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Implementing the Clinical Nurse Leader Role in a For-Profit Environment

A Case Study

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The Clinical Nurse Leader project marks the first time in 35 years that nursing has introduced a new role to the profession. The project has evolved to include partnerships between more than 90 universities and 190 clinical sites. The authors present a case study of how a for-profit medical center created a sense of urgency for change, built a business case, and redesigned professional nursing practice to implement the Clinical Nurse Leader role.

In 2004, the American Association of Colleges of Nursing (AACN) convened stakeholders to discuss what changes were needed in nursing education for the future to address the growing body of knowledge about the need for improvements in healthcare. Participating nursing leaders were urged to think completely out of the box as they looked at the issues and challenges of today's healthcare delivery system. Their discussions led to the design of the Clinical Nurse Leader (CNL) role and the initiation of the CNL pilot project.[1]

American Association of Colleges of Nursing's request for proposals had a unique requirement. Universities and colleges interested in offering the CNL curriculum had to engage a healthcare service partner that was committed to redesigning nursing care delivery to incorporate the new CNL role.[2] With more than 90 universities and 190 clinical partnership sites,[3] many service partners have found implementing a new nursing role and redesigning a professional nursing practice challenging. Rogers,[4] in his work on the diffusion of innovation, noted that implementing an innovation is a difficult process even when a new idea may have obvious advantages. The purpose of this article was to provide a case study of those challenges and the process used by one medical center to create a sense of urgency for change, build a business case, and redesign professional nursing practice. An unusual feature of this case study is that the service partner, St Lucie Medical Center (SLMC), is part of a for-profit hospital corporation, one of few for-profit corporations involved in the nationwide CNL project.

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The CNL Role

Like many colleges of nursing that received the request for proposals from AACN in 2004, the faculty of the Christine E. Lynn College of Nursing at Florida Atlantic University (FAU) was intrigued and recognized the need to assess interest from potential service partners. Chief nursing officers (CNOs) in the community told us that the practice challenges described in the CNL white paper[1] were consistent with their experiences (Figure 1). They also told us that the role competencies for the CNL (Figure 2) were skill sets that were critically needed for registered nurses (RNs) to be leaders at the point of care.[5] The congruence between what the academic setting could offer in terms of curriculum and their need for improvements in

- Patient care demand exceeds nursing supply
- Need to redesign nursing care delivery systems
- More complex, high risk patients who require exquisite nursing care
- Need for improved continuity across the continuum
- Numerous "broken systems" that require clinical leadership and intervention
- Competency issues with new graduates
- Lack of nursing leadership at the point of care
- Drive for reimbursement on nursing sensitive indicators
- Need for evidenced-based nursing practice at the point of care

Figure 1. Practice challenges creating a need for clinical nurse leader's role.

practice prompted 6 service partners to participate in the pilot project.

Florida Atlantic University created a traditional master's degree program to support the development of the CNL role competencies using the AACN curriculum framework.[6] Discussions with the service partners confirmed that graduates would need to be able to demonstrate how their new role adds value to the provision of care. The service partners wanted to offer their best and brightest nurses an opportunity to become CNL candidates. Key areas of concern from the partner's perspective were helping graduates to understand the complexity of the healthcare delivery system, financial reimbursement, and evidence-based practice. Communication, conflict management, delegation, and team collaboration were felt to be essential leadership skills. The development of the academic curriculum progressed quickly, and the first class started the program in fall of 2005.

Designing the curriculum was not as challenging as planning for the incorporation of a new role into the practice setting. Work patterns can be rigid, and the introduction of coworkers with new skill sets can be threatening. As functions change, so must the form or model for the delivery of care. Redesigning nursing care delivery is at the core of the CNL pilot project. In her role as a CNL project consultant to AACN , Tornabeni[7] has noted that the context of how nurses practice has changed, and the work of nursing needs to be realigned to reflect this. As one CNO in the partnership commented, if redesigning nursing care delivery was easy, we would have already done it. St Lucie Medical Center enthusiastically embraced this challenge. This is their story.

The CNL Role: A Case Study

St Lucie Medical Center, an affiliate of the Hospital Corporation of America, is a 194-bed for-profit organization located on the Treasure Coast of Florida. The facility has been challenged in recent years by both rising patient acuity and an influx of new residents, creating increased demand for healthcare service. Moreover, the progressive campaign by regulatory agencies for standardized metrics to promote patient safety (such as core measures) and the fundamental change from "fee for service" to pay for performance have created an environment requiring a change in SLMC's "business as usual" approach. The CNO recognized these changes, saw the CNL project as a unique opportunity, and

Nursing Leadership
- Effects change through advocacy for the profession, interdisciplinary healthcare team and client.
- Communicates effectively to achieve quality client outcomes and lateral integration of care for a cohort of clients.
- Actively pursues new knowledge and skills as the CNL role and the needs of clients and the health care system evolve.

Care Environment Management
- Properly delegates and utilizes the nursing team resources and serves as a leader and partner in the interdisciplinary health care team.
- Identifies clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client centered.
- Uses information systems and technology at the point of care to improve health outcomes.
- Participates in systems review to critically evaluate and anticipate risks to client safety to improve quality of client care delivery.

Clinical Outcomes Management
- Assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting recognizing the influence of the meso- and macrosystems on the microsystem.
- Assimilates and applies research-based information to design, implement and evaluate the client plans of care.
- Synthesizes data, information and knowledge to evaluate and achieve optimal client and care environment outcomes.
- Uses appropriate teaching/learning principles and strategies as well as current information, materials and technologies to facilitate the learning of clients, groups and other health care professionals.

Figure 2. American Association of Colleges of Nursing end of program competencies for the clinical nurse leader's role.

Lateral Integration of Care – facilitate, coordinate and oversee the care provided by the healthcare team.
Interdisciplinary Care Planning – communicate and collaborate with other members of the healthcare team.
Physician Liaison – collaborate with physicians regarding the patient's plan of care by taking an active role in patient rounds.
Resource Person – educate staff through mentoring, coaching and clinical conferences.
System Analyst – manage and coordinate care at the multidisciplinary level.
Evidence-based Practice (EBP) – raise questions to challenge existing practices in an effort to promote EBP.

Figure 3. Key aspects of the St Lucie Medical Center clinical nurse leader's job description.

seized the moment in SLMC's history to strengthen nursing practice.

Building the Business Case

In the spring of 2005, the CNO presented information to the senior executive team about the impact of core measures, pay for performance initiatives, shortened lengths of stay, and the growing concern of the nursing shortage on patient care. She proposed the CNL role and SLMC's participation in the pilot project as a solution to current problems and future challenges. She advocated that an improvement in care coordination, patient safety, and staff engagement depended on strong nursing leadership at the point of care. Knowing the economic climate, she proposed that the project would need to be full-time equivalent (FTE)–neutral within the division of nursing. In addition, she proposed that there would be an improvement in staff retention, decreased complications, and enhancement in nursing documentation to meet reimbursement requirements. Based on SLMC's vision, which includes employee engagement, customer loyalty, quality care, and cost effectiveness, the following initial quantitative indicators were chosen: (*a*) staff retention, (*b*) physician and patient satisfaction, and (*c*) core measures improvement. Because of the focus on outcomes, the administrative team approved a pilot for the CNL project.

Planning Phase

With guidance from information presented during the CNL partnership meetings, SLMC's nursing leadership met in the spring of 2005 to discuss potential CNL candidates and selection strategy. After a rigorous interview process, 4 SLMC baccalaureate-prepared RNs were selected to begin a nursing graduate program to prepare them for the CNL role. The 4 CNL candidates came from various nursing backgrounds, ranging from bedside nursing to patient care coordinator (PCC) role. They had diverse experience, proven success in their previous roles, and high interest in this project. The 4 candidates were approved by the CNO, met the criteria for admission to the CNL graduate program, and were subsequently sponsored by SLMC to receive a full scholarship.

With the assistance of grant funding from 2 agencies, a consultant from Creative Healthcare Management was engaged by FAU to help SLMC lay the foundation for a new professional nursing care delivery model that would incorporate the CNL role. Meetings were held with a focus group comprised of nursing leaders, PCCs, CNL students, and staff nurses. By the end of 3 sessions of open dialogue, the group had successfully accomplished the following:

- established the nursing philosophy and principles to guide the project,
- identified differences in the PCC and CNL roles,
- drafted the CNL job description (Figure 3), and
- framed the new nursing care delivery model for the pilot units.

With the support of the CNL students and the FAU faculty, the management team decided to move forward with the project and allow the CNL students to pilot the role even before completing the curriculum.

The pilot units were a 36-bed progressive care unit and a 45-bed general medical/surgical unit. These units were selected because of the volume of patient admissions, transfers, and discharges; growing number of new graduate nurses; increasing patient acuity; inconsistent patient satisfaction scores; and number of patients with a diagnosis of congestive heart failure and pneumonia who required core measure monitoring. Both units had strong leadership support, which proved to be pivotal to the success of the project. The size of the units also allowed greater flexibility in managing nursing hours and redesigning the nursing care delivery model.

With the pilot units identified, the nursing leadership met with the CNL students to discuss the logistics of how the project would be implemented. As plans evolved, they were also discussed

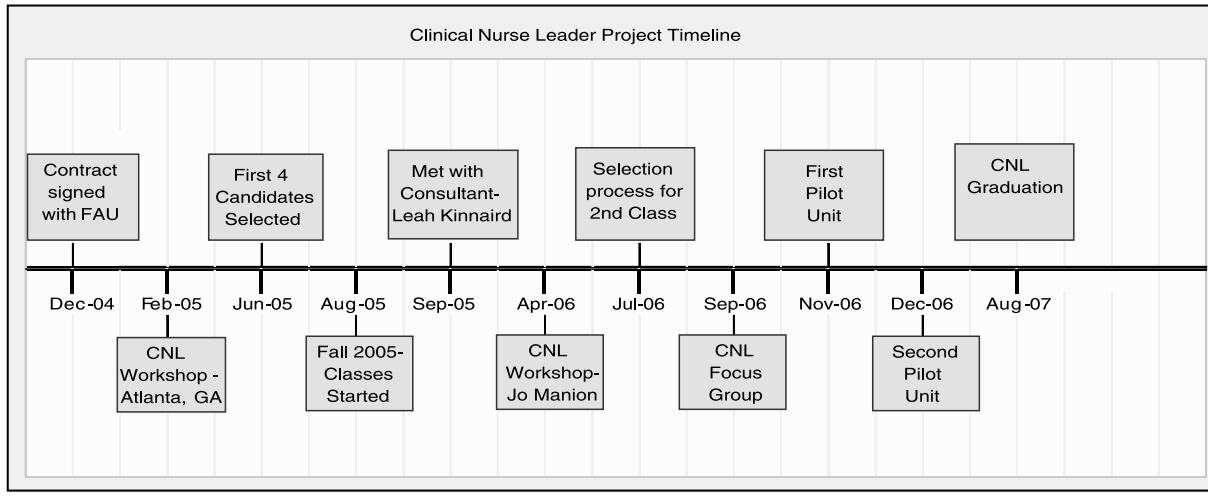

Figure 4. Time line of the clinical nurse leader project at St Lucie Medical Center.

at the CNL partnership meetings. A time line was developed (Figure 4), and methods to communicate with staff and physicians were established. The proposed CNL job description was reviewed with the CNL students for their final input, and the outcome measures were designated. Change, as Copnell and Bruni[8] have observed, especially in nursing practice, is thought to be a rational process but difficult to achieve; therefore, staff engagement, commitment, and ownership of the project had to be gained to ensure success.

Discussions about the CNL role and proposed revisions to the delivery model were conducted at staff meetings before the implementation of the project. This process was essential to create an avenue for the staff to raise questions and nursing leaders to clarify misconceptions and establish role differentiation. One of the most important elements in the discussion was for nursing leaders to provide reassurance that the role of each team member was critical to the success of the project. These discussions continued through implementation of the role. To maintain the integrity of the CNL role, a summary report from the focus group during the initial phase of the project was revisited, and role modifications were made as appropriate. The CNO and the nursing leadership team recognized that they would play a key role in maintaining the momentum of the project during the planning, implementation, and evaluation phases.

Implementation Phase

With guidance from Kotter's[9] change theory, the nursing leadership decided that the new nursing care delivery model and CNL role would be implemented one unit at a time. The new nursing care delivery model was designed to address care fragmentation, improve physician communication, provide support to bedside nurses, and offer a consistent care leader at the point of care, especially for high acuity and core measure patients. In November 2006, the CNL project was implemented in the progressive care unit.

Two CNL positions were introduced while maintaining the current bedside staffing model. Each CNL was assigned a patient load of 18, with each CNL working closely with 3 staff nurses and 2 patient care assistants. An hour-long weekly meeting was conducted by the department director to allow for an open discussion and assess the progress of the project based on staff personal experiences.

The most common concern raised by the staff involved role delineation. Role conflict and overlap between the CNLs and the PCCs were the focus of discussion. The plan to begin the pilot with 1 unit proved extremely effective because the leadership team was able to focus on 1 unit and closely monitor the progress of the project. This was accomplished by a daily dialogue between the leadership team and the CNLs and PCCs. Necessary modifications were made to strengthen and value these 2 roles. In an effort to maintain the integrity of the CNL role, the PCC's responsibility was modified to focus on the administrative aspect of unit management, whereas the CNL role was focused on the clinical outcomes and practice development. Furthermore, the PCC role was structured as a team leader, overseeing the overall unit operation including staff scheduling and assignment, unit throughput, and coordination of unit-based activities. Having a clear delineation between the 2 roles, the bedside nurses gained expert resources on both clinical and administrative aspects of patient care.

In December 2006, the new nursing care delivery model with 2 CNL positions was introduced

Table 1. Pre–CNL and Post–CNL Implementation Outcomes, General Medical/Surgery Department and Progressive Care Unit

Indicators	4th Quarter of 2006	4th Quarter of 2007
Employee engagement		
Nursing turnover rate—NQF	6.13%	3.20%
Customer loyalty		
Patient satisfaction	3.40	3.46
Physician satisfaction[a]	2.96	3.13
Quality care cost effectively		
Core measure—AMI	90%	97%
Core measure—CHF	91%	96%
Core measure—pneumonia	80%	85%

Abbreviations: AMI, acute myocardial infection; CHF, congestive heart failure; CNL, Clinical Nurse Leader; NQF, National Quality Form.
[a]Annual survey.

to the second pilot unit, a general medical/surgical unit. In keeping with the new delivery model, the bedside staffing standard was reinforced. A focus group comprised of CNLs, PCCs, staff nurses, and patient care assistants met regularly with the department director to discuss the progress of the project. Equipped with lessons learned from the first pilot input from the staff and improved clarity about the CNL role, a better transition and acceptance of the CNL role occurred.

To meet the goal of staying FTE-neutral while implementing the CNL project, each unit's patient support structure was revamped. This was accomplished by converting the unit secretary position to a CNL position. This strategy allowed the leadership team to incorporate advanced-studies–prepared and clinically competent nurses, which were fundamental to achieving positive outcomes. In addition, an opportunity arose when a low-volume specialty program was eliminated, allowing the CNO to move a vacated FTE to each pilot unit. Although the project was not budget-neutral, it met the target of remaining FTE-neutral.

Evaluation Phase

In an outcome-driven environment, nursing leaders were sensitive to the need to present data during the pilot phase to demonstrate how the new delivery model was impacting care and other organizational indicators. To evaluate the outcome of the project, SLMC project leaders reviewed the chosen indicators and compared the preimplementation and postimplementation data. The core measure results (congestive heart failure, acute myocardial infarction, and pneumonia), physician and patient satisfaction, and nursing turnover showed early improvement, as indicated in Table 1.

The CNLs on the pilot units began the collection of qualitative data, such as the identification of near misses on their units and situations wherein physicians have opted not to transfer patients to intensive care unit because of the presence of the CNL on the unit. The facility joined the AACN evaluation project and is part of a replication study to assess CNL role outcomes. As the CNL role at SLMC continues to evolve, CNL-sensitive outcome measures are being identified and analyzed to capture the true impact of the role not only in patient outcomes and staff engagement but also in the overall health of the organization.

Lessons Learned

During the process of transforming the nursing care delivery model at SLMC, there were many lessons learned. A critical factor in the success of the development and implementation of the CNL project at SLMC has been the commitment of the CNO. This strategy rings true with the assertion of Redfern et al[10] that the development of a culture to promote changes in nursing practice depends on strong leadership. Morijkian et al[11] have noted from their research that CNO support is a critical success factor to leading innovative changes in their organization. Maintaining the momentum of the project by having regular meetings with the CNLs and the nursing staff was important, as was maintaining close communication with the academic partner. Other key leadership strategies are outlined in Figure 5.

1. Gain CEO and CFO Support – upfront & ongoing.
2. Select the right staff to pilot the role.
3. Maintain strong relationships with the academic partner.
4. Keep staff engaged with weekly discussions during the startup phase.
5. Market the CNL® role to key physicians in the organization.
6. Select pilot units where there is management support and an opportunity to impact care.
7. Consider how to integrate Case Managers.
8. Keep the CNL® role unit based (not at meetings).
9. Select and measure outcomes both pre and post implementation.

Figure 5. Key leadership success strategies.

A major caveat to the introduction of the CNL role is the lack of empirical evidence because the role is brand new. It is not unusual for organizations to face challenges during each phase of the process; however, it is extremely important to learn valuable lessons along the way and make necessary adjustments until the proposed goals are achieved and objectives are met. Even so, as the healthcare environment evolves, so must our approach to meeting the demands of the communities we serve.

Conclusion

The case study of SLMC illustrates how nursing leadership can effectively establish a business case and plan strategically to drive innovative practice changes even in a for-profit environment. Although the sustainability of early successes is not known, similar outcomes data from partners involved in the AACN project have been very encouraging.[12-14] As the CNL pilot project's journey continues, the ultimate success will depend on what value the CNL role adds to patient care and to the organizations that implement it.

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