THE ACADEMIC STORY: INTRODUCING THE CLINICAL NURSE LEADER ROLE IN A MULTIFACILITY HEALTH CARE SYSTEM

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Introducing the clinical nurse leader (CNL) role in a multifacility health care system is an exciting but obstacle-filled journey. This story includes facilitating factors, opportunities, and successes plus suggestions for other academic-practice partners considering implementing the CNL role. A sample course sequence with course descriptions is provided. (Index words: Clinical nurse leader; Partnerships; Academia–Practice) J Prof Nurs 29:264–269, 2013. © 2013 Elsevier Inc. All rights reserved.

THE AMERICAN ASSOCIATION of Colleges of Nursing (AACN) introduced the clinical nurse leader (CNL) role in response to the changing health care environment and the challenges faced in providing safe, cost-effective nursing care. The Institute of Medicine’s (IOM) publication, To Err is Human: Building a Safer Health System (2000) had a major impact on health care, calling to the attention of all health care providers the need to make major, far-reaching changes. The IOM publication provided a significant portion of the foundation supporting the introduction of the CNL role (AACN, 2005). The CNL role developed in response to the need for unit-based leadership to monitor and direct holistic care with special attention to nurse sensitive indicators; the need for a higher educated nursing workforce with clinical judgment skills and advanced leadership abilities; and the need for a unit-based (microsystem) plan to deliver best practices that foster safety for all (Hix et al., 2009). These special skills and competencies are included in the CNL educational process, giving the CNL an opportunity to positively impact the health care patients receive.

This article provides an insightful description of our own academic-practice partnership journey, one of steps and missteps, successes, and opportunities. Implications for educators and leaders in other settings who are considering CNL role implementation are discussed, hopefully making this journey smoother for others.

CNL Outcomes

CNLs have demonstrated impact on patient outcomes, improved quality, and cost savings since the role was initiated in 2005, making it a valuable addition to the nursing care delivery model. CNLs instituted changes that have led to compliance to patient care standards, increased patient satisfaction scores, increased safety, and decreased length of stay. Stachowiak (2011) conducted a study on a unit with a complex medical patient population. Pre- and post-CN L implementation data were collected from Press Ganey and the hospital clinical database. The CNL role influenced compliance with appropriate discharge instructions, increasing their performance from 55.5% to 85.7%. Length of stay decreased from 6.749 to 6.679, which translated into a savings of more than $50,000 a month. At the same time, patient satisfaction with nursing care increased from 85.9% to 93.1%, illustrating some of the benefits to implementing the CNL role. Hartranft, Garcia, and Adams (2007) reported, “Related to patient safety, the outcomes for the CNL rooms are zero falls with injury and nosocomial infections and pressure ulcers, improved patient satisfaction, and 100% achievement of Centers for Medicare and Medicaid Services core measures” (p. 262). The scores on these core measures are becoming increasingly important for health care facility’s financial survival.

The Veterans Health Administration adopted the CNL role quickly after its introduction by the AACN. Ott et al. (2009) reported many measurable improvements because
of this decision. These improvements included a 55% decrease in canceled procedures, pressure ulcer prevalence dropped from 12.5% to 4.2%, which resulted in a substantial savings, and ventilator-associated pneumonia rates dropped from 21.7% to 8.7%, representing only a few of the improvements cited with implementation of the CNL role.

Evidence strongly suggests that the CNL role can make a measurable difference in patient care. Realizing the significant contributions of the CNL role facilitated the decision to develop the CNL graduate program in partnership with a local health care system.

**Academic–Practice Partnerships**

In an effort to realize patient care changes associated with the CNL role, AACN highly recommends a new type of partnership between academia and practice for CNL education (AACN, 2004, 2007; Wiggins, 2006). Because nursing education moved away from being a service provided by hospitals, the gap between academia and practice has widened (Huijer, 2010; Sherwood & Drenkard, 2007). The academic–practice relationship is frequently difficult, and building collaborative partnerships is challenging. The task of building relationships is supported by having common goals for the welfare of patients, linking academia and practice in the effort to address the issues so vividly described in the IOM report (2000). The AACN is taking a step toward bridging this gap and promoting professional practice by suggesting that academia and practice come together in a new and unique manner. Academia is encouraged to have formal agreements with practice partners who subscribe to the implementation of the CNL role and will provide clinical experience for the CNL students. Each partner brings a special expertise, and they share a common goal: implementation of the CNL role for the advancement of the nursing profession. We are building bridges, together, to span the academic–practice gap.

**Participants/Setting**

The system chief nursing officer (CNO) of a 14-facility health care system in north central Texas previously implemented many of the concepts and care delivery components of the CNL role in Florida. Her work there directly related to the AACN's work and was eventually incorporated into the CNL role (Porter O'Grady, Shinkus Clark, & Wiggins, 2010; Sherman, Shinkus Clark, & Maloney, 2008). She continues as a driving force for the CNL role reviewed the CNL plan and advised the CNL role.

In 2008, our first practice partner's CNO enlisted faculty leaders to become partners in a CNL education and implementation project. The academic partner already offered degrees at the bachelor's, master's, and practice doctorate levels. The idea of adding another master's program was met with mixed enthusiasm among the nursing faculty. We are experiencing a nursing faculty shortage and are turning away qualified nursing student applicants because of strained faculty resources. The dean is an enthusiastic leader with a proactive approach to situations, always looking for innovative answers to meet current demands. She could see the advantages of the CNL role in health care and believed that there was a positive future for the CNL. She was able to persuade acceptance and help develop support, bringing faculty together and finding the needed resources. Thus, the CNL program has begun.

**Curriculum**

The CNL is a generalist prepared at the master's level to provide care on a specific microsystem. This point-of-care provider is expected to be a patient and community advocate, a nurse resource and provider of safe cost-effective care, a designer of individualized plans of care, a delegator, and a decision maker (AACN, 2004). A dominant component of the CNL curriculum includes expertise in finding, implementing, and evaluating evidence-based practice, increasing patient safety and decreasing errors.

A group of faculty members worked on the curriculum with the help of the curriculum guidelines presented by AACN (AACN, 2007). The curriculum consists of 33 credit hours. See Table 1 for the course sequence and descriptions.

During the curriculum development phase, a stakeholders' meeting was held, providing input for the curriculum and developing academic–practice relationships. Twenty-five prospective students, faculty, and practice partner nurses (staff level through CNOs) attended. At this meeting, each of the CNL courses was presented with their corresponding description and objectives. The stakeholders were given the AACN's *The Essentials of Master's Education in Nursing* draft (2010) in an abbreviated form and the associated suggested learning experiences. In small work groups, the stakeholders matched the essentials and learning experiences to the most appropriate course, thus validating the inclusion of all the essentials while building practice partner understanding of curriculum development.

**Facilitating Factors**

During the development stage of the CNL program, a consultant with expertise in developing and implementing the CNL role reviewed the CNL plan and advised both the academic and practice partners. This occurred in separate and joint meetings. The consultant's experience with both the practice and academic aspects of the CNL initiative was invaluable (Sherman, 2008). She shared liberally her experience and materials, building the confidence to succeed. Her visit was also beneficial in persuading those faculty members who continued to doubt the wisdom of offering another master's program option. She guided the discussion about making choices between academic programs and how those choices may impact patient care, noting that patient care outcomes should be the focus of academia and practice.
Members of the faculty, practice partners, and CNL students traveled to a large medical center in the northeast where a CNL program has been in existence for several years. This facility provided an outstanding orientation program. They shared projects, curriculum, implementation process, and allowed us to follow CNLs through a day in their microsystem, the point-of-care unit where a CNL practices. The CNO presented information about strategies for influencing physicians such as CNLs including physicians in multidisciplinary rounds and having physician representation on the CNL advisory council. She discussed strategies for making the business case for the CNL role, bringing the CNLs together as a cohesive group, and keeping them grounded in the microsystem (Tornabeni, Stanhope, & Wiggins, 2006).

Networking at educational opportunities has brought us resources from across the United States, reassuring us that we are on the right track and stimulating our creativity and vision for the future. Our dean arranged for several faculty members to attend the CNL Summit each year. Members of our practice partners also attend the summit, providing more opportunities to deepen your relationships. With this additional exposure to the benefits of the CNL role, the total faculty is becoming more cohesive and more fully supportive of the CNL program.

The practice partner began their own planning for role implementation. The system’s center for learning had professional staff that helped facilitate preceptor selection, facility readiness for CNL implementation, and selection of employees who met specific criteria for recommendation to the CNL program. Of special significance is the role that the system CNO played in establishing a system-wide CNL advisory council and allocating resources for program start up.

The CNL program would never have begun without the direction provided by the AACN and the influence, support, and leadership of the dean and the practice partner CNO. This process has provided opportunities to develop as transformational leaders; we were able to pull a productive and effective team together against harsh and unexpected odds including the economic downturn and pioneering a new nursing role.

Opportunities

Textbooks specific to CNL education and role implication are only recently coming to market (Harris & Roussel, 2010; Harris, Roussel, Walters, & Dearman, 2011). The CNL Association has developed an excellent Web site (http://cnlassociation.org) with free Webinars, publications, chats, and a listserv. This site also includes specific information of value to students, increasing their

Table 1. CNL Curriculum for the BSN–MSN Program

<table>
<thead>
<tr>
<th>Semester</th>
<th>Course and description</th>
<th>Credit hours</th>
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<tbody>
<tr>
<td>First summer</td>
<td>Leadership in clinical microsystems: focuses on nursing leadership strategies in the context of the CNL role, examines lateral integration of care through effective use of change and communication strategies related to the complex health care environment, particularly in clinical microsystems, and discusses the impact of macrosystem variables on health delivery and outcomes and effective use of self as leader</td>
<td>3</td>
</tr>
<tr>
<td>First fall</td>
<td>Advanced research</td>
<td>3</td>
</tr>
<tr>
<td>First spring</td>
<td>Advanced pathophysiology</td>
<td>3</td>
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<tr>
<td>First spring</td>
<td>Advanced physical assessment</td>
<td>3</td>
</tr>
<tr>
<td>First spring</td>
<td>Advanced pharmacotherapeutics</td>
<td>3</td>
</tr>
<tr>
<td>Second summer</td>
<td>Financial concepts in health care</td>
<td>3</td>
</tr>
<tr>
<td>Second summer</td>
<td>Health policy law ethics</td>
<td>3</td>
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<tr>
<td>Second fall</td>
<td>Care environment management: examines evidence-based decision-making strategies that can be used in the clinical microsystem and analyzes cost–benefit analysis, risk analysis, outcomes assessment, health care economics, ethical and legal issues surrounding health care, and relevant theories related to clinical decision making</td>
<td>3</td>
</tr>
<tr>
<td>Second fall</td>
<td>CNL practicum: precepted clinical course where students implement the CNL role using change, communication, and decision-making strategies; an evidence-based capstone project has begun</td>
<td>2</td>
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<tr>
<td>Second spring</td>
<td>Clinical outcomes management: explores evidence-based strategies to improve client care and manage clinical microsystem including ways to address nurse sensitive outcomes and evaluation of nursing interventions</td>
<td>3</td>
</tr>
<tr>
<td>Second spring</td>
<td>CNL residency: practicum course; students immerse themselves in the CNL role by implementing leadership, communication, decision making, and advanced client care strategies in a health care setting; the capstone project is completed</td>
<td>4</td>
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ability to network with CNLs nationwide, bringing continuing education and up-to-date information at a click of the mouse. Contributing to this accumulation of material is an opportunity for all of us who are pioneers of the CNL role.

The lack of resources within the graduate nursing program is one of the biggest challenges that we face. With the added CNL students, the core courses such as pathophysiology, assessment, pharmacology, and research have had to add additional sections. There are few faculty applicants with the credentials and experience to teach in the CNL program. In response to this challenge, we have developed new ways to better utilize our resources. We have sought and received more support from our practice partners, providing additional resources and strengthening our partnership. One added incentive for current faculty involvement in the CNL program is the opportunity to obtain CNL certification.

The waiver period offered by the AACN for faculty to take the examination without graduating from a CNL educational program will expire on December 2016.

When the first cohort was admitted to the CNL master's program, we were not aware of any CNLs practicing in this geographical area. This meant that there were no role models, no CNL preceptors, and no previously certified CNLs for faculty. Three full-time faculty and two adjunct practice partner educators have taken advantage of the AACN waiver program. The lack of CNL preceptors has led to an innovative way of providing guidance and oversight for the CNL students. Doctorally prepared and CNL-certified faculty work with the CNL students to develop preceptor teams. These teams include a nurse, minimally prepared at the master's level, as the primary preceptor. Other team members are selected to provide a multiprofessional group with involvement in the student's microsystem. This approach is most successful. The preceptor team helps the CNL student learn skills in group leadership, multiprofessional project development, and lateral integration (Spitzer, 2010) of care initiatives. The preceptor team model increases visibility and understanding of the CNL role throughout the facility, providing mutual benefits, supporting CNL education, and educating other disciplines about CNLs.

The specific roles of each partner (practice and academia) and the CNL were unclear and not well defined at the beginning of our journey. These few issues about roles and responsibilities were resolved because we have mutual goals related to successfully implementing the CNL role. In the process of defining roles, job descriptions were refined, and a clearer vision developed for the CNL, both for education and practice. The practicum evaluation tools, which were developed from the AACN (2007) guidelines, were provided to the practice partner to communicate CNL competencies at graduation. These have now been included into CNL job descriptions and CNL facility orientation programs.

We began with one faculty person assigned to the CNL program as lead teacher and coordinator. It quickly became obvious that a team approach was needed to meet the needs of 14 different facilities and the growing number of students in a role that was unfamiliar to both academia and practice. Most of these facilities had meetings that required attention from academia in addition to the usual faculty role. Working this closely with our practice partners increased cooperation, communication, and understanding but required more time from academia than other programs not so closely tied to specific practice partners.

**Successes**

Facilities now have data to make a strong business case for continuing the CNL care delivery model. Our first graduates (spring 2011) passed the CNL certification examination and have produced successful, cost-effective quality projects. They have data to support increased quality and productivity in their respective microsystem. One capstone project focused on decreasing heart failure readmissions, a devastating outcome for patients and health care facilities. The student reported a drop of readmission rates from 22% to an average of 9% (Adams, 2011), saving patients the trauma of another hospital admission and the hospital from added nonreimbursable services. A second project targeted patient throughput with emphasis on completing a greater percentage of discharges before noon. This required working with a multiprofessional team of physicians (to obtain early morning orders), nurses (to complete the discharge), and other disciplines such as social service and case management. This student reported a 19.9% improvement in before-noon discharges (Franks, 2011), making rooms available for incoming patients, the effects being felt all the way to the emergency department where dealing with patients waiting for beds was problematic.

Other successes include a growing and improving CNL program. The CNL curriculum has been revised in response to student input, making the learning experience more fruitful, bringing more satisfaction to the teacher and student. For example, one curriculum change was to move the CNL course, leadership in the microsystem, to the beginning of the course sequence. This course introduces the CNL role, allowing the beginning student to develop a vision of what lies ahead. One of the assignments in this first course is to develop a concise response to “what is a CNL,” often called the 2-minute elevator speech. The speech is based upon the AACN White Paper (2007). Because the CNL role is new, students were being asked repeatedly by family and health care colleagues to explain what they were taking in school. Having an answer readily available was very helpful, building student confidence and bringing understanding of the CNL role to others. At the suggestion of students, we moved one of the leadership textbooks, Quantum Leadership: Advancing Innovation, Transforming Health Care, (Porter-O’Grady & Malloch, 2011) to an early course in the curriculum so that it is now used from the beginning.

The economic downturn slowed the CNL partnership progress, and the first cohort of students was six. The strong, positive leadership from both partners prevailed,
and the second cohort was 18 giving us a total of 33 students in the CNL program. A third cohort of 15 began on May 2011. Two additional practice partners were added in 2010 and a fourth in 2011, expanding our program and bringing additional resources and opportunities.

Implications for Educators

We learned many lessons in our journey with the CNL curriculum and role implementation, making our program stronger and deepening academia–practice relationships. Suggestions to other academic partners considering adding a CNL master’s track to their programs include the following:

- Clearly define the academic/practice partnership roles. Be specific about who is ultimately responsible for what decisions and functions. Make sure students understand these roles. Because our students were all employees of our practice partner, sometimes the student/employee line became blurred, leaving students, faculty, and facility management confused.

- Plan a joint scholarship agenda and include it in the memorandum of understanding (contract). A specific research agenda and methods to share data need to be established at the beginning. Research projects and dissemination of information related to the CNL are more complete when both partners participate. This is a joint effort, and reporting from only one perspective does not provide the reader with a total picture.

- Develop a faculty team of at least three to develop and implement the program. Because one faculty member represented the academic partner in such a large practice partner project, it was overwhelming at times. The opportunity to discuss issues and project implementation with colleagues can only produce better outcomes.

- Secure specific clerical support from the beginning. The start-up of a new program requires many meetings and careful detail to communication. Consistent clerical help is invaluable.

- Establish a personal presence in each facility that is part of the partnership. Having one central advisory council is not sufficiently representative. The academic partner needs to be involved in explaining the educational component of the CNL role implementation at the individual facility level, preparing the way for student success.

Conclusion

This has been an exciting adventure, like learning a new dance to music with a different beat. We are fortunate to have dynamic and committed nurse leaders guiding the CNL implementation. Support for consultants and faculty education and travel has made this a smoother and more successful journey. We face the usual challenges that come with change and innovation, breaking down barriers, building up facilitating forces, and sustaining positive outcomes. The reward is worth the struggle. The CNL has the potential to meet the need for unit-based leadership, a higher educated nursing workforce, and improved safe and cost-effective patient care. The CNL role has the potential to address many of the quality issues that the IOM so vividly described. We hope that sharing our story will make a difference for you.

References


