Building the Business Case for the Clinical Nurse Leader Role

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Several landmark reports have addressed the current health care crisis and a prevailing need to transform the workplace, align nursing education and clinical practice, and provide financial incentives for organizations to invest in high quality nursing care.[1-4] While multiple reports call for change, consensus on a uniform approach to addressing identified issues and creating financial incentives remained circuitous until the American Association of Colleges of Nursing (AACN) introduced the Clinical Nurse Leader[SM] (CNL®) role. The role was created in partnership with the academic and practice sectors to deliver clinical leadership to individuals and families within a microsystem of care.

An advanced generalist at the point of care, the CNL is prepared to deliver and direct evidence-based practice, evaluate patient outcomes, assess risk, and enhance team competence while improving the overall coordination and delivery of care for an individual or group of patients at the microsystem level in all health care settings.[5]

An unparallel opportunity now exists for health care organizations and academic institutions to partner and build the business case for the CNL role across all settings in which health care is delivered. This article provides the core elements necessary for building a business case for the CNL and explains how the role can create opportunities for health care organizations to capitalize on resources available from affiliating university faculty and use mass customization as a strategy to meet the challenges inherent in the delivery of quality and safe care. For purposes of this article, a business case is defined as a multifocal document that elicits the support and participation necessary to move an idea to reality. The business case describes the idea or issue

and what impact it will have on the organization in terms of costs and benefits.[6]

Mass customization is defined as the ability to profile patterns of need and offer individual services on a large scale.[5,7]

CRAFTING A BUSINESS CASE FOR HEALTH CARE CHANGE

Divergent thought is prevalent throughout the literature on antecedents and barriers to the delivery of quality and safe health care despite a preponderance of evidence to guide clinical practice.[8-10] The prevailing reason that health care organizations cite for not implementing quality-enhancing interventions and introducing new roles that can change care delivery is the absence of business cases.[11]

One of the first steps in crafting a business case for health care change is determining organizational readiness and how the resources of an affiliating university can be utilized to mutually benefit both organizations.[11] The senior leaders of both organizations must be committed to the project and to an evaluation of outcomes. Clearly defining and delineating discrete actions, interventions, timelines, partnership gains from the affiliating university, and potential impacts prove useful in securing buy-in and commitment by senior leaders.

For health care organizations that are unionized, a readiness assessment of union issues and their supportive involvement early on in the development of a business case become central to eliminating the appearance of predecisional bias and conflicts that may arise if their constituents question them about an idea prior to discussion by management. Sharing the idea with staff and affiliating faculty during focused discussions can provide valuable input that can support arguments for building the business case as one prepares to address senior leaders and assessing organizational readiness. Benchmarking an organization and identifying the gains to be realized by using academic partner resources are valuable information that can also be used to justify the project and shape what the organization wishes to accept, maintain, or improve.[12] Once organizational readiness from the health care facility and the affiliating university is established and the overall concept is approved by the senior leaders, the business case content can be developed and the idea turned into reality.

BUILDING THE CNL BUSINESS CASE

When organizing the content of any business case, information should be assimilated that is specific to a minimum of six components: relevant background information, problem/opportunity, objectives, project costs and benefits, any pros or cons, and alternatives and consequences to the project development or nonapproval.[7] Hence, the life cycle of the business case moves from idea to gaining support, project development, implementation, and evaluation. Developing a business case requires that even the most confident leader build a data-driven case that resonates confidence and assures all stakeholders that the idea will result in high impact quality outcomes. The six business case components and examples that may be included are presented as a guide for health care facilities planning to introduce the CNL role at the clinical microsystem level.

The first section of the business case is the *relevant background information*. In this section, the identified audience is introduced to the issue or subject. A general description of what historically has led to introducing the role, building the business case, and the current state of an issue should be provided, citing regulations, facility and service line policies, and any unit-specific qualitative data. Examples include changing reimbursement regulations, care demands, and the fragmentation of care resulting in performance targets in a specific area or service line being unmet for the third consecutive quarter. As a result, losses in revenue, coupled with dissatisfied patients, staff, and stakeholders mandate a call for action.

In response to the identified need, introducing an advanced generalist nurse role, the CNL, into the care delivery system at a microsystem level is requisite to reversing the identified continuous deficit cycle. As a unit-based, nonmanagerial nursing staff member that assumes accountability for health care outcomes and uses evidence-based knowledge to guide actions, the CNL coordinates and delegates care provided by the health care team. As this role has been introduced in health care systems, resounding clinical impacts are being realized and anecdotal reports are being published by practicing CNLs that further support how the microsystem can be redesigned to meet complex patient care needs.

The problem/opportunity statement is the second section of the business case and should succinctly provide what the initiative is trying to accomplish. For example, changes in reimbursement regulations require that care is coordinated and continued stays in acute beds must be supported by documented evidence approved by third party payers. Another example offered is existing performance data that reveal that patients are not being discharged timely and discharges are not coordinated or adequately planned resulting in staff and patient dissatisfaction, increased lengths of stay, and revenue loss that the facility must absorb.

Introducing the CNL role is one attempt to reverse the disequilibrium caused by poorly coordinated discharges, dissatisfaction, and revenue losses. The CNL is a lateral integrator of care who is able to anticipate risk and coordinate care while being a steward of the environment and human and material resources. The CNL critically evaluates and anticipates risks to patients and manages care and triggers at the point of care to individuals, clinical populations, and communities. As affili-

ating faculty prepare CNLs for practice, rich opportunities avail themselves for advancing knowledge and introducing evidence into the facility that helps alleviate issues and drive outcomes evaluation of the CNL role.

Objectives for the business case compose the third section and identify what the initiative will accomplish and the expected deliverables available in measurable terms within a specified timeframe. Examples may include:

- Introducing the CNL will reduce delays in discharge on medical and surgical units by 50% the first quarter and by 90% by the end of the fiscal year.
- Surgical cancellations will be reduced from 15% to 8% by the third quarter and operating room efficacy will be increase from 65% to 85% as the CNL coordinates perioperative initiatives.
- Nursing hours and expenditures for sitters will be reduced by 85% by the fourth quarter and sustained throughout the planned patient assessment and education interventions by the CNL. Affiliating faculty will assist staff develop a poster presentation for a national conference and manuscript for submission on sitter hour reduction strategies this fiscal year.

The fourth section of the business case is *projected costs and benefits*. A description of the initial and ongoing costs should be provided including direct, indirect, recurring, and any capital costs that may be incurred by interventions and planned initiatives. Any projected gains to be realized from the partnership with the affiliating university should be identified. A detailed budget worksheet throughout the lifecycle of the business case will prove useful to senior leaders at the facility and affiliating university and serve as a reference point when projecting spending for each quarter of the budget cycle. Table 1 provides an example of how to develop a basic cost and benefit summary spreadsheet where the CNL is introduced in the care delivery system and how the impacts targeted at reducing procedure cancellations in a gastrointestinal (GI) lab are realized.

The fifth section of the business case should identify the pros and cons, a list of the positive and negative attributes associated with the initiative. Examples of *pros and cons* may include:

- Opportunities for a new and innovative redesign of the care delivery system are possible with the introduction of the CNL.
- Changes in quality scores and education of staff on new technology will occur as the CNL targets specific areas requiring change and intervention at the microsystem level.
- Evidence-based practice can be mounted as the hallmark for practice change where the CNL is providing care and directing staff.
- A stable pool of well-developed staff who are continuously seeking new learning opportunities will be an outgrowth of the CNL practicing within the microsystem.

Table 1. Cost and Benefit Summary, Cancellation Rates-GI Lab

Cost Benefit Summary	Before CNL	After CNL
Cancelled GI procedures	30%	10%
Loss in revenue	$195,000	$39,000
CNL annual cost		$70,000
Total savings realized by CNL introduction		$86,000

- Improved patient outcomes and satisfaction can increase the profitability of a specific service line as CNLs are employed and initiate actions directed at change, quality, and safe care.

These are a few examples experienced by early adopters of the CNL role nationally.

Cons of introducing the CNL into the workforce may include:

- Change in an existing care environment that is chaotic and not ready may further disrupt the organization and lead to negative outcomes for the CNL role.
- Organizations that do not differentiate role and functions of the nurse manager, clinical nurse specialists, nurse educators, staff nurses, and other members of the interdisciplinary team prior to introducing the CNL may lead to role confusion and duplication of duties.
- Introducing a role that is cost neutral may require redesigning other roles or the use of an unfilled staff position may increase staff dissatisfaction.

While the pros and cons identified are not exhaustive, nurse leaders should use objective data, opinions, and value statements when developing this section and extrapolate data trends and forecasts.[12]

The final section of the business case should include *alternatives and consequences*. This section provides the reader, stakeholders, and the approving official with an outline of the possibilities to address any issue(s) and any future opportunities. For each alternative, the key people and drivers of the initiative, processes, and systems impact should be included. Specific impacts, risks, and opportunities that enhance the business outcomes of the alternative(s) are central to distinguishing the current alternative(s) from others that may have been previously provided or discussed to improve patient care outcomes, safety, and efficient business practices.

For example, introduction of the CNL on an inpatient surgery unit will significantly impact the reduction of orthopedic complications by the development of a preoperative teaching program and postoperative protocols championed by the CNL and collaborative developed with surgeons, physical therapists, staff members, patients, and affiliating university experts. Some business cases list as an alternative or consequence do nothing or the status quo in the final section. As a con-

sequence, the risks associated with the status quo should be succinctly outlined, detailing potential revenue losses and diminished patient outcomes if the status quo is maintained.

MASS CUSTOMIZATION: EXAMPLE OF A CNL IN A GI LAB

As health care organizations have successfully built business cases resulting in the adoption of the CNL role, patterns of need were profiled and individual services on a larger scale were offered using the talents and skills of practicing CNLs. One of the fundamental components of the CNL role is mass customization.[5] CNLs are prepared to use evidence-based approaches to identify patterns and modify actions that meet specific needs of individuals, populations, or communities within a microsystem. Successes are achieved as the CNL collaborates with individuals to provide patient-focused and safe care.

Zipkin[7] identified the key capabilities of mass customization systems: elicitation, process flexibility, and logistics. As health care organizations consider a mass customization strategy, careful analysis on the ability to deliver high-quality, safe, and timely access and services to patients and integrate the key capabilities must be considered. A discussion of each capability is provided using experiences by a CNL who used mass customization as a strategy to redesign services and increase efficacy in a GI lab.

The CNL artfully elicited what patients, family members, and staff desired when making appointments for GI procedures. This was accomplished through individual questioning and focused groups. Data were gathered about educational needs, best times for procedures, and thoughts of how flow processes could be improved that would expedite and reduce waiting once arriving the procedure and post procedure processes. All members of the GI team were kept informed about the findings, and the CNL elicited their participation in data collection and review of findings. This reduced the costs associated with survey sampling, mailings, and the potential for a poor response rate. In sum, the CNL was able to elicit what patients, families, and staff desired and collected information necessary to the other two capabilities, process flexibility and logistics.

Based on the information elicited, the CNL collaboratively developed process changes whereby flow, efficiency, and cancellation rates were reduced; patient, family, and staff desires were addressed; patient education became more user friendly and informative; and the staffing levels based on scheduled procedures could be adjusted to reduce slack time and increase satisfaction. Logistically, scheduling procedures was greatly enhanced and changes in processes followed whereby patients were contacted at least two times before procedures to answer questions, provide information, or reschedule if desired.

The CNLs expertise resulted in increased GI lab efficiency, resource utilization, and reduced postprocedure time through all phases: staging intake, procedures, and recovery. As managers realized the utility of the CNL and actions, funds were allocated for a new GI and recovery suite that further enhanced the efficacy and funding of other CNLs in outpatient areas to increase flow processes and the satisfaction of patients, families, and staff.

For mass customization to be effective, all three elements—elicitation, process flexibility, and logistics—must be linked to form a unified whole. Mass customization crosses many traditional boundaries in business sectors and can be applied to health care. The knowledge, agility, and expertise of the CNL are key to microsystem successes and enabling an organization to realize goals and objectives that meet customer expectations and needs.

CONCLUSION

As the CNL role is introduced and functions in multiple health care settings and organizations, many of the inherent challenges associated with quality, safety, and efficient care delivery can be resolved. However, business cases must be built on explicit support action and strategically outlined anticipated outcomes that resonate throughout the organization and maintain strong partnerships with affiliating universities. The CNL is eminently positioned to organize, facilitate, and serve as an agent of change at the microsystem level. The vision of clinical leaders and educators whose foresight and fortitude lead to the introduction and implementation of the CNL role will be realized in an environment where high-quality, safe health care is delivered and academic and service partnership flourish.

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1541-4612/2008/ $ See front matter
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doi:10.1016/j.mnl.2008.06.002