and teamwork, and promoting the sound use of human resources (p. 19).

Corporate Nurse Executive

The position of the nurse executive at the corporate level in MHHCSs has been in existence since the mid 1970's. As with the development of most new entities, little is documented about what constitutes the CNE position today. The most frequently quoted survey concerning nursing at the corporate level was conducted by the National Commission on Nursing (Beyers, 1982 & 1984). This preliminary study provided some information on the existence of corporate nursing and the identification of various nursing roles, titles, and responsibilities. One of the areas addressed in this study, with a limited response rate, related to the position of the CNE. The CNE was defined "as the one holding the corporate level position in a multihospital system with designated functions for nursing service" (p. 69). The results of this part of the study showed that "of the nine most frequently quoted functions, management education and consultation were most consistently reported" (p.73). Consultation is a service offered to assist LNEs and other members of the health care team in problem resolution, interdepartmental/intraorganizational relationships, and in the promoting of corporate mission, goals and objectives within the total organization (Beyers, 1986; Donaho, 1986; Nail & Singleton, 1986 & Holt, 1988).

Colleagues in the corporate office are for the most part non-nurses. The responsibilities of the nurse executive in the corporate office encompasses broad areas of health care that are not isolated solely to nursing and nursing practice issues. The CNE is expected to define and interpret nursing to other members of the corporate management team and work in a collaborative manner to facilitate the delivery of services. Of importance is the peer relationship between the nurse executive and other corporate executives and the full participation of the CNE in the decision making process (Stevens, 1985; Mark, Turner, & Englebart, 1990).

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Beyers (1984) has described the role of the nurse executive as a member of the corporate office. Removed from the daily operations for nursing services in the health care institutions, the corporate nurse executive has accountability ranging from staff, to line, or a combination of both. There seems to be two roles for the corporate nurse executive, each with the same purpose (provision of cost-effective, efficient, quality nursing services for the patient) and fit (personal values, philosophy match the organization's). In one role the nurse executive is responsible for operations; in the other for policy. The nurse executive for operations is concerned with institutional relationships and functions; whereas the nurse executive responsible for policy formulation oversees generalizable programs/projects and long-range planning (pp.32-35).

Stevens (1985) has proposed two practice dimensions for corporate nurse executives: the nurse executive in the local facility of the MHHCS and the nurse executive located at the corporate office of the MHHCS. The local nurse executive (LNE) in a MHHCS experiences a role change that requires skill in communication, networking, joint decision making, and collaboration with other LNEs. The nurse executive on the corporate level tends to see the position from a system wide perspective, working with other corporate executives. On the corporate level the CNE becomes the spokesperson for nursing and works in developing corporation wide systems for nursing. The CNE must also possess the skills to concentrate on relationships that are upward and outward; fulfill the duties of figure head (ceremonial duties); engage in strategic planning, marketing and public relations. In addition, skills will also be needed to assist in the selection of hospital directors of nursing compatible with the corporation, and serve as role model and mentor (p. 241).

The role of the nurse executive within the MHHCS corporate structure addresses some of the following areas: mission, goals and objectives of the organization. Accomplishing these areas depends upon the CNE's use of developed leadership skills:

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personal and professional power, influence, effective communication, and the establishment of meaningful relationships among the professionals of the corporate office and the various institutional level executives. Two approaches can be used for the accomplishment of organizational goals and objectives: a nursing council of the MHHCS LNEs to focus upon professional nursing issues, and the placement of a nurse executive on the corporate board of directors (Fine, 1989; Flarey, 1991; Singleton & Nail, 1986).

Aydelotte (1988), Beyers (1988), and Donaho (1989) suggest that the responsibilities of the CNE include: strategic planning, program and policy development, and the efficient use of resources. These three authors have also identified functions/characteristics that are specific to the corporate nurse executive. For Beyers (1988), leadership is foremost in the nonprofit corporate nurse executive role. The nonprofit corporation is service oriented and holds many of the values associated with nursing such as compassion, caring, satisfaction from service to others, and effective resource utilization. The job of the corporate nurse executive is the effective integration of the values of the corporation into the professional behaviors at every level of the corporation (pp. 74-78).

Donaho (1989) says the difference between the corporate level nurse executive and the local nurse executive is that the former reports results to many different forums. These include hospital executives, corporate officers, and boards of directors. Contrasted to the CNE, the local executive reports only to the one institution. These reporting relationships are based on the expectations of the role of the CNE (pp. 655-657).

Aydelotte (1989) presents characteristics that she sees as essential for the CNE. They are: the flexibility to achieve goals by various methods; the ability to work with limited resources in the resulting competition between systems and professionals;

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imagination and intelligence; open-mindedness; appreciation of the human element in the enterprise; and the acceptance of accountability for actions and decisions (p. 11).

Summary

The emerging position of the CNE was explored and described by using concepts and sub-concepts gleaned from the business and nursing literature. Three major concepts have been identified; role, responsibilities, and relationships. Each one of these three major concepts has sub-concepts. The concept of role includes three sub concepts: skills, functions, and characteristics. The concept of responsibility has two sub concepts: corporate responsibilities and institutional responsibilities. The concept of relationships includes the: relationships held with other corporate executives, LNEs and executive teams of member health care facilities.

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CHAPTER III

METHOD

This chapter addresses the study's research design, sample, setting, instrumentation, reliability and validity, procedures for data collection and analysis of data. It further describes how the methodology and procedural steps were implemented. The exploratory descriptive research design (Brink & Wood, 1994) was used in eliciting a position description of the nurse executive at the corporate level from the perspective of individuals currently in the roles.

Research Design

An exploratory descriptive design was used in order to answer the question: What is the position of the nurse executive at the corporate level in a MHHCS? A mixed method of data acquisition resulted in acquiring both qualitative, unstructured data and quantitative, structured data. The exploratory descriptive study examined the characteristics of a specific population, CNEs in the United States. Since a review of the literature did not reveal any significant research in the area, the exploratory descriptive design of this study was appropriate. Given the substantial lack of research in this area, the investigator sought to explore the topic for herself. This is an initial step in the development of new knowledge (Brink & Wood, 1994).

Because of the flexibility of exploratory descriptive designs, the variable under study, CNE position, generally is not under the investigator's control. Rather, the variable is said to be under the control of the situation, observed or reported by those in the position or as the investigator comes upon them (Brink & Wood, 1994, pp. 101-103, 116-117, 231).

Sample

A convenience (nonprobability) sample of nurse executives located at the corporate level in MHHCSs was used for data collection. This type of sample is particularly useful when the total population is unknown or not available. Further, a

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convenience sample is important in exploratory descriptive studies, because it provides a base for further research and augments interpretation of the study's results (Brink & Wood, 1994, pp. 27, 133-134).

The inclusion criteria for subjects were as follows: hold the position of nurse executive, male or female, at the corporate level with responsibility for nursing; have at least one year of experience in the position; possess a role equivalent with other corporate executives; be in a MHHCS as a place of employment and listed in the AHA Guide to the Health Care Field, Section III, Multihospital Systems (1993); and be located in the United States.

The exclusion criteria for subjects were as follows: any person responsible for nursing in a multihospital health care system who is not a nurse; CNEs with less than one year of experience in the position at the corporate level of the MHHCS; nurses who function solely as consultants; nurses whose sole responsibility is quality improvement, health care policy development, education, research or any other types of support services.

Setting

The setting for the study, was located at the corporate level of multihospital health care systems (MHHCSs). An MHHCS is composed of two or more hospitals that are owned, leased, sponsored or contract managed by a central organization. The MHHCSs in this study were either not-for-profit or investor owned for-profit systems. These health care systems are located in the United States (AHA guide to the health care field, 1993, B2) and are organized for the purpose of shared services, shared purchasing, the development of capital and new service areas such as managed care (Beyers, 1988).

Instruments

Three instruments were developed by the investigator from the business and nursing executive literature for use in data collection: The Telephone Interview Guide; Corporate Nurse Executive Descriptive Questionnaire (CNEDQ); and the Demographic

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Data Collection Form. They were developed to obtain descriptive words and statements, and to elicit perceptions and feelings of the subjects about the CNE position.

The Telephone Interview Guide (Appendix E) was developed for use by the investigator to provide guidance during the unstructured telephone interview. The guide also served to remind the investigator to elicit copies of position descriptions and organizational charts.

The CNEDQ (Appendix G) was the second instrument developed. The purpose of this instrument was to identify a description of the corporate position from the CNE's perspective and own words. Approximately a 60 minute block of time was necessary for the completion of the CNEDQ. The CNEDQ contains 30 open-ended questions divided into four parts: setting, role, responsibilities, and relationships. The questions sought the same type of information in exactly the same way, thus contributing to reliability of data. This instrument was not highly structured, allowing for the subjects to freely respond to the questions in their own words. These are descriptions resulting from nonfactual questions and may or may not accurately reflect the facts (Brink& Wood, 1994, p. 148). The CNEDQ instrument was reviewed by two selected nurse executive educators and one selected CNE. This allowed for clarification and improvement of the questionnaire while also establishing the amount of time required for completion. This review established face validity of the CNEDQ. In addition, a pilot study was conducted on a small group of three nurse executives who have experiences similar to the nurse executives for whom the CNEDQ was designed. The CNEDQ was tested on these nurse executives to obtain clarity, adequacy for the research conducted, and freedom from problems and bias. Further discussion of reliability and validity of the CNEDQ is addressed in association with content analysis (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991, p. 334).

The third instrument developed was the Demographic Data Form (Appendix H). This form asked factual questions about the subjects themselves in an effort to better

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describe the CNE position. Selected primary self-reported data such as age, basic preparation for nursing, and length of time in the CNE position were collected.

Data Collection

The data collection procedures used allowed for the flexibility which is characteristic of exploratory descriptive studies (Brink & Wood, 1994). The process for collecting data for this study follows:

1. A list of 294 MHHCS was obtained from the AHA Guide to the Health Care Field, 1993, B2.

2. A letter (Appendix A) was written to the president/chief executive officer of each MHHCS identified in The AHA Guide to the Health Care Field, asking if a CNE position existed at the corporate level.

3. Presidents/chief executive officers were requested to return the enclosed stamped self-addressed post card (Appendix B) within approximately two weeks, checking either Yes or No regarding the CNE position.

4. If the presidents/chief executive officers checked Yes, they were requested to provide the CNE's name and telephone number.

5. If less than 20 CNEs were identified by the presidents/chief executive officers, then a follow-up letter addressed to the Corporate Nurse Executive (Appendix C) would be sent to those MHHCS who did not initially respond. They were then requested to return the post card within approximately two weeks providing their name and telephone number. This step was later determined unnecessary.

6. The investigator contacted each identified CNE of a MHHCS by telephone. The investigator introduced herself, explained the purpose of the study, and secured an agreement to participate.

7. The Telephone Interview Guide (Appendix E) was used to request copies of organizational charts and position descriptions for CNEs if available.

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8. During the telephone interview the CNEs were asked if they had formal contractual written agreements with their organization.

9. The investigator also requested that one of the two signed consent forms be returned with the organizational charts, position descriptions, CNEDQ, and the Demographic Data Form (hereafter referred to as the data collection packet).

10. All of the telephone interviews were tape recorded in order to preserve the original comments of the respondents. Anonymity of the respondents was maintained. The tape recordings were transcribed and stored in a secure place in order to insure further confidentiality. The subjects could review their interview tapes upon request. All tapes were erased with the completion of the study.

11. At the conclusion of the telephone interview a data collection packet was mailed directly to the CNEs who met the study inclusion criteria and agreed to participate in the study. The packet included a cover letter explaining the study (Appendix F); the CNEDQ (Appendix G); Demographic Data Form (Appendix H); and, two consent forms (Appendix I). A Two Day Priority Mail stamped, self-addressed envelope was provided by the investigator to the CNE for returning the data collection packet.

12. After receiving the data collection packets from the CNEs, the investigator retained the option of doing a second tape recorded telephone interview, if needed. The follow-up telephone interview was unstructured and was to be used to augment data collected from the CNEDQ, the Demographic Data Form, and the first telephone interviews. After reviewing the returned data collection packets, this step was determined unnecessary.

The use of the Telephone Interview Guide, the CNEDQ, and the Demographic Data Form by the investigator was predicated on the following factors: the number of nurse executives in the role; the cost of travel associated with personal interviews; the length of time required by the nurse executive to verbally answer the questions leading

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to role description; and, the documented low return rate of mailed questionnaires. There are three advantages of using the interview: clarification of the purpose of the study, the gaining of a higher commitment of the subject's participation, the increased retention and higher response rates. The advantages of the two instruments (CNEDQ and the Demographic Data Form) included reduced expense in time and money, relative anonymity, and a standardized format which allowed the subjects to respond to the questions without dependence on the interviewer (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991).

The disadvantages of the interview technique, such as excessive time and expense, were offset by the use of the CNEDQ. The disadvantages of the CNEDQ such as low return rate and confusion on the manner of responding to certain questions, were reduced by seeking in the first interview a commitment from the CNEs to participate and a clarification of responses received in the CNEDQ and Demographic Data Form. If further clarification was determined necessary, a second telephone interview was to be used. However, it was not necessary. Uniformity in data collection procedures assured the collection of specific information provided from the telephone interviews, the CNEDQ, and the Demographic Data Form (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991).

Data Analysis

One of the ways data can be analyzed in exploratory descriptive studies is by using the technique of content analysis. Content analysis allows for the studying of the unstructured data in the form of the written word. The data collected from the telephone interviews, the returned mailed instruments (CNEDQ and the Demographic Data Form), position descriptions, and organizational charts, were analyzed by a pre-defined process. This process identified phrases; provided descriptive summaries of the data categories using the structure of the CNEDQ; and determined common themes from the returned data (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991).

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The procedure for content analysis involves a number of steps directed by the research questions. The steps for analyzing the content were adapted from Waltz, Strickland, and Lenz (1991) and are as follows:

1. All of the data obtained from the telephone interviews, the CNEDQ, the Demographic Data Form, the position descriptions, and the organizational charts were content analyzed using the research questions as a guide.

2. The responses from the CNEDQs, the Demographic Data Forms, position descriptions, organizational charts, and transcribed telephone interviews were read and assimilated, then documented on blank CNEDQs with corresponding codes according to repetition of words, phrases and ideas.

3. Using the original words of the subjects, similar data were clustered in the categories as coded for the CNEDQ.

4. Descriptive summaries of the categories were written after the data were analyzed (pp. 299-307).

This investigator quantified selected data and used descriptive statistics to seek additional meaning and insight into the role of the nurse executive at the corporate level.

The descriptive summaries reflected, as accurately as possible, the comments of CNEs, thus preserving the reality being studied. Consistency in identifying and in assigning the units to categories was assessed by having another rater review categorization and assignment of units determining reliability (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991).

Validity for the CNEDQ was determined with an affirmative answer to the following three questions: Do the questions asked elicit a description of the role of the corporate nurse executive? Does the method of analysis result in an accurate representation of the phenomenon under study (CNE)? Do the nurse executives selected to review the two instruments (CNEDQ and the Demographic Data Form) and those nurse

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executives who participated in the "pilot study" judge that the Telephone Interview Guide, the CNEDQ, and the Demographic Data Form "on the face of it" collected what it was designed to collect? Affirmative answers to these questions determined a degree of validity (Brink & Wood, 1994; Waltz, Strickland, & Lenz, 1991).

Summary

This chapter addressed the study's research design, sample, setting, and instrumentation. Data collection procedures and methods for analyzing the data were described. Both reliability and validity were considered as components to content analysis.

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CHAPTER IV

RESULTS

A convenience sample composed of 14 CNE subjects was used for this study. The presidents/chief executive officers of 294 MHHCSs were surveyed by letter requesting the name and telephone number of their CNE by return post card. There were 201 (68%) responses received from the Presidents/Chief Executive Officers of the MHHCSs resulting in the identification of 65 CNEs. The investigator contacted the 65 CNEs identified by post card; 22 (34%) of the CNEs identified met the study's inclusion criteria; 14 (64%) of the 22 CNEs who met the inclusion criteria returned the data collection packet mailed directly to them.

A description of the corporate nurse executive was obtained by examining data from the use of a combination of two data collection techniques: the Telephone Interview Guide and the CNEDQ. The Telephone Interview Guide provided pre-determined open-ended questions designed to elicit eligibility for participation, commitment to the study, organizational charts, position descriptions, and information regarding the use of a written employment contract by the CNEs.

A description of the corporate nurse executive in a multihospital health care system evolved from the descriptive summaries written for the categories of role, responsibility, and relationship. These categories were developed from a review of the literature and were used for structuring the questions found in the Corporate Nurse Executive Descriptive Questionnaire (CNEDQ). In the process of analyzing the data from this study, themes emerged which enhanced the description of the CNE position. Data were collected from telephone interviews, position descriptions, organizational charts, the CNEDQ, and the Demographic Data Form. The data collected were then shuffled from one category to another. During this process five dominant themes emerged: health care environment, collaboration, global vision, change agent, and nursing's perspective. A model of a position description for the corporate nurse

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executive of a MHHCS is presented in Appendix J. This description is in the CNEs own words and used for the purpose of reporting results to the subjects. In addition results from the Demographic Data Form are presented.

Demographic Characteristics

The demographic characteristics of the 14 CNE subjects are presented in Table 1. The results cannot be generalized to all CNEs but some observations can be made. Thirteen (93%) of the 14 subjects were women, reflective of the predominance of women in the nursing profession. There are no minorities represented among the subjects; all (100%) were Caucasian. Basic nursing education varied among the CNEs, which may reflect the nursing profession's failure to resolve entry-into-practice issues. Advanced educational preparation (13 subjects or 93%) demonstrates the CNEs' knowledge and effectiveness in their position. The subjects with advanced degrees reported having a combination of nursing and non-nursing degrees. This may be reflective of the lack of standardized educational programs in nursing administration. Experiences varied: all (100%) of the subjects reported the necessity of working their way through clinical and managerial paths. One CNE expressed: "This type of experience leads to credibility with LNEs, local level administrative staff, and your colleagues in the corporate office."

Insert Table 1 about here

Setting

Data indicated that the purpose of a MHHCS is to deliver efficient, cost-effective quality care. To accomplish this end, a variety of health care services are contract managed, leased, and/or owned by the MHHCSs. According to the subjects, patient services are discharged through regionalization, integrated health care delivery systems, community based health care systems, and integrated networks. Also, the

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Table 1

Demographic Characteristics of 14 CNE Subjects Located in 14 MHHCS Headquarters

	n	%
AGE		
40 - 49	6	43
50 - 59	6	43
60 and above	2	14
SEX		
female	13	93
male	1	7
MARITAL STATUS		
single	4	29
married	8	57
divorced	2	14
BASIC EDUCATION		
diploma	7	50
associate degree	1	7
baccalaureate	6	43
HIGHEST DEGREE EARNED		
baccalaureate	1	7
masters in nursing and/ or related field	11	79
doctorates in nursing or related field	2	14

table continues

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SALARY RANGE	n	%
$70,000 - 79,000	3	21
80,000 and above	11	79
RACE		
Caucasian	14	100
EXPERIENCE TYPES		
managerial	14	100
consultation	1	7
staff nursing	9	64
PROFESSIONAL EXPERIENCE in years		
Present Position		
1 - 5	9	64
6 - 10	4	29
11 and above	1	7
Nursing Administration		
1 - 9	2	14
10 - 19	6	43
20 - 29	4	29
30 and above	2	14
Nursing		
20 - 29	6	43
30 - 39	5	50
40 and above	1	7

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CNEs who participated in the study provided examples of various types of services offered from acute care to home care; birthing centers to hospices; physician practices to managed care, HMOs, and PPOs; the provision of medical supplies to the development of computer software programs for record keeping and education; in-home infusion therapy to psychiatric half-way houses. The CNEs concluded that the MHHCSs provide a multitude of services in meeting the health care needs of the patient/consumer/ customer.

Category Summaries

The summaries for each of the three categories role, responsibilities, and relationships were developed by the investigator from the data obtained from the CNE subjects' own words. The investigator wrote each one of the descriptive summaries using the exact words, phrases, and sentences of the CNE subjects.

Role

Role is the official rank or status held within the MHHCS by the employee. From the perspective of the CNEs in the study, the CNE holds the pre-eminent nursing role and is the designated spokesperson for the nursing profession. The subjects also felt that success of the CNE is predicated on the functions performed and the effective use of the skills and characteristics possessed.

The CNEs see themselves as responsible for a variety of functions in an atmosphere of collaboration within the context of a multidisciplinary team. This study indicates that the CNE provides administrative leadership of a strategic nature for patient care services while identifying contemporary and future nursing issues that will impact the corporation. The study also shows that the CNE designs strategies to address the issues. It also indicates that the CNE provides "hands-on consultation" to assist hospitals and facilities comprising the MHHCS to provide quality patient care services while enhancing organization profitability. The CNEs see themselves as visionaries who advance the practice of nursing through the development of innovative

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models of patient care and delivery systems, thus functioning as "change agents and facilitators for agreed upon system change." As advocates they foster "the physical, psychological, emotional, spiritual and social well-being of all individuals in accordance with the mission of the MHHCS." The subjects state that they have authority and responsibility for the development of quality care standards. They also describe participation in strategic decision-making, planning, coordinating, and directing a variety of patient services as one of the components in "maintaining nursing's perspective within the MHHCS."

Fulfilling the required duties depends upon the CNEs' utilization of the skills necessary to perform in the role. Some of the skills identified by the subjects in this study include the ability to communicate in an excellent manner (inclusive of computer, written, and verbal skills), as well as the ability to prioritize and handle many activities and projects simultaneously. CNE subjects in this study pointed out in vague general statements the need for current leadership and management skills, knowledge of pertinent issues arising in a rapidly changing health care delivery system, and an understanding of the contemporary and professional nursing issues affecting the delivery of patient care. The CNEs see these requirements as necessary for individuals in their role. In order to function effectively, CNEs said they should "possess relational skills, while being creative and critical thinkers in addressing issues from a global perspective." In addition to these skills, the CNEs are required to be "collaborators, consultants, negotiators, conflict resolvers, facilitators, politicians, risk takers, fiscal managers, problem-solvers, decision-makers, and implementors of shared governance."

Other characteristics provided by the subjects that would enable the CNE to be effective in the role are the identification with, the sharing in, and a commitment to the mission, philosophy, goals, and vision of the MHHCS. As stated by one CNE, "the CNE

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should possess superior intelligence, analytical capabilities, ethical, moral, and personal values built on conviction, honesty and integrity."

According to the subjects, another aspect of the position is that of role model. At the corporate level and throughout the MHHCS, the CNE is a role model for nursing using knowledge of nursing and nursing practice to influence patient care delivery services within the multidisciplinary environment. Other characteristics indicated by the subjects include diplomacy, flexibility and a unifier in diverse situations. The CNE is also enthusiastic, energetic, comfortable with ambiguity, and non-confrontational in addressing critical issues affecting nursing and health care delivery. Possessing a sense of humor was indicated as important by many CNEs in the study.

Responsibilities

Responsibility includes the ability to answer for one's performance in a position. From the perspective of the subjects in the study, responsibilities are met by "commitment." The CNEs see themselves as responsible for displaying a commitment to the "philosophy, mission, and values of the MHHCS." They actualize this commitment by the successful integration of the mission into the delivery of professional care to those who use the services provided by the MHHCS. One CNE summarized the expressions of the other subjects by stating, "the responsibilities of the CNE, associated with the provision of services, are determined by the demands of a changing environment and health care reform."

CNEs see themselves as providing leadership not only on the corporate level, but also throughout the system resulting in nursing's collaboration with other disciplines in the MHHCS. "Through collaboration, nursing meets the challenges of the future by participating in the development of corporate level vision, mission, and goals," stated another subject in the study. CNEs also identified the provision of assistance to LNEs in making the "local vision, mission, and goals congruent with those at the corporate level."

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Subjects identified in the CNEDQ and their position descriptions other responsibilities that needed to be addressed in order to be effective nurse executives at the corporate level. These responsibilities are: providing efficient cost-effective quality care, the implementation of nursing projects and nursing research on the corporate and local level, facilitating change within nursing practice on the local level, integrating nursing's unique contribution into the development collaborative models for health care delivery. The nurse executive at the corporate level facilitates opportunities for education, annual meetings, consultation, and networking at both the system and local levels. In addition, site visits are performed to further service the local MHHCS' hospitals and other health care facilities. One CNE expressed: "I represent the clinical service perspective in all corporate level planning, decisions, and strategies." CNEs stated they assist local hospitals and other health care facilities to achieve clinical outcomes, service and financial targets. CNEs formulate a vision and philosophy for nursing that serve as guidelines for the development of patient care standards. The vision also addresses nursing practice standards that are accepted by the local nurse executives. CNEs assist LNEs to successfully meet the criteria established by accrediting agencies "by coaching, developing and mentoring nurse managers and executives." Subjects in the study also saw themselves as assisting in the education and recruitment of qualified nurses for executive positions as well as participating in the interview process for other executives at the corporate and local level. In their positions in the MHHCS, CNEs acknowledge the necessity to be aware of the internal and external environment of the MHHCS and that environmental impact upon the ability to provide services. While identifying issues of concern, the CNE is active in assessing, formulating, and implementing corrective plans of action.

Committees. CNE nursing and interdisciplinary committee membership on both the corporate and local level is the mechanism most identified by the subjects to fulfill their responsibilities. All fourteen CNEs reported holding membership on

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corporate level committees while only 4 (29%) reported holding membership at the local level. Table 2 (Selected Committee Membership: Corporate and Local Level as Reported by 14 CNEs) represents committee examples that were the most commonly cited by the CNEs. Other examples identified by the subjects for committee participation range from the evaluation of hospital mergers to all policy issues that

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Insert Table 2 about here

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would directly or indirectly impact nursing personnel. Committee participation also involves the development of staff continuing eduction and the provision of clinical facilities for student education in nursing, medicine and allied health. Consultation and work re-design are other topics identified for committee participation. Since CNEs operate out of a combination of line and staff authority, committee work may enable them to directly influence the delivery of patient services.

Four (29%) of the CNEs felt that they should have more input on budget/fiscal management, service strategies such as managed care and managed care products, information systems, medical records, credentialing, and membership on some local committees "to expand the thinking to system policy." The majority (71%) of the CNEs felt membership at the corporate level requires participation in all the "business of that group." Therefore, "I provide input into all policy development at the system level," stated one subject. Policy development at the MHHCS corporate level demonstrates how the CNE participates as an "equal partner."

Policies. The results of committee work are usually seen in the development of policies, procedures, projects and services provided by the MHHCS. CNEs, as members of the corporate executive staff and members of numerous committees, have written and contributed to corporate policies and guidelines. In the development of these policies and guidelines, concern for the "patient" and for "nursing" was a prevalent

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Table 2

Selected Committee Membership: Corporate and Local Level as Reported by 14 CNEs

COMMITTEES	
Corporate Level	Local Level
Ad Hoc	Ad Hoc
Task Forces	Task Forces
Nursing Council	Nursing
Financial Planning	Budget
Strategic Planning	Strategic
Mission	Mission
Delivery of Services	Patient Care
Ethics/Legal	Ethics
Quality Care	Quality Improvement
Professional Activities	Allied Health
Systems Executive	Department Directors
Corporate JCAHO	JCAHO
Governance Councils	Computer Software
Institutional Review	Medical Policy

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expression. Nine (64%) CNEs reported that nursing policies and procedures were developed at the system level, while 4 (29%) responded that this was not the case in their MHHCS. One CNE reported that nursing policy and procedure was not applicable at the system level.

The policies, procedures, projects and services developed at the corporate level by committees and approved for implementation are communicated to the local hospitals and other health care facilities of the system in one of the following ways:

- Corporate level to LNEs to make a statement of specific changes;
- Corporate level to appropriate department/division head;
- Corporate Nursing Committee develops, Nursing Vice President Conference approves, MHHCS's committees approve as appropriate, Corporate Policy and Procedure committee approves and publishes, Nursing Vice Presidents inservice in their departments;
- Nursing Council shares and develops policies and procedures, which are adopted with changes for specific differences in each local hospital or facility;
- Reviewed by CNE or delegated to nursing practice committee, then distributed to local hospitals and facilities for implementation with adaptation as needed.

The CNEs from those MHHCSs which do not develop policies and procedures at the corporate level reported this activity as a local responsibility and use the mechanism required by JCAHO for MHHCS.

CNE Board Membership. Membership on boards (system, local level hospital boards, and boards other than system or local level) is seen as a responsibility by all of the CNEs in the study. The CNEs who hold board membership see themselves as reporting patient service activities and concerns. They also keep board members abreast of current clinical nursing practice. All fourteen responded to holding board

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membership; 4 (29%) reported holding membership on MHHCS boards and 10 (71%) reported not holding MHHCS board membership; 3 out of 14 hold membership on local level hospital boards and 11 (79%) do not hold board membership at the local level. One CNE holds membership on a board that cannot be classified as either MHHCS or local level board; 13 (93%) do not hold membership on other boards.

The CNEs who responded "yes" to membership on corporate boards saw their contributions as the orientation and education of board members. They also represented nursing's role in the organization, participated in strategic planning, discussed clinical reports, and presented patient care issues.

One subject stated that "board membership enhances the role of the CNE by providing nursing a seat at the table." This position enables nurses to have continued involvement in collaborative projects, programs, and board committees. CNEs reported that membership on the board provided an introduction to board functions and a perspective on the operation of the MHHCS. The subjects also reported that they had a better understanding of the contributions board members make in representing the MHHCS in the community. One CNE expressed that it was a conflict of interest for CNEs to hold membership on the board of the MHHCS that employed a CNE but thought it might be appropriate for CNEs to hold membership on other MHHCS boards.

Effectiveness. One of the responsibilities identified by the 14 CNEs in the CNEDQ and the position descriptions was effectiveness. Does the CNE effectively meet the responsibilities identified for this role? Evaluation of the CNEs performance is one way to determine effectiveness. The CNEs of MHHCSs identified two types of evaluation: formal and informal. The subjects are evaluated formally by either the board of directors or by the Chief Executive Officer (CEO) to whom they report. This evaluation is based on their ability to meet the goals and objectives established at the corporate level for their department or division. In addition, the CNEs are evaluated

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informally by receiving feedback from customers, peers, MHHCS hospital executives, and LNEs, as to how the CNEs fulfilled their agreed upon services.

Contracts. Health care reform is effecting changes in the manner in which business is done. One example of such change is the re-structuring, right-sizing, and down-sizing activities of most MHHCSs. In some instances these activities threaten job security of employees. In light of health care reform, during the telephone interview, CNEs were asked if they had a written contract with the MHHCS that described the terms of employment. They were also asked what their feelings were concerning contracts and would working with a contract provide a sense of job security.

Of the 14 subjects in the study, 12 CNEs were interviewed by telephone, all responded to the question about written contracts. The two who were unavailable for interview were initially contacted through their secretaries. They were interested in participating in the study and met the criteria for inclusion. A data collection packet was mailed to them. No data about written contracts are available for these two CNEs. Of the 12 remaining CNEs, 10 (67%) had no contract, one was a state employee, and the other CNE had a severance agreement. Even though no CNEs had contracts, four (33%) felt that in certain situations a contractual agreement would be appropriate. They believe that nurse executive positions are becoming more vulnerable due to the rapidity of change within the health care system. "This constant change challenges the creativity of the CNE to manage change and threatens effectiveness. I haven't felt the need (for a contract) up until now," stated one of the subjects. "A contract provides time for both sides to meet their obligations." Expressed in another way, "These positions turn over so rapidly, and it has nothing to do with the quality of your work. (With some assurance of the job security resulting from the contract), you do a much more credible and lasting systems' change as opposed to playing cosmetically around the edges. Contracts are one way to provide protection and security." Contracts are seen by these

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four CNEs as effective in negotiating responsibility and exacting outcomes as well as assuring clarity of expectations for the individual and the organization.

The eight (67%) other CNEs felt there was no need for a contract, especially "if it was the culture of the organization and none of their peers in the corporate office worked under contract." One CNE said, "A contract would not be beneficial: it works against us in terms of our being in a professional relationship." Therefore, according to these subjects, CNEs rely on the results of formal and informal evaluation in maintaining their position within the MHHCS.

Relationships

Relationship is the bond among the CNE and other corporate executives within the MHHCS, the LNEs, and executive teams of member health care facilities. The 14 CNEs reported the connection with the LNE and executive teams of member health care facilities were either a "staff or line position, providing consultation, guidance, leadership, resources, and support." This connection is evidenced by the types of activities in which the CNEs reported involvement on the local level. This involvement is based on a peer relationship with regular communication and dependent upon need.

Other areas that CNEs identified as collaborative working relationships include assisting with the recruitment and evaluation of directors of nursing, group work for the purpose of strategic planning and operational decision making, consulting on goal achievement and problem solving, providing crisis intervention, and acting as a change agent. The CNE also represents the MHHCS for policy and procedure interpretation and is a consultant for clinical nursing issues. One CNE expressed the relationship with the local level as one of collaboration "involving all executives in teams for a variety of projects." This CNE believes that "project successes have been largely due to the contribution of individuals with a variety of knowledge and their commitment to working together."

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The CNEs located in the corporate office of the MHHCS state that membership is held on senior management teams, executive councils, governance councils and boards. The subjects also report working as "peers in an atmosphere of collegiality and collaboration." These CNEs described themselves as "consultants" for peers in the corporate office of the MHHCS on "issues involving nursing and patient service activities," as a resource to the chief operating officer of the MHHCS "on nursing's perspective of patient care delivery," as members of various committees, and as project team members and developers. "Nursing is considered an equal partner in our philosophy of multi-disciplinary care," stated one CNE.

According to the CNEs, the reporting relationship in a MHHCS is predicated upon the structure of the corporate office. If the CNE is a department or division head, the reporting relationship for 4 (29%) is either to the system president or chief executive officer (CEO). Ten (71%) of the CNEs report to the executive vice president or chief operating officer (COO) of the specific department/division.

A cadre of professionals engaged in patient services at the corporate level and office staff report directly to 11 (79%) CNEs. Only three (21%) of the CNEs stated that no one reported directly to them. Figures 1 and 2 show the organizational relationships of the 11 CNEs. Although several types of reporting relationships exist at the MHHCS' corporate level to identify the organizational structure, the most prevalent design identified by the subjects is that of office/division of patient care services. The least reported by the CNEs is that of Vice President for Nursing or Professional Services. This representation is reflected in the organizational charts and the various titles provided by the subjects with the words "Vice President for Patient Care." The CNEs no longer see the structure as solely the provision of nursing and medical services rather the structure is a collaborative effort using interdisciplinary teamwork and peer relationships. These relationships are located within the corporate office and on the local level. They help to carry out the mission and goals of the system. "Nursing is

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considered an equal partner in our philosophy of multi-disciplinary care," stated one CNE. Figure 1 is a diagram showing the formal relationships within the corporate office of the MHHCS, the way they are grouped together and who reports to whom. Figure 1 also depicts the type of relationship of the CNE to the LNEs.

Insert Figure 1 about here

Figure 2 is a diagram showing the formal relationships within the corporate level of the MHHCS, the way they are grouped together and who reports to whom. Figure 2 also depicts the type of relationship of the CNE to the LNEs.

Insert Figure 2 about here

Networking. Networking can be described as an informal relationship among peers through professional organizations and other arenas that provide support to the CNE. With few exceptions, CNEs in this study experienced benefits from networking. "Networking with other nurses in similar settings is vital in gaining insight into the role as lived out in other systems." It provides opportunities for the CNEs to come together to share insights, experiences, and knowledge about current and future trends in a rapidly changing health care environment. According to the CNEs in the study, networking provides occasions for CNEs to gain understanding, to stay informed on a variety of issues, to experience different perspectives, and to identify needed resources. In the words of one of the subjects in this study, "I have found time spent with peers who have similar experiences, trials, challenges and organizations to be very beneficial. I believe my best source of support and information has generally been another CNE."

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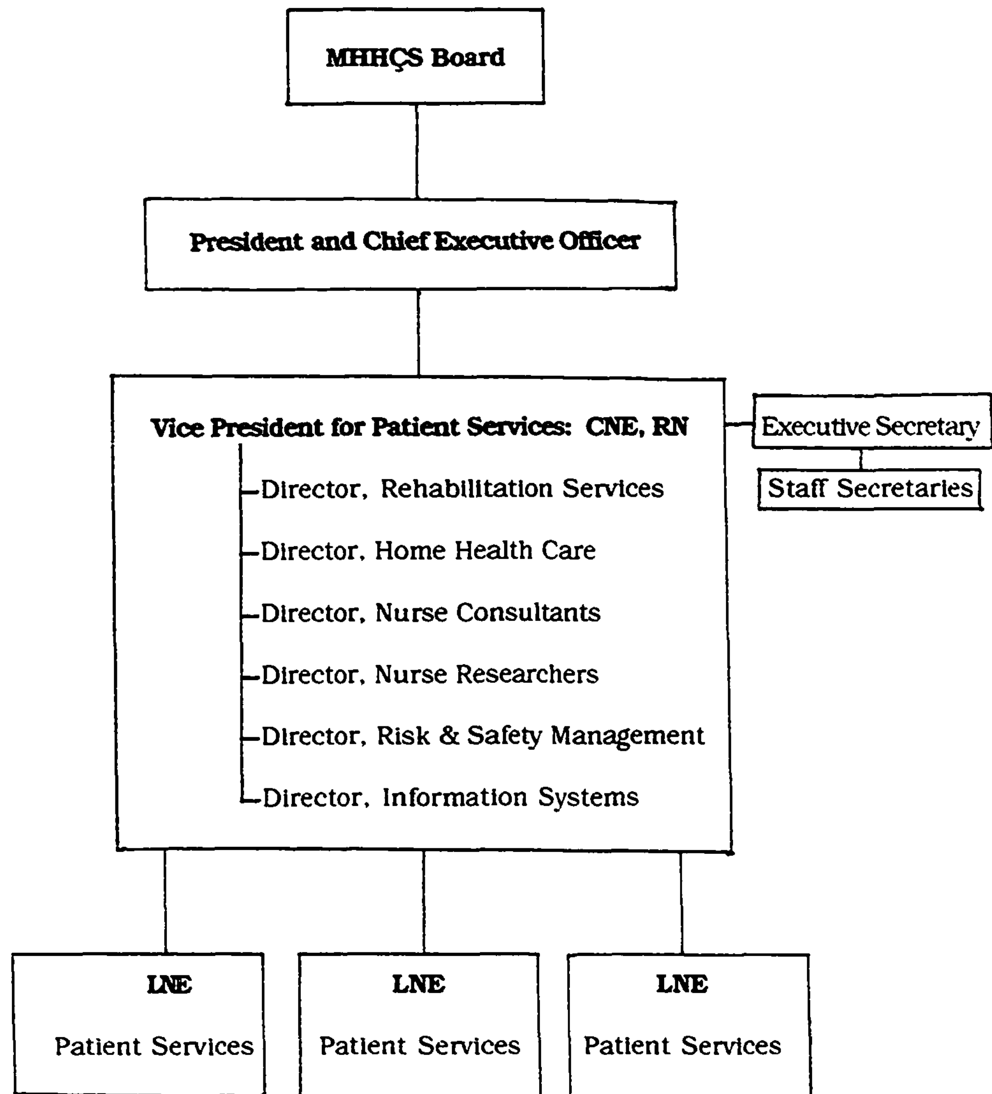

Figure 1. Sample organizational chart showing CNE line relationships

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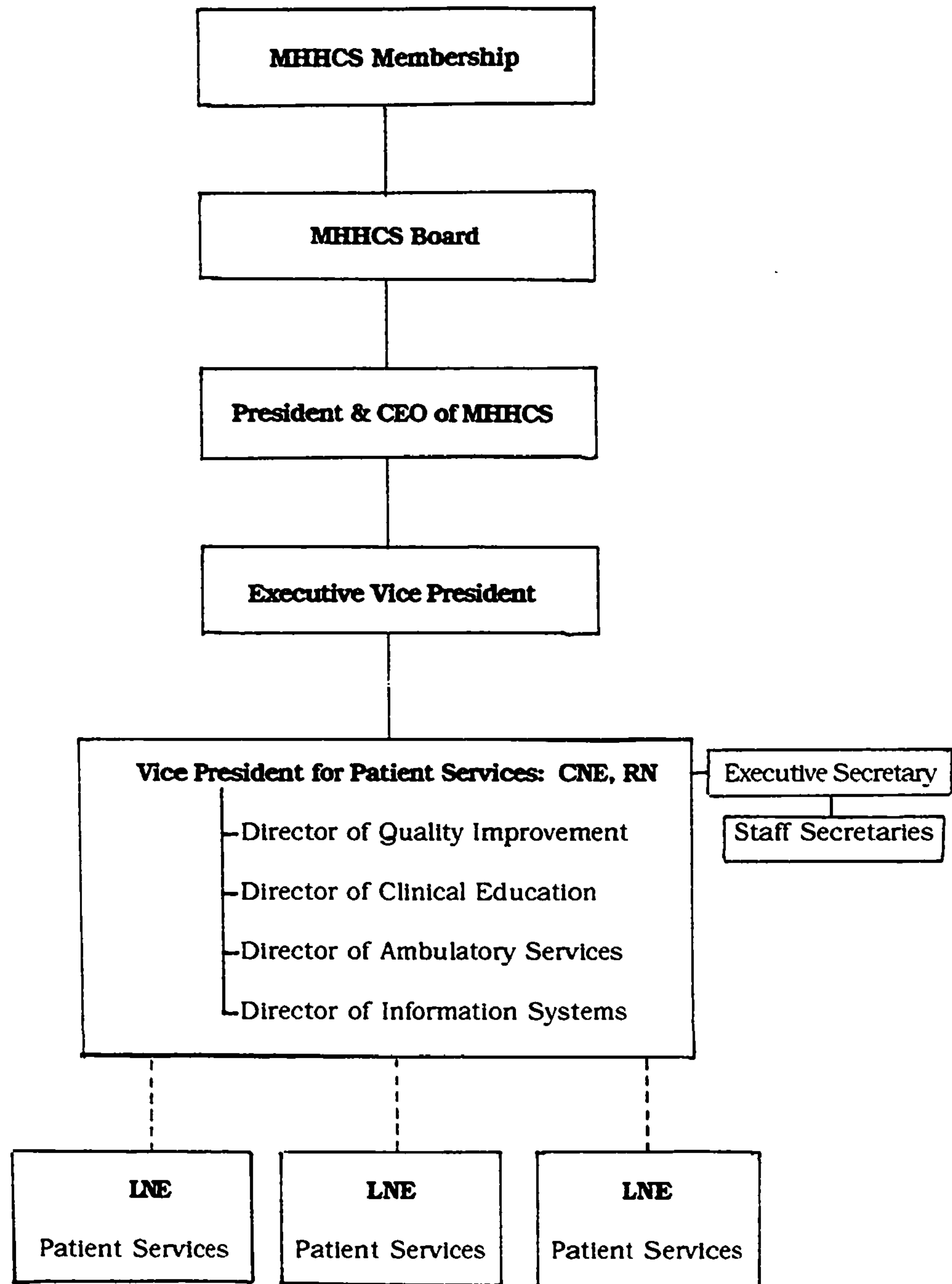

Figure 2. Sample organizational chart showing CNE staff relationships

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Themes

Data collected from each of three identified categories of role, responsibilities, and relationships indicate the existence of certain themes. The themes which emerged from the data are: the CNEs' impact on the health care environment; the CNE as collaborator; the possession of a global vision by the CNE; the ability of the CNE to influence change; and the CNE as a preserver of nursing's perspective in the system.

Health care environment

The health care environment is continually changing. New models of health care delivery are emerging. One such example is the delivery of health care by managed competition. The CNE's role will continue to grow and evolve. This evolving role requires the CNE to be flexible in functioning as a agent of change in the health care environment. In this capacity, the CNE is in touch with the metamorphoses in health care, comprehends their impact, responds from a nursing perspective, all in the best interest of the patient. In order to be effective in this environment, the CNE must be a risk taker possessing a global vision and must work in collaboration with all disciplines at the MHHCS level and on the local level.

Global vision

The CNE possesses a vision of health care and nursing that is global in nature. This vision recognizes the forces that are currently shaping the environment. The CNE has the farsightedness to develop new models of nursing for the delivery of patient services. While the vision is that of the CNE, it is not developed in isolation. Collaboration with LNEs and other members of the health care team is needed to maintain the global perspective and implement the vision. The vision might call for the continued advancement of nursing practice out of the acute care setting into community based models of nursing such as advanced nurse practice clinics, ambulatory care settings, home nursing care, and chronic care centers. How these services are delivered within the context of a MHHCS is dependent upon the CNE's

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ability to think creatively and be in touch with current clinical nursing practice. The CNE should also be able to impart knowledge and experience in the developing and administering of these services.

Collaboration

Collaboration is the ability to work with other members of the MHHCS to meet the mission and goals of the system. The CNE's success is predicated on developing interdisciplinary teams and "building coalitions" in order to implement projects, programs, policy and procedures within the MHHCS. As one CNE expressed, "It is important to be able to transcend nursing and function in a role which addresses the overall best approach to an issue for patient care, rather than just seeing it from a nursing perspective."

Nursing's perspective

The CNE serves as a representative of professional nursing and provides nursing's viewpoint for patient care services to the MHHCS, the board of directors, the professional community, the consumer community, and accrediting bodies. Nursing's scope on the delivery of patient care services has been developed not at the expense of other health care professionals but in collaboration with them. Preserving nursing's perspective demands that the CNE be knowledgeable about the health care environment, possess a global vision, be a creative thinker, be a developer of patient services, as well as a creator, facilitator and implementor of change. Instilling the perspective of nursing into the system requires the ability to develop close working relationships with medical staffs, administrative staffs, and other health care providers. The CNE position is not only a nursing position but also one of patient services. As such it requires the CNE to be knowledgeable about the realm of services provided by ancillary health care professionals as well as their qualifications. This knowledge preserves nursing's integrity as a profession and allows for the collaboration needed to deliver safe, cost-efficient, quality health care to the consumer.

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Change agent

Due to the rapid change in the health care environment, the CNE possesses the capability to accomplish results through influence. This influence often supplants operational responsibility. In order to be an effective change agent, the CNE must have demonstrated success as a leader and manager. In adapting to the responsibilities of the role, the CNE must embrace change while a more integrated system is developed in the delivery of health care. The CNE will continue to develop the role and identify the responsibilities that will be needed to function in the position.

Description of the position

During the telephone interviews all CNEs expressed an interest in the "results." Some of the subjects wanted "to see how others did it," thus gaining a "broader picture of the position." All 14 CNEs returned a position description with the CNEDQ and the Demographic Data Form. Using the themes identified by the CNEs as a focus point a compilation of the most commonly used terms were grouped according to role, responsibility, and relationship. These three categories provided the organizational format for the Description of the CNE Position found in Appendix J.

Summary

This chapter contains descriptive summaries for three categories: role, responsibilities, and relationships. Data collected from the CNEs in the telephone interviews, CNEDQ, Demographic Data Form, position descriptions, and organizational charts were used to develop the summaries. Themes arose and were used as focal points for describing the position of the CNE.

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CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The purpose of this study was to explore and describe the position of the nurse executive at the corporate level of a multihospital health care system. The exploratory descriptive design was used because little or no research had been conducted on what constituted the position of the CNE in a MHHCS. The data acquired from the telephone interviews, the open-ended CNEDQs, the position descriptions, and the organizational charts were descriptive in nature. They allowed the CNEs to naturally describe the position from their perspective and in their own words. In providing a description of the position of the CNE, this study identified characteristics, skills, and functions from the data collected in individual CNE interviews and instruments. A description of the CNE position augments and enhances the existing literature on nurse executive practice at the corporate level. The resulting increase in understanding the role of the CNE lays the groundwork for advancing that position. Recommendations for further research are also addressed.

The categories of role, responsibilities, and relationships were the groupings used to describe the CNE position in a MHHCS. The descriptive summaries written for the categories of role, responsibilities, and relationships provided answers to the three research questions: (1) What is the role of the CNE of a MHHCS? (2) What are the responsibilities of a CNE in a MHHCS? and (3) What are the relationships of the CNE within the MHHCS?

There were five recurring themes (health care environment, global vision, collaboration, nursing's perspective, and change agent) isolated from the data that determined how the CNEs described their positions. These themes also provided the background for the conclusions in this study.

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Health care environment

Due to the ever-changing health care environment, the CNE must possess the ability to comprehend, respond, and facilitate change. The nurse executives at this highest level in the corporation see themselves involved in "change not only from a nursing perspective but also from a patient services perspective." The spirit is one of risk taking and collaboration with other health care providers.

Collaboration

The CNE cooperates with the executive members of the MHHCS in addressing the organization's mission and goals. The CNE also works with "peers within the MHHCS in a collaborative manner to identify issues of concern in patient service areas, financial management, and quality improvement." This supplies the CNE with additional information for decision-making and exercises the talents and abilities of all members to plan and implement resolutions.

Global vision

The CNE possesses a vision of health care that is all encompassing. This vision "contributes from nursing's perspective" to the development of new and streamlined, cost-effective quality delivery systems.

Change agent

Due to the rapid degree of change in the health care environment, the CNE possesses the capability "to accomplish results through influence." This influence often supplants direct operational responsibility.

Nursing's perspective

The role of the CNE allows for collaboration with LNEs and other nurses of the MHHCS. Its purpose is to develop, present, and maintain nursing's philosophy and vision for the corporation. Nurses provide a unique contribution to the care of the patient. According to one subject, "the CNE places before the MHHCS the professional nursing perspective in the delivery of patient care services." The CNE is able to

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cooperate with other health care professionals and, by knowing their practice, is able to work with them in delivering the care needed.

Recommendations for future research

This study is foundational. The data collected aids in describing the role of the nurse executive at the corporate level in a multihospital health care system. Additional studies are needed to enhance the description of the CNE position. This particular study recognizes the role of the CNE as an expansion of that of the LNE. From their personal perspectives, the CNEs, in describing their role and responsibilities, used their own words in stating some of the same characteristics, functions, and skills used by LNEs as identified in the review of the literature by the investigator. The acknowledged difference was the depth of mastery and the arenas of application. As a member of a MHHCS, the CNE can be in a most influential position. A person in this position can promote quality, integrity, and humanism of patient care systems.

In light of health care reform, further research should be directed toward the role and responsibilities of the CNE of the future. These changes involve managed competition, capitation, integrated delivery networks, the continued move toward advanced clinical nursing practice, and the declining interest in the position of nursing administration. With additional research on the position of the corporate nurse executive, the influence of nursing at the corporate level will continue to grow and expand its contribution to the development of patient care services in a multihospital health care system. In addition, the investigator believes a study should be done to examine the relationship between CNEs and LNEs.

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Appendix A

Letter: Presidents/CEOs of MHHCSs

RSM

Religious Sisters of Mercy
977 Navarre Avenue
New Orleans, LA 70124

Sr. Michael Mary Gutowski
Phone: (504)-482-7403

Terence F. Moore, President
MidMichigan Regional Health System
4005 Orchard Dr.
Midland, MI. 48670

November 1, 1994

Dear Mr. Moore:

I am a doctoral candidate at the the Louisiana State University Medical Center School of Nursing in New Orleans. My dissertation topic deals with the role of the nurse executive at the corporate level. The purpose of this letter is to determine if you have a nurse executive employed in administrative practice at the corporate level in your Health System.

I greatly appreciate any assistance you provide by suppling the information requested on the enclosed postcard and returning to me by November 15, 1994. Thank you in advance for helping me to identify the nurse executive located at your corporate office.

Sincerely,

Michael Mary Gutowski, RSM

Enclosure

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Appendix B

Postcard: Presidents/CEOs of MHHCSs

Front

Michael Mary Gutowski, RSM
977 Navarre Ave.
New Orleans, La. 70124

Back

System code #______________________

Nurse executive in corporate office?_____Yes _______No

If yes, name: ________________________________

Phone number: ____________________

Your assistance is appreciated

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Appendix C

Letter: CNEs of MHHCSs

RSM

Religious Sisters of Mercy
977 Navarre Avenue
New Orleans, LA 70124

Sr. Michael Mary Gutowski
Phone: (504)-482-7403

Corporate Nurse Executive
MidMichigan Regional Health System
4005 Orchard Dr.
Midland. MI. 48670

November 15. 1994

Dear Corporate Nurse Executive:

I am a doctoral candidate at the the Louisiana State University Medical Center School of Nursing in New Orleans. My dissertation topic deals with the role of the nurse executive at the corporate level. If you are the corporate nurse executive responsible for nursing practice in your Health System. please fill in the enclosed card and return by November 30. 1994.

I greatly appreciate your supplying the above information. Thank you in advance for your assistance.

Sincerely.

Michael Mary Gutowski, RSM

Enclosure

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Appendix D

Postcard: CNEs of MHHCSs

Front

Michael Mary Gutowski, RSM
977 Navarre Ave.
New Orleans, La. 70124

Back

System code #________________________

Nurse executive in corporate office?_____Yes ______No

If yes, name: ____________________________________

Phone number: ______________________

Your assistance is appreciated

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Appendix E

Telephone Interview Guide for the Investigator

1. INTRODUCTION

   A. INTRODUCE SELF AND GIVE BACKGROUND OF PROGRAM

   B. STATE PURPOSE OF DISSERTATION STUDY

   C. INDICATE THAT THE PARTICIPANT'S RESPONSES ARE IMPORTANT

   D. TAPE RECORD TO PRESERVE COMMENTS

2. If you agree to participate in this study, I would like to ask you some questions. Our conversation should last about 20 minutes.

3. Any information you give me is confidential. Your name will be known only to me for the purpose of a follow-up telephone call, if needed. EXPLAIN HOW THE TAPE RECORDING WILL BE HANDLED TO PRESERVE CONFIDENTIALITY.

4. PAUSE AND WAIT FOR RESPONSE. IF THE NURSE EXECUTIVE DOES NOT WISH TO PARTICIPATE, THANK THAT PERSON FOR THE TIME SPENT THUS FAR. May I turn on the tape recorder?

5. QUESTIONS

   A. TITLE

      - What is your title?

   B. ORGANIZATIONAL STRUCTURE

      - Would you be willing to send me a copy of your organizational chart?
      - Is there anything about your organizational chart that you would like to share with me?

   C. JOB/POSITION DESCRIPTION

      - Do you have a written job/position description?
      - Would you be willing to send me a copy your job/position description?
      - Would you explain how it was developed?
      - IF NO DESCRIPTION: Are you developing one?

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D. CONTRACT

- Do you have a contract that is a written agreement between you and the organization, describing the terms of employment?
- Is there anything about your contract agreement you would be willing to share?

6. CONCLUDING REMARKS

A. THANK THE INDIVIDUAL FOR DOING THIS INTERVIEW AND FOR AGREEING TO PARTICIPATE IN THE STUDY

B. DATA COLLECTION PACKET WILL BE FORWARDED VIA US POSTAL SERVICE

C. CONTENTS OF THE DATA COLLECTION PACKET

- TWO CONSENT FORMS
- CORPORATE NURSE EXECUTIVE DESCRIPTIVE QUESTIONNAIRE
- DEMOGRAPHIC DATA FORM
- PRE-PAID SELF-ADDRESSED TWO DAY PRIORITY MAIL ENVELOPE

D. INFORM THE PARTICIPANT TO FEEL FREE TO ADDRESS QUESTIONS TO ME AT (504) 482-7403.

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Appendix F

CNEDQ Cover Letter

RSM

Religious Sisters of Mercy
977 Navarre Avenue
New Orleans, LA 70124

Sr. Michael Mary Gutowski
Phone: (504)-482-7403

Corporate Nurse Executive
MidMichigan Regional Health System
4005 Orchard Dr.
Midland, MI. 48670

December 1, 1994

Dear Corporate Nurse Executive:

I am a doctoral candidate at the the Louisiana State University Medical Center School of Nursing in New Orleans. My dissertation topic deals with the role of the nurse executive at the corporate level of multihospital health care systems. This letter is a follow up of our telephone interview and forwards to you the enclosed packet.

The purpose of this study is to explore and describe the position of the nurse executive at the corporate level of a multihospital health care system. It should take you about 60 minutes to complete the questionnaire and the demographic data form. If you are interested in participating in this study, please sign the enclosed consent forms. Keep one for yourself and return the other consent form along with the completed <u>Corporate Nurse Executive Descriptive Questionnaire</u> and <u>Demographic Data Form</u> along with your organizational chart and job description by December 30 1994, in the pre-paid Two Day Priority Mail envelope. Call 1-800-222-1811 and follow the company's directions for pick-up. The investigator will assume all expenses associated with the return of the packet.

I will appreciate all of your responses. Thank you for participating in this study.

Sincerely,

Michael Mary Gutowski, RSM

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Appendix G

Corporate Nurse Executive Descriptive Questionnaire

Directions:

The purpose of the Corporate Nurse Executive Descriptive Questionnaire (CNEDQ) is to obtain a description of the role of the corporate nurse executive (CNE) from your perspective and in your own words. The CNEDQ is composed of 30 open ended questions addressing setting, role, relationships, and responsibilities. The CNEDQ will take approximately 60 minutes to complete. The time you take to complete the CNEDQ will be most welcomed. Your contribution will provide a valuable service in providing an initial personal account of your role as a CNE in a MHHCS.

Terms used in the CNEDQ are defined as follows and will assist you in responding to the questions.

Definition of Terms

AHA--American Hospital Association.

Characteristic--a distinguishing trait.

Contract--a written agreement between the CNE and the organization, describing the terms of employment.

Corporate level--the location (corporate office) of the highest executive management position in a multihospital health care system.

Corporate Nurse Executive (CNE)--the nurse executive at the corporate level of a MHHCS with responsibility for nursing.

Function--a special duty required in work.

Health Care System--identified as both multihospital and diversified single hospital systems.

Local Nurse Executive (LNE)--the nurse at the executive level of management in the hospitals owned, leased, sponsored or contract managed of a MHHCS.

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Multihospital Health Care System (MHHCS)--two or more hospitals owned, leased, sponsored or contract managed by a central organization for the purposes of shared services, purchasing, development of capital and new service areas.

Position/role--official rank or status held within the MHHCS by the CNE.

Relationship--the connection between or among persons.

Responsibilities--able to answer for one's conduct and obligations.

Setting--the corporate office of a MHHCS and the hospitals that are leased, owned, sponsored or contract managed by an MHHCS.

Skills--a learned power of doing something competently; a developed aptitude or ability.

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Setting

1. Is there a designated structure for nursing located at the multi-hospital health care system (MHHCS) corporate office?

______Yes ______No

If yes, identify the structure and provide an explanation (department/office/division, incorporated into clinical or profession services, etc.).

2. Are there mechanisms (councils, committees, projects, etc.) you use to work with nurses within the MHHCS corporation?

If yes, identify these mechanisms and describe responsibilities and accountabilities.

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3. In addition to hospitals, what other types of health care facilities are leased, owned, sponsored or contract managed by your MHHCS? Give examples.

4. Describe your MHHCS as to how it delivers services (integrated network, community health system, etc).

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5. How do you as the Corporate Nurse Executive (CNE) provide input into your MHHCS corporate policy development?

6. Into what specific areas, in addition to nursing, of policy development do you provide input?

7. Are there any other areas of policy development in your MHHCS that you believe the CNE ought to be a part?

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Role

1. What are your functions as CNE (staff accountabilities, line accountabilities, research development, educational opportunities, etc.) at the corporate level?

2. What are the management skills that are useful to you as a practicing CNE?

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3. Identify the nursing skills that you feel are needed to perform as a CNE (implementing new practices, assessment of nursing services, etc.)?

4. What do you think are the distinguishing traits needed to perform in this position?

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5. What functions do you perform for local hospitals that are leased, owned, sponsored or contract managed by your MHHCS?

6. Describe the educational preparation and experience you believe is needed to perform in this role?

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Relationships

1. What is your relationship (line, staff, resource, etc.) to the local nurse executives (LNEs) in the hospitals that are leased, owned, sponsored or contract managed by your MHHCS?

2. Discuss your relationship, if any, to the other executive team members of hospitals that are leased, owned, sponsored or contract managed by your MHHCS (purpose, frequency, etc).

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3. To whom do you report (provide title) at the corporate level of the MHHCS?

4. Who reports (provide title) to you at the MHHCS corporate level?

5. Discuss your relationship, if any, to the other executives in the corporate office of your MHHCS?

6. Discuss how you think networking with other CNEs, with professional organizations and with mentors influence your ability to function as a CNE.

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Responsibilities

1. What are your obligations, if any, for hospitals that are leased, owned, sponsored or contract managed by your MHHCS?

2. What outcomes are expected of you as the CNE of a MHHCS?

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3. On what is your job performance evaluated at the corporate level?

4. On what is your job performance evaluated by the hospitals that are leased, owned, sponsored or contract managed by your MHHCS?

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5. Are you a member of the corporate board of your MHHCS?

_____Yes _____No

If yes, what do you see as your contribution as a CNE?

6. How does your membership on the MHHCS board enhance your role as a CNE?

7. Are you a member of the corporate board of any other MHHCS?

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8. Do you hold membership on any of the hospital boards that are leased, owned, sponsored or contract managed by your MHHCS?

9. Are you a member of any existing committees at the corporate level of your MHHCS? If so, list.

10. Are you a member of any existing hospital committees of your MHHCS? If so, list.

11. If there are nursing policies and procedures developed at the corporate level, describe how they are communicated and implemented in the hospitals that are leased, owned, sponsored or contract managed by your MHHCS?

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Appendix H

Demographic Data Form

Please complete the following:

Age range:

20-29________30-39________40-49________50-59________60 and above________

Gender: Male______ Female______

Ethnic Origin: ________________________

Marital Status: Single_______ Married_____ Widowed___ Divorced____

Basic educational preparation for nursing____________________

Highest degree held____________________________________

Highest degree held in nursing____________________________

Number of years in nursing_______________________________

Length of time in present position__________________________

Number of years in nursing administration___________________

What types of positions have your held in the past? ____________________________

____

____

____

____

____

____

Salary range: $49,000 or below____ $50,000-$59,000____ $60,000-$69,000____

$70,000-$79,000____ $80,000 or above____

Thank you for your participation in this study. Your responses to the questions will be most helpful in describing the position of the corporate nurse executive.

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Appendix I

Consent Form

LOUISIANA STATE UNIVERSITY MEDICAL CENTER IN NEW ORLEANS

CONSENT FORM

1. STUDY TITLE: The position of the nurse executive at the corporate level of a multihospital health care system: An exploratory descriptive study.

2. PERFORMANCE SITES: The corporate level of Multihospital health care systems in the United States as identified in the American Hospital Association Guide to the Health Care Field (1993).

3. NAMES AND TELEPHONE NUMBERS OF INVESTIGATORS:

Michael Mary Gutowski, RSM, MN, RN.	(504) 482-7403 (24 hours)
Principal Investigator	(504) 286-4845 (office)
Marie DiVincenti, EdD., RN	(504) 529-4201 (24 hours)
Faculty Advisor	(504) 568-4141 or 4144 (office)

4. PURPOSE OF THE STUDY: This is a research study. The purpose of this research study is to explore and describe the position of the nurse executive at the corporate level of a multihospital health care system.

5. SUBJECT INCLUSION CRITERIA: (1) hold the position of nurse executive, male or female, at the corporate level with responsibility for nursing; (2) have at least one year of experience in the position; (3) function on a level equivalent with other corporate executives; (4) are selected from the list of the American Hospital Association Guide to the Health Care Field, Section III, Multihospital Systems; and (5) are located in the United States.

6. SUBJECT EXCLUSION CRITERIA 1) non nurses who are responsible for nursing in multihospital health care systems; (2) corporate nurse executives with less than one year of experience in the position; (3) nurse consultants; and (4) nurses in quality improvement, health care policy development, education, research or any other types of support services.

7. DESCRIPTION OF THE STUDY: The position of corporate nurse executive in a multihospital health care system will be explored and described. A convenience sample (using subjects that are available at the time of data collection) composed of approximately 20 corporate nurse executives will be used. Data collection methods will include the use of unstructured telephone interviews, demographic data form, and a written open ended questionnaire. The procedure for data collection is: identified corporate nurse executives will be contacted by telephone; if the corporate nurse executive is interested in participating in this study, the subject will be sent by the investigator via US Mail a cover letter, the Corporate Nurse Executive Descriptive Questionnaire, the Demographic Data Form, and two consent forms. A pre-paid Two Day Priority Mail envelope will be provided for the corporate nurse executive to return a system organizational chart, a job description, the completed questionnaire, the demographic data form, and one signed consent form within three weeks of receipt. After receiving the above information, the investigator may choose to do another telephone interview. This interview will be guided by the responses received from the first telephone interview and by the responses to the questionnaire and data form.

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All of the data obtained from the telephone interviews and the questionnaire will be the content analyzed using the research questions as a guide. The responses from the questionnaires and interviews will be transcribed and reviewed by the investigator. This investigator may choose to quantify some data.

8. BENEFITS TO THE SUBJECT: Subjects will have the opportunity to describe from their perspectives and own words the position of the corporate nurse executive. The subject's responses will contribute to the research on nursing administrative practice and to the education of nurse executives.

9. RISKS TO SUBJECT: There are no known risks or discomforts.

10. ALTERNATIVES TO PARTICIPATION IN THE STUDY: There are no alternatives to participation in this study.

11. SUBJECT REMOVAL The subjects who terminate their position at the multihospital health care system during the study period will be removed.

12. SUBJECT'S RIGHT TO REFUSE TO PARTICIPATE OR WITHDRAW: Study subjects may refuse to participate or withdraw from the study at any time. If one should decide to withdraw, all data obtained will be destroyed. Should significant new findings develop during the course of the research which may relate to the subject's willingness to continue participation, that information will be provided to the subject.

13. SUBJECT'S RIGHT TO PRIVACY: The results of this study may be published. The privacy of subjects will be protected and the subject's names will not be used in any manner.

14. RELEASE OF INFORMATION: The findings of this study will be used in the investigator's doctoral dissertation; the results may be published and may be presented at conferences.

15. FINANCIAL INFORMATION: Participation in this study will not result in any type of financial remuneration to the subjects.

16. SIGNATURES: The study has been discussed with me and all my questions have been answered. I understand that additional questions regarding the study should be directed to investigators listed on page 1 of this consent form. I understand that if I have questions about subjects rights, or other concerns, I can contact Dr. Perry G. Rigby, Chancellor, at (504)-568-4801. I agree with the terms above and acknowledge I have been given a copy of the consent form.

______________________________ ____________

Signature of Subject Date

______________________________ ____________

Signature of Witness Date

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Appendix J

Description of CNE Position

MHHCS

Position Title: Vice President Patient Care Services

Division/Location: Patient Care Services/MHHCS

Date: March 24, 1995

I. Position Summary:

This is the paramount nursing position in the MHHCS. The CNE provides leadership for nursing and patient care services, while ensuring that nursing and patient care perspectives are represented at the corporate level. Participating in the development and planning of programs, policies, and services, the CNE works toward accomplishing the mission of the MHHCS.

II. Organizational Relationships:

- CNE Reports to: President and Chief Executive Officer
- Reports to CNE: Director, Rehabilitation Services
  Director, Home Health Care
  Director, Nurse Consultants
  Director, Nurse Researchers
  Director, Risk & Safety Management
  Director, Information Systems
  LNEs
  Executive Secretary

III. Duties and Responsibilities:

A. Responsible for enhancing nursing system wide.

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- Collaborates with corporate executives to ensure that nursing's perspective is presented and included in MHHCS decisions and projects.
- Provides opportunities for LNEs to participate on the Nursing Council, various MHHCS committees, and task forces assuring that nursing's expertise is provided for the delivery of patient care.
- Conducts research to design new models of nursing for providing patient care services.
- Collaborates with other division executives and MHHCS hospitals/patient care facilities staff on the development, implementation, and evaluation of projects, policies, and procedures affecting the mission and goals of the MHHCS.
- Is responsible for ensuring that nursing meets the standards of the designated accrediting agencies system-wide.
- Serves as a liaison for nursing to the board of directors by communicating nursing's activities, programs, issues and trends.
- Collaborates with other divisions regarding continuing education to see that necessary educational programs are provided to address the needs of the professional nursing staff and other patient services staff.

B. Promotes divisional fiscal accountability.

- Collaborates with Directors, and LNEs on strategies for fiscal accountability.
- Collaborates with the MHHCS division of finance to improve/design mechanisms for financial reporting and allocation of resources.
- Acts as a resource consultant and advisor.

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C. Additional duties and responsibilities.

- Responsible for implementing and monitoring continuous quality improvement into the division and local institutional operations.
- Responsible for developing and maintaining a relationship with professional and academic organizations in order to influence the future direction of nursing.
- Provides guidance, leadership, resources, and support to division directors, LNEs, and executive teams of member health care facilities.
- Establishes strategic direction in collaboration with department directors and LNEs for the Division of Patient Care Services.

IV. Position Qualifications:

A. Education

- Baccalaureate in Nursing with a Masters in Nursing or a related field.
- Continuing Education Requirements as dictated by the State Board of Nursing.
- Demonstrated knowledge of business and nursing management principles.

B. Experience:

- Clinical nursing experience in a variety of health care settings.
- Progressive nursing management experience for at least five years.
- LNE for at least three years in a hospital of a MHHCS.

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VITAE

Frances Lorraine Gutowski was born in Kansas City, Missouri, July 10, 1944, the daughter of Michael Isadore Gutowski and Erma Hickam Gutowski. She is a 1962 graduate of St. Teresa Academy in Kansas City, Missouri, and a 1965 graduate of Mercy School of Nursing in Fort Scott, Kansas. She entered the Institute of the Sisters of Mercy of the Americas, St. Louis Region, in September of 1965. From 1965 until 1971 she attended Mercy Junior College, held staff nurse responsibilities at Mercy Regional Medical Center, Vicksburg, Mississippi, and received her baccalaureate in nursing from Marillac College in St. Louis. From 1971 until 1974 she was Assistant Director of Nursing Service, Mercy Hospital of Laredo, Laredo, Texas. During that time she held responsibility for both the management and nursing functions of the pediatric and medical/surgical nursing units. In 1974 she was assigned to Mercy Hospital of New Orleans, New Orleans, Louisiana, as assistant director of nursing. In addition to her nursing and management functions, she supervised the service program for student nurses in management clinical rotation and was a preceptor for Tulane University graduate students in nursing service administration. In September, 1978, she began graduate studies in nursing at Louisiana State University Medical Center School of Nursing, New Orleans, Louisiana, culminating in May of 1980 with a Master of Nursing Degree. She was a resident in nursing administration at Ochsner Foundation Hospital from 1980 until 1981. From 1981 to 1982 she was assistant director of nursing at St. Claude General Hospital. As director of nursing at Crescent City Health Care Center (1983-85), she was responsible for establishing the nursing department in a new facility and for its daily operation. In the Spring of 1986 she began her employment at Dillard University as assistant professor in the nursing division. In the summer of 1990, she was admitted to the doctoral program in nursing at Louisiana State University Medical Center School of Nursing, New Orleans, Louisiana. She is a member in good standing of

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the Roman Catholic order of the Institute of the Sisters of Mercy of the Americas. St. Louis Region. and is known as Sister Michael Mary Gutowski. R. S. M.

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