Should the perioperative director report to the CNO or to the COO?

Is it better for the director of perioperative services to report to the chief nursing officer (CNO) or to the chief operating officer (COO)? The question stirred lively debate at the OR Business Management Conference in May in Albuquerque, NM. A panel at the meeting advocated reporting to the COO so the OR gets the resources and support it needs. But some in the audience commented that the COO does not always understand the clinical issues important to nursing.

The OR Manager Salary/Career Survey, conducted since 1991, has consistently found that about 70% of respondents report to nursing rather than the administration.

There are strong advocates on both sides. But in interviews with surgical services directors, administrators, and consultants, opinion leaned toward the COO.

Much depends on the organization and the individuals involved, those interviewed stressed.

“Typically, with perioperative services, we’re viewing a business that accounts for maybe 50% of the hospital’s revenue and upwards of 60% of its net income,” a panel member, Jeffry Peters, president and CEO of Surgical Directions, a Chicago-based consulting firm, told OR Manager.

Though there is no one answer, he sees a shift to having the periop director report to the COO. That is because “a lot of the decisions that need to be made are financial decisions that have a significant impact on the hospital as a whole.

“There also are more physician issues in the OR than in almost any other service in the hospital, so you need administrative backing for that.”

Reporting to the COO eliminates a layer of management because the chain of command does not have to go through the CNO.

“This doesn’t diminish the nursing aspects of the profession, and the director still needs to be an advocate for that,” he adds.

Peters is currently working with a health system in the East that has recruited a perioperative director who will be on a parallel level with the CNO reporting to the senior administration.

Power of the committee

Susan Bisol, RN, MSN, CNOR, vice president of operations for the Consulting and Services business of Cardinal Health, sees a variety of arrangements, including reporting to the CNO or COO. In some facilities, the person is both the COO and CNO. She also sees service lines, where surgery has its own VP. In her opinion, the key to strong surgical services management is a well-developed perioperative executive committee.

“If I am a director, that is where my power comes from,” she says. If the committee is weak, the reporting structure is more important. In that case, she sees benefits to reporting to the COO—“I can manage nursing; it is the other departments such as radiology and the lab where the COO can bring some authority to help with throughput for perioperative patients.” On the other hand, it’s beneficial to have a relationship to the nursing department for patient flow issues such as bed shortages, which can hold up cases in the OR.

Another question is whether the perioperative director should report to the same exec as the materials management director.

“Some of our biggest issues are with materials management. Perioperative directors need materials expertise to help them manage supply costs that, other than labor, are the bulk of the budget,” Bisol notes.

Pros and cons

The cons of reporting to the CNO outweigh the pros, in the opinion of Kathy Miller, RN, MSHA, CNOR, associate administrator for perioperative services at the
University of Mississippi Medical Center in Jackson, Miss. She has been a perioperative director in 3 organizations as well as an OR consultant. In 2 organizations, she reported to the CNO; she is currently a member of the hospital administration.

On the plus side of reporting to nursing: “They understand nursing needs and support practice standards. You definitely want the CNO to stand along side you if the COO says, ‘Change the staffing mix to 30% RNs and 70% techs.’” For those reasons, she believes, “You should always have a dotted line to nursing.”

But Miller finds there are more arguments against reporting to the CNO:

• Staffing budgets are different for the OR than other nursing units, which tend to budget in terms of nursing hours per patient day.

• The OR has a far larger budget than other nursing units, particularly for capital equipment, and other nursing units may not understand why the OR budget gets so much attention.

• The majority of time in nursing meetings is spent on issues that don’t concern the OR.

By reporting to the COO, “you get a better business perspective,” she says, which is increasingly important in a time of shrinking reimbursement. Perioperative directors are expected to develop business plans for their programs and pro formas for equipment, activities that aren’t common in nursing departments.

Agreeing is Julie Blatnik, RN, BSN, CNOR, clinical director of surgical services at St John Hospital, in Maplewood, Minn, who reports to the CEO. Blatnik has been an OR manager in both academic and community hospital settings and has reported through both nursing and administrative channels.

“I think reporting to the CEO allows for making key decisions quickly. Surgical services is one of the most difficult departments to manage. You have multiple customers, and when you need a decision, you need it now.”

When there is a new technology that surgeons want but isn’t in the budget, it helps to have a direct line to the top executive rather than going through the nurse executive, who may not be familiar with the need for the equipment.

Differences have blurred

An arrangement that works well is “a dotted line to the CNO with a direct line to the CEO or COO,” comments Suzanne Richins, RN, MBA, DHA, FACHE, the COO at Kadlec Medical Center in Richland, Wash, and a former perioperative director. “The CNO has responsibility for patient care in the traditional sense, while the COO has responsibility for the financial viability of the organization.”

A growing number of COOs have nursing degrees, she notes.

“Over time, the differences have blurred. More CNOs understand the value of the numbers and making decisions based on data.”

Also blurring the lines is the crossover between interventional radiology and surgery.

“This may weight the decision in favor of reporting to the COO because of the more global view needed for capital purchases,” Richins adds.

Advocates for the CNO

Reporting to the CNO also has its proponents.

“I prefer a direct report to the CNO with a very solid dotted line to the CEO,” comments Penny Ashburn, RN, CNOR, director of perioperative services at Yampa Valley Medical Center in Steamboat Springs, Colo, which has 3 ORs and performs about 5,000 cases a year.

“I feel strongly that we need to have a relationship with the nursing department because we are nurses. It’s easy to get absorbed in our technical world. But the doctors go straight to the CEO, and I need to be able to go to the CEO without being locked into a chain of command. In this facility, I have a strong relationship with the CEO, the COO, and the CNO.”

Noting that she has been in the OR for 38 years and a manager for 21 years, Mary Starkweather, RN, BSN, CNOR, says although she has a close working relationship with the CEO, she prefers to report to nursing.

“So much of what we do is nursing related—I would not want to lose that,” says
Starkweather, who is director of surgical services for the 5-OR department at Mercy Hospital in Cadillac, Mich, with a volume of 4,800 procedures a year.

When physicians go to the CEO, “which happens no matter whom you report to,” she hears about it immediately from the CNO. “If you have good communication, it doesn’t become an issue.”

If she reported to the CEO, she believes “I would miss out on the nursing point of view. Patient safety is so crucial. The physicians are important, but if we didn’t have patients, none of us would be here.”

Managing in a matrix

More common today are service lines or matrix organizations with multiple reporting lines. In these structures, reporting lines cut across boundaries rather than going through a traditional chain of command. Management experts say these arrangements can work well in a complex organization like a hospital where there is a need for cross-functional relationships. But they can also cause confusion about who is in charge.

Tighe Simons, RN, BBA, director of the Department of Surgery at Mission Hospitals in Asheville, NC, is in a matrix. Her primary reporting relationship is to the vice president for operations, but she also has a close relationship with the nursing vice president. There also are several service lines that cross boundaries.

She sees no conflict in serving both the business and nursing sides—in fact, she sees them as closely connected.

“If you have a clinical background, nursing is second nature. The beauty of making our business model more efficient is that we have more resources for our recruitment and retention as well as state-of-the art equipment. That’s part of our business strategy—to keep the focus on patient care and patient safety.”

At Eastern Maine Medical Center in Bangor, Tom E. Callan, RN, MHA, is patient care administrator for the surgical services line, which includes the main OR, postanesthesia care unit, patient intake, outpatient surgery, the eye center, endoscopy, and several patient care units.

He reports to the vice president for patient care services, who is a physician, with a dotted line to the vice president for nursing.

He finds this dual reporting structure works well.

“It gives me the freedom to be creative and independent. You can have multiple reporting and be successful. We’ve been able to grow our business in excess of 3% a year.”

A lot depends on the individuals, he adds. “No one reporting structure is ideal. It’s the individual who makes it a success.”

Bisol observes that these kinds of structures take political savvy because “these dotted lines can be very confusing.”

Managing upward

Whatever the structure, much of a director’s success depends on the ability to cultivate a good relationship with senior execs.

“I’m not sure the position matters as much as the individual and the political savvy that person has,” Bisol notes. “The key for me is who is the best connected. If I am the director, I want to report to the person who is going to enable my success: Who is the best coach, the best facilitator? Who owns most of the bats and balls?”

An argument for reporting to nursing is that the CNO will best understand the OR’s need for clinical educators to keep the staff abreast of rapidly changing practice and technology. CNOs also understand why orientation requires more resources, with fewer experienced nurses entering the OR.

Though directors may find it easier to appeal to the CNO for clinical issues, Bisol observes that in these tight times “it’s not easy to sell those positions even to the CNO unless you can justify them based on recruitment and retention.”

Another hard fact in today’s world is that the person you report to today may decide to leave tomorrow.
Best of both

Some have the best of both worlds.

At Poudre Valley Hospital in Fort Collins, Colo, Robin Ramsey, RN, BSN, CNOR, administrative director of surgical services, reports to the hospital’s president—an RN who started out as the CNO and became COO before taking the position of president.

“It works well because I have an ear at the top,” says Ramsey. “We have a good working relationship. It is so important at my level to feel comfortable with the executive.”

If she had to choose between reporting to the COO or CNO, which would she select?

All things being equal, “the COO would be my choice,” she says. “But the bottom line is whether that person is 100% business or is also open to the nursing and clinical side of the hospital business.”

Also important to the decision would be which administrator she thought she could develop the best rapport with.

It’s critical for a perioperative director to have a good relationship with his or her superior, whether the CNO or COO, so the expectations are clear, and the director is confident of the exec’s commitment and support.

—Pat Patterson