



Academic Health Focus

Nurse Leadership at Mayo Clinic: Integrating Nursing, Clinical Practice, and Interdisciplinary Education

Over the years, Governance Institute research on hospital and health system board composition has shown that nurses make up a very small fraction of board leadership, and many organizations do not have nurse representation on their boards at all. With the increasing industry focus on patient experience and value-based care, we believe the nurse perspective is critical in order to improve in these areas. Despite this, we have yet to see an uptick in the number of nurses on boards.

We recently spoke with Pamela O. Johnson, M.S., RN, NEA-BC, FAAN, Chair of the Department of Nursing and Chief Nursing Officer of Mayo Clinic, to find out what makes Mayo unique in its emphasis on nurse leadership and educating the nurse leaders of the future. Pam took on her role in 2011 as the first CNO in the organization's history.

This is the final in a series of articles focusing on the importance of nurses on boards and in healthcare leadership positions, focusing on case examples of organizations that emphasize nurse leadership. These articles are being published in partnership with the Nurses on Boards Coalition. The Mayo Clinic is a Founding Healthcare Leadership Organization Strategic Partner of the Nurses on Boards Coalition.

Organization Profile

Mayo Clinic is a non-profit organization committed to clinical practice, education, and research, providing expert, whole-person care to everyone who needs healing. Mayo has major campuses in Rochester, MN; Scottsdale and Phoenix, AZ; and Jacksonville, FL. The Mayo Clinic Health System has dozens of locations in several states. The organization provides care to 1.3 million patients with over 4,700 staff physicians and scientists, and 14,000 nurses in a single integrated nursing practice.

In your experience, what is the effect of having a nurse in the boardroom on the nurse's relationship with the board, physicians, physician leaders, and other senior leadership?

Pam Johnson: This is important in two spheres. First, nurses are a significant component of the healthcare team, and spend more time with patients than any other discipline. They have a deep understanding of patient needs and expectations along the entire care continuum, and care for patients at all hours of the day and night. The nurse leader is able to bring an important lens and perspective to the boardroom regarding patient experience, quality and safety, and additional dimensions like organizational processes and systems to improve effectiveness and efficiency.

Second, having a stable, competent staff is core to everything else. Satisfied staff who feel valued

remain with an organization. Discussions on investing in and supporting all of our staff to meet the strategic priorities of the organization are important topics at the board table. Because nurses make up most of the workforce in organizations, the perspective that a nurse leader brings to the boardroom is key. Physician burnout is a hot topic right now but it is true for all roles. We are seeing very high turnover rates in healthcare workers across the country. Turnover is expensive.

In addition to a stable workforce, you need nurses who are well-trained, well-educated, and able to anticipate and manage the increasing complexity of patients and their family dynamics...what are staff members, especially nurses looking for in an organization that they want to be a part of? Nurse leaders are able to provide that perspective in board discussions.

It's such a fabulous time to be a nurse in this country because so much of what patients are wanting and needing across the entire healthcare continuum is care that nurses are well positioned to provide through their education, training, and connection with patients. It's care provided in a multitude of settings—critical access hospitals, clinics, remote monitoring, connected care, etc. The use of technology in this new digital age is allowing nurses to connect with patients differently, in a way that is meaningful for them as patients, to increase the quality of their care, that is convenient, and decreases out-of-pocket cost. It's a whole different level of connection and another example of the conversations that are occurring at board tables where nurse executives have a unique contribution to make as organizations strategize, problem solve, and position themselves to meet the needs of patients going forward.

We look at nurse leadership as a bridge between physicians and the systemic quality improvement processes being implemented by staff at the bedside. How does nurse involvement in leadership and quality improvement help engage physicians in efforts to put in place care procedures and protocols?

PJ: This is actually one of my passions here at Mayo. I think we need to constantly be looking at putting the patient at the center of our care and decision making. Not what the nurse wants, not what the physician

Pam's Questions for Boards to Consider:

- How do we engage and recognize the value of all of our employees to help meet the priorities of our organization?
- How are we positioning ourselves to anticipate the needs of patients in ways that are meaningful to them?
- Are we considering creative and innovative solutions to address our challenges that taps the talent of all key stakeholders?
- How are we holding everyone accountable related to mutual respect, staff engagement, collective decision making, and working together (physicians, nurses, and senior leadership) to nurture and invest in an organizational culture where people want to come to work and stay with us?
- How can we be more efficient in the care we provide as an organization while also increase quality? Are we focusing on practice redesign and leveraging the contributions of our nurses and other multi-disciplinary team members to standardize care, and improve quality in an increasingly cost constrained environment?
- How do we collectively look at challenges and problem-solve together to work together with a shared accountability?
- As we make decisions for the organization, are we solving one question but inadvertently causing another unforeseen consequence or problem because we aren't considering the broad ramifications?
- How are we leveraging the knowledge and experience of nurses to tackle the issues above?

wants, but what the patient needs. As we make decisions at Mayo, the patient is always at the center and we wrap a team around the patient, leveraging our collective knowledge and expertise. To do that, first you need physician leaders who understand the importance of a true multi-disciplinary approach and partnership with nurses. That requires physician leaders who role model and expect their physician colleagues to demonstrate the necessary "people skills" that engage and encourage nurses and allied health team members to contribute their own

knowledge and expertise by speaking up to stop potential patient events that can cause harm.

I'm a strong believer in a physician-led organization—not physician-controlled, but physician led. Physician leaders who lead with an expectation of mutual respect, inclusion, and the importance of that interdisciplinary mindset, coupled with nurse leaders who also have that vision and mindset—can work together, promoting common expectations and an understanding that none of us make decisions in isolation of each other. In today's complex healthcare environment, decisions made by one role are likely to impact other roles. Our decisions are better because of the multitude of perspectives and input we seek from each other.

How can we be more efficient in the care that we provide, reduce waste, improve outcomes, and really leverage that collective mindset? What does the patient experience

Leveraging Nurses to Reduce Physician Time Burden

Nurses can spend valuable time with patients in physician offices and clinics to provide anticipatory education to the patient about the following items, which frees up physician time to focus on the patient exam, while at the same time enhancing the patient experience and patient adherence to physician recommendations:

- Practice redesign
- Self-care at home
- Symptom management
- Follow-up care

Mayo Clinic: Clinical Leadership Dyad Structure

Pam Johnson is the system CNO; a physician leader who is the executive dean of the practice serves as her dyad partner at the system level. Dyad or triad partnerships also exist at the department level, the division level, and at the front line. Dyads are made up of a combination of either a physician and nurse or a physician and administrator, depending on the issue(s) being addressed; a triad includes all three roles. In addition, the clinical committee structure includes multi-disciplinary or cross-section clinical practice leaders who collectively address clinical and administrative topics.

in an episode of care? What opportunities is our quality data showing us? What does it look like for patients as they cross the transition? One challenge for many organizations is assuring patient access for clinic visits. There are a multitude of examples of physicians and nurses working together to expedite the flow of care and improve efficiency and effectiveness through protocols, procedural guidelines, etc. that truly leverage the scope of the RN role. It all starts with bringing the right roles/teams together in a true partnership to explore what's possible.

Tell me about Mayo's integrated nursing practice.

PJ: When we moved from a holding company to an operating company, the expectation from our CEO was that we would become one system, where patients could enter Mayo Clinic at any of our doors and have that same high standard of care. Nursing began that journey in 2011 when I became the system CNO.

We now have one organizational administrative structure for nursing, and I'm ultimately accountable for the practice of 14,000 nurses across all of Mayo Clinic. Each regional site (Arizona, Florida, and our four regional community practices) has its own CNO. All of the nurses at those sites report to a CNO, and then each of them have a direct line reporting to me. This provides a single organizational structure where nursing has the accountability

and the authority for professional nursing practice. In a number of other organizations, nurses have the accountability for their practice but at the end of the day, the authority lies with someone who is not a nurse. That doesn't align with our organizational values; it would be like an orthopedic surgeon reporting to a nurse or a pharmacist. Nursing should be treated like every other clinical discipline, with the accountability and authority to govern itself.

We work in a matrix-based organization, so while the nurses administratively report up through the Department of Nursing, day to day they work together in operational teams caring for patients. Our integrated administrative structure assures a common foundation and platform that assures a consistent and common standard of expectations and practice for our nurses. For example, before we had the integrated nursing practice, we had hundreds of job descriptions that were very task oriented. Now we have one staff RN job description based on the ANA standards of practice. We have one clinical standard of care and we have consistent policies, procedural guidelines, protocols, and order sets that our nurses follow wherever they work across sites.

We also have one committee structure. I lead the nurse executive committee for the enterprise. We also have one nursing clinical practice committee, one nursing education committee, and one nursing research

committee at the system level. All of these committees include nursing representation from across all of our sites; committee members make decisions about practice, education (orientation, staff development competency), and research through a shared decision-making model. The communication and discussion are bi-directional. Once a decision is made at the system level, it is expected that it will cascade throughout our practices. Our regional and site nursing leadership assure that occurs. The committee structure provides not only a clear line of accountability and authority for our integrated department but also assures a common standard of practice for all.

What is the relationship between the nursing committees and the physician committees?

PJ: Most of our committees are multi-disciplinary. For example, we have a clinical practice committee that includes nurse leaders, physicians, and others. Concurrently, nursing has its own nursing clinical practice committee where we address nursing-specific practice issues. This provides an opportunity to align our efforts and assure strong bi-directional communication for both practice committees. It also provides an opportunity to expedite decision-making because the communication flows are clearly known by stakeholders.

What are some examples of how the integrated nursing practice, committee structure, and leadership have helped further system goals and helped patients?

PJ: Our patients are very complex and the acuity is increasing. We need to ensure that we hire nurses who have the skills and attributes to take care of our patients and complement our organizational values. Once hired, we want to assure that nurses receive a consistent orientation, demonstrate

“In other organizations, nurses have accountability but lack authority because they report up to leaders in roles other than nursing. That doesn't align with our organizational values; it would be like an orthopedic surgeon reporting to a nurse or a pharmacist. Nursing is a professional discipline, therefore, like other professional disciplines, nursing should have the authority and accountability for itself. To me that's non-negotiable.” —*Pamela O. Johnson, M.S., RN, NEA-BC, FAAN*

the necessary competencies and have ongoing staff education opportunities that will help them be successful. That foundation is consistent across all sites and regions. We focus on diffusing best practice from one site to all sites so that we don't waste our time re-inventing what's already been established as best practice in one part of our system.

Our nursing practice committee assures that we have identified a common standard of practice that is evidence-based and focused on the unique needs of specialty patients. We evaluate problems and issues that sites are having so that we have one common agreed upon solution.

With a common standard of practice, patients can move between care settings (for example, moving from a Mayo acute care hospital to a Mayo critical access hospital) with confidence that they will receive the same level of care provided by Mayo physicians, nurses, and other team members. It's a seamless transition of care that improves the patient's sense of safety, security and overall satisfaction.

How do the academic and research arms of Mayo affect the way that you practice and the way that nurses lead at Mayo?

PJ: As an academic medical center, we're in a constant learning mode. In Rochester alone, we work with 11 academic institutions; we have students and residents working with our staff across many parts of the practice. There's always

interdisciplinary teaching going on. We teach and learn from each other, whether at the bedside, in the work units or in simulation labs, learning to manage patients together.

In addition, we are constantly asking “why” and seeking to address unmet patient needs that improve outcomes and overall healthcare delivery. We have a professional environment that fosters inquiry and support for our physician and nurse scientists to pursue research both within their own professional spheres, and working together in partnership to generate knowledge that is translated to patients across the entire care continuum.

Are the medical school students being trained with the understanding that they'll be part of a multi-disciplinary team and work with nurses as partners?

PJ: Absolutely. First of all, it is role-modeled for them. They see how Mayo physicians interact with Mayo nurses. Our medical students and residents are expected to treat nurses as their partners in care, discussing patient conditions, sharing their assessments and insights and developing plans of care together. Our staff physicians (called consultants at Mayo) reinforce that expectation by asking the residents and medical students, “What information did the nurse provide you? How did you incorporate what you heard from the nurse?” Concurrently, nurses are expected to speak up and step into those discussions and interactions. It goes both ways.

Let's bring things up to the board level: tell me about nurses on the board at Mayo.

PJ: I was on the Mayo Board of Trustees for a two-year rotational term representing administration and the first nurse executive to fill that seat. I've since rotated off. My vision is to influence having the system CNO role as a separate, permanent position on the board.

What information do you feel the boards need to know about nursing in their organizations?

PJ: Nurses are the largest health profession in the country and we know that health is integral to the efforts of many boards across the country. This is true for healthcare systems, but also boards who touch community health, wellness and health promotion, health of populations, and health policy. Nurses are integrally involved on the front line of this work every day—it is our passion. Nurses have the knowledge, breadth, and depth of experience to understand what our patients and consumers need, and what staff need to feel valued and recognized as key members of organizations they work for. The contributions nurses make towards the strategic goals of their organizations cannot be understated. I am confident that once boards experience the nurse's broad perspective and contributions they will wonder why they didn't include a nurse sooner.

What advice do you have for boards out there in organizations that don't have such a degree of clinical integration? What things would be important for them to focus on first?

PJ: Talk with nurse executives and nurse leaders about their perspectives and input on addressing the strategic priorities of your organization and the role that nurses can play in contributing to those priorities, but also their views as healthcare leaders, in addition to their roles as nurse leaders. With nursing as the largest employee group in most healthcare organizations, and knowing that organizations need strong nursing engagement to be successful, it is important to engage nurse leaders in discussions to explore what will draw and retain this critically important workforce.

