

# INNOVATIVE PARTNERSHIPS: THE CLINICAL NURSE LEADER ROLE IN DIVERSE CLINICAL SETTINGS

CAROL ANN BARNETT LAMMON, PhD, RN, CNL,\*  
MARIETTA P. STANTON, PhD, RN, C, CNAAC, BC, CMAC, CCM, CNL,† AND  
JOHN L. BLAKNEY, RN, MSN‡

The American Association of Colleges of Nursing in collaboration with leaders in the health care arena has developed a new role in nursing, the clinical nurse leader (CNL). The CNL is a master's-prepared advanced nurse generalist, accountable for providing high-quality, cost-effective care for a cohort of patients in a specific microsystem. Although initial implementation of the CNL has been predominantly in urban acute care settings, the skill set of the CNL role is equally applicable to diverse clinical settings, such as smaller rural hospitals, home-based home care providers, long-term care facilities, schools, Veteran's Administration facilities, and public health settings. This article reports the strategies used and the progress made at The University of Alabama Capstone College of Nursing in the development of innovative partnerships to develop the role of the CNL in diverse clinical settings. With academia and practice working in partnership, the goal of transforming health care and improving patient outcomes can be achieved. (Index words: Clinical nurse leader; Settings; Partnerships) *J Prof Nurs* 26:258–263, 2010. © 2010 Elsevier Inc. All rights reserved.

OVER THE LAST decade, a series of reports by the Institute of Medicine (2000, 2001, 2004), The Joint Commission (2002), the American Hospital Association (2002), and the Robert Wood Johnson Foundation (2002) have described a health care system in crisis. The nursing shortage looms, medical errors are unacceptably high, implementation of evidence-based practice to achieve the best outcomes lags years behind research, health care waste and costs soar, delivery of care is fragmented, patient and family satisfaction is low, people are living longer lives

complicated by chronic illnesses, and health disparities are all too common. Responding to the call for change and the need to positively impact these issues, the American Association of Colleges of Nursing (AACN) in collaboration with leaders in the health care arena developed a new role in nursing, the clinical nurse leader (CNL).

The CNL is a master's-prepared nurse generalist, accountable for providing high-quality, cost-effective care for a cohort of patients in a clinical microsystem. A clinical microsystem is the place where patients and families and care teams meet (Nelson, Batalden, & Godfrey, 2007). A microsystem, although often interpreted as a hospital unit housing 15–20 patients, may also include any primary, secondary, or tertiary setting where care is delivered. Thus, the CNL can function as a leader across all health care settings; however, the implementation of the CNL role may vary across settings (AACN, 2007). The CNL relies on skills in patient care and requires in-depth knowledge in quality management, nursing leadership, evidence-based practice, risk appraisal, and outcomes analysis. This advanced nurse generalist coordinates care of a distinct

\*Associate Professor and CNL Curriculum Coordinator, Capstone College of Nursing, The University of Alabama, Tuscaloosa, AL.

†Professor and Assistant Dean of the Graduate Program, Capstone College of Nursing, The University of Alabama, Tuscaloosa, AL.

‡Instructor and Faculty Mentoring Coordinator, Capstone College of Nursing, The University of Alabama, Tuscaloosa, AL.

Address correspondence to Dr. Stanton: Professor and Assistant Dean of the Graduate Program, Capstone College of Nursing, The University of Alabama, Tuscaloosa, Alabama, Box 870358, Tuscaloosa, Alabama 35487-0358. E-mail: [mstanton@ua.edu](mailto:mstanton@ua.edu)  
8755-7223/10/\$ - see front matter

group of patients and has decision-making authority to change care plans when necessary. The CNL is a resource for clinical decision making and serves as lateral integrator of care. As an active member of the interdisciplinary health care team, the CNL designs and directs cost-effective and evidence-based care within a microsystem. The CNL is accountable for clinical outcomes as well as influencing work environments (AACN, 2007).

To date, implementation of the CNL role has been predominantly in urban acute care settings; however, the skill set of the CNL is equally applicable to diverse clinical settings. Smaller rural hospitals, home-based home care providers, long-term care facilities, schools, Veteran's Administration facilities, and public health settings all can benefit from the impact of the CNL on evidence-based, cost-effective, and outcomes-focused health care. This article reports the strategies used and the progress made at The University of Alabama Capstone College of Nursing (CCN) in the development of innovative partnerships and the successful integration of the CNL role across diverse clinical settings.

### **Introduce the CNL Role to Potential Clinical Partners**

The CNL role is the first new role in nursing since the development of the Clinical Nurse Specialist. Our initial response to the CNL role as described in the *Working White Paper on the Role of the Clinical Nurse Leader* (American Association of Colleges of Nursing, 2003) was to approach our local regional medical center to determine the level of interest in partnering to educate and employ CNLs. A meeting was held to discuss the CNL role and this new educational opportunity. Representatives from a variety of local community health care agencies were invited to attend. As the CNL role was presented, many of the community agencies expressed interest in the CNL role, citing potential benefits to their agency and the clients they serve.

The CNL role components that are of particular interest to these diverse clinical groups included development of a point of care provider that could provide clinical leadership, care coordination within and across health care settings, outcomes management, and staff education and mentorship. Although it was envisioned that implementation of the CNL role would vary across these diverse clinical settings, all potential partners agreed that several of the core competencies of the CNL were standard across all agencies: promotion of patient-centered care, promotion of effective interdisciplinary teamwork, employment of evidence-based practice, application of quality improvement, and increased utilization of informatics. All of the diverse clinical agencies viewed the role of the CNL to be one of leading and managing the staff to promote patient-centered care rather than provider of care to a caseload or patient assignment. All agencies employ a variety of health care providers and viewed the CNL as an integral part of the multidisciplinary health care team, working to improve the quality and coordination of care. In fact, most agencies viewed the CNL as the hub of the multidisciplinary team,

placing high value on the lateral integrator role component. All of the agencies believed that the CNL would enhance quality patient care by supplying evidence to promote best practices and would bring the needed skills for the development and evaluation of evidence-based care protocols. In many diverse care settings, health disparities are all too common. The agencies valued the CNL educational focus of human diversity and cultural competence that the CNL could bring to the design of evidence-based health care practices and protocols. All the agencies embraced the CNL as a person that would be accountable for the outcomes and clinical indicators appropriate for the setting. The ability to use and manipulate databases for outcomes assessment was viewed as a valuable skill the CNL would bring to the clinical agency.

### **Lay the Groundwork for the CNL Program**

Starting a CNL program in a school of nursing requires clinical partners, an understanding of the contribution of the academic and clinical partner to the CNL program, curriculum development, funding, and students. Initially, four clinical agencies in our area committed to partnering with the CCN to develop a program to educate CNLs:

- DCH Regional Medical Center, a regional acute care facility serving 11 predominantly rural counties in West Alabama. We later added the smaller rural hospitals in the DCH Health System.
- Alacare Home Health and Hospice, providing home-care services statewide.
- Tuscaloosa Veteran's Administration Hospital, providing primary, long-term, and mental health care services for veterans.
- Alabama Department of Public Health, providing public health services statewide.

A Memorandum of Agreement for the CNL partnership, delineating the responsibilities of each partner, was negotiated and signed by the Dean of the academic partner and the Chief Nursing Officer of each clinical partner. This was an effective strategy in delineating the basics of the partnership and later proved to be useful when we expanded our partnerships beyond the original four clinical partners.

The CNL role was integrated into the existing Master of Science in Nursing (MSN) program at the CCN in June 2006. Nursing faculty, along with contributions from adjunct faculty from the partnering clinical agencies, made revisions in courses for the CNL track in the existing MSN program. The CNL program was supported in part by a 3-year grant from the Health Resources and Services Administration (HRSA)<sup>1</sup>, which provided funds to support personnel and materials necessary for program

<sup>1</sup> This project was supported in part by funds from the Division of Nursing (DN), Bureau of Health Professions (BHPr), HRSA, Department of Health and Human Services (DHHS) under Grant DO9HP07455 and title VIII for \$978,000. The information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should be any endorsements be inferred by the DN, BHPr, HRSA, DHHS, or the U.S. government.

expansion. Students were recruited from each of the four initial partners for the first class of CNL students.

## Foster Successful CNL Role Development and Integration in Each Clinical Setting

### Provide Information

Because our initial partners included a mix of an acute care agency, as well as more diverse clinical partners, a variety of strategies were used to develop the CNL role in each of the various clinical settings. A copy of the CNL toolkit AACN was provided to each partnering agency. As the tool kit was reviewed, practice partners were asked to focus on the competencies, roles, and responsibilities of the CNL. Meetings were held between the academic and practice partners to determine how the role could be adapted to the setting and to identify “holes” in current care practices [that were] amenable to intervention by CNLs.

Strategies for fostering successful CNL role integration in clinical settings included a series of informative workshops lead by national speakers, student presentations of CNL immersion experiences, and reports of

annual CNL summits. Grant resources and funds provided by DCH Regional Medical Center provided funding for a series of workshops featuring national consultants on the CNL initiative. The initial workshop lead by Dr. Rose Sherman presented “The Case for the CNL in Today's Health Care Environment: Why Join the CCN Partnership.” This initial workshop laid the groundwork for understanding the potential impact of the CNL role in meeting the challenges faced in health care today and the need for academia and practice to partner to develop this new nursing role.

A second workshop, jointly led by Dr. Rose Sherman and Ms. Nancy Hilton MSN, presented “The Institutional Implications of the CNL Program.” The potential financial and quality outcomes resulting from CNL practice were explored. In the afternoon of this workshop, partners participated in small group sessions to complete a heuristic (Figure 1), identifying the CNL role and responsibilities in their agency. Unique organizational needs and measurable outcomes that could be impacted by the CNL were also identified. Partners were encouraged to identify desired measurable outcomes in five areas: clinical, financial, functional,

The University of Alabama  
 Capstone College of Nursing  
 Clinical Nurse Leader  
 Heuristic Outline

**I. Define the CNL Role for your facility in conjunction with the CNL role as defined by AACN.**

Example for a regional medical center:

*The Clinical Nurse Leader (CNL) focuses on providing high quality cost-effective care for a cohort of patients in a specific microsystem or unit. The CNL relies on skills in patient care and requires in-depth knowledge in quality management, nursing leadership, evidence-based practice, risk analysis, and outcomes analysis. This master's prepared nurse generalist coordinates care of a distinct group of patients and has decision-making authority to change care plans when necessary. The CNL is a resource for clinical decision making, and serves as lateral integrator of care. The CNL is an active member of the interdisciplinary health care team designing and directing cost-effective and evidence-based care within a microsystem. The CNL is accountable for clinical outcomes as well as influencing work environments.*

**The CNL role defined for your facility:**


**Figure 1.** Heuristic outline for agency-specific development of the CNL role and clinical immersion experience.

**II. Identify key responsibilities for the CNL role**

Examples of key responsibilities:

- a. *Clinical Care*
  - i. *Education*
    - 1. *Staff*
      - a. *Unit specific orientation and mentoring programs*
      - b. *evidence-based clinical practice initiatives*
    - 2. *Patient*
      - a. *Unit specific patient teaching initiatives*
  - ii. *Staff Competencies*
  - iii. *Patient Satisfaction*
- b. *Clinical Outcomes*
  - i. *National Patient Safety Goals*
  - ii. *JCAHO Standards*
  - iii. *Core management Initiatives*
  - iv. *Infection Control*
  - v. *Patient Care Outcomes*

**Key Responsibilities for your organizational needs:**


**III. Immersion Experience Defined:**

Development, implementation and evaluation of a program to achieve an identified goal.

Examples of identifiable goals that can be measured for evaluation:

- i. *increase medication accuracy*
- ii. *decrease infection rates*
- iii. *decrease pressure ulcers*

**Immersion Experience for your organizational needs:**


Figure I (continued).

satisfaction, and quality—developing a clear vision of how the CNL could be effective in each diverse clinical setting.

A third workshop led by Dr. Leah Kinnaird of Creative Health Care Management discussed “Reworking the Nursing Organizational Structure: Implementation of

the CNL.” Integration of the CNL role and its impact on other roles within the health care organization were explored. An introduction to using relationship-based care to transform the workplace was also discussed at this workshop. The concept of transformational leadership was integrated into coursework and clinical experiences, and all agencies and students were provided copies of *Relationship Based Care* (Koloroutis, 2004).

Our most recent partner meeting led by Dr. James Harris presented “Making the Business Case for the CNL.” Exploration of the financial impact of the CNL was the focus of this session. Clinical agencies dealing with the impact of the Centers for Medicare and Medicaid Services (CMS) regulations, such as Pay for Performance, “Never Events,” and Present on Admission, were especially interested in the role of the CNL in improving the cost-effectiveness of care provided in their agency. This meeting also featured clinical immersion project presentations from our first graduating CNLs representing an acute care setting, a public health department, a VA hospital, and a home-based home care agency. A report of the most recent AACN CNL partnership meeting in Tucson (2008) was also given, providing an information link between the local CNL movement and the national CNL initiative.

This series of meetings and workshops allowed academic and practice partners to network with each other as the CNL role was initiated in each agency. Interaction with national consultants in the CNL movement and reports from national meetings (regarding implementation of this new role) allowed partners to hear and benefit from viewpoints from around the country.

### Develop CNL Preceptors

Another strategy employed to successfully integrate the CNL role into diverse clinical settings was preceptor development. An online preceptor training program was developed and posted on our CNL Web site. A faculty mentoring coordinator was instrumental in the development and implementation of this preceptor training program. Master's-prepared nurses working in a “CNL role” were encouraged to take advantage of the opportunity to sit for the CNL certification examination. Two nurses working in acute care settings were successful in achieving CNL certification and agreed to serve as preceptors for CNL students. At least one student was recruited from each agency to complete the CNL program and upon graduation will be able to serve as preceptor for future students. Finally, faculty and preceptors in each agency worked closely together to coordinate initial clinical immersion experiences in each agency.

### Educate Nurse Executives

The CCN joined with the local Alabama Organization of Nurse Executives to increase awareness of the CNL initiative among nurse executives statewide by participating in the 2007 annual meeting. Speakers included Dr. James Harris and Dr. Rose Sherman discussing “Implementing and Sustaining the CNL Role: Practice and

Academic Perspectives.” Representatives from each of the four CNL programs in the state presented the nurse executives with an overview of the various programs. This forum was well received by Chief Nursing Executives around the state and ultimately resulted in additional clinical partners for our CNL program.

### Develop Vibrant Clinical Partnerships

The final strategy used to integrate the CNL role was to work toward developing vibrant clinical partnerships with each of the diverse agencies. The establishment of a contract between an academic institution and a health care agency is not enough to make an effective CNL partnership. Effective vibrant CNL partnerships also involve mutual cooperation between the partners to transform the workplace and incorporate the CNL role into the organization. Effective partnerships involve shared responsibility for improving patient outcomes. Partnering with a clinical agency requires time, commitment, mutual cooperation, and give and take. There must be joint contribution to the partnership through shared knowledge, property, assets, activities, and meetings (Stanley, Hoitling, Burton, Harris, & Norman, 2007). Examples of some activities undertaken to build vibrant partnerships between the CCN and the diverse clinical agencies included joint development of learning modules for courses, joint recruitment of potential CNL students, joint development of clinical immersion experiences, provision of learning opportunities for faculty and practice partners, cooperative efforts to obtain and house training equipment such as high-fidelity patient simulators, and cooperative grant writing to obtain funding for outcomes improvement projects in partnering agencies.

### Work Through Problems

Perhaps the greatest problem our program faced in its initial years was recruitment of sufficient students. Initial efforts to recruit adequate numbers of students from our original four clinical partners did not provide enough students to sustain the program. Although several students were recruited from the larger acute care facility, the smaller nontraditional clinical areas were only able to send one or two students at the most to the CNL program. Targeted recruiting efforts, such as attending education day events, unit-by-unit recruiting, and speaking to nurse managers about the benefits of a CNL in their microsystem, attracted more CNL students from these agencies; however, more growth was needed to sustain the program for the long term.

A two-pronged effort has been effective in improving our student enrollment. First, we *work forward* by taking the initiative of approaching traditional and nontraditional clinical agencies, offering to do a presentation for the nurse administrative team in the hospital on the role of the CNL. Attracting new clinical partners provides a new recruitment pool of potential CNL students. Secondly, when approached by a potential student from an agency for which we do not have a partnership

agreement, we approach that agency to develop such a partnership. This *backward approach* to recruitment has been proven to be the most effective strategy in increasing the number of clinical partners and subsequent student enrollment.

A second ongoing problem is obtaining funding for graduate student education. Although some clinical agencies have funding for student education, this pool of scholarship money is limited by the economic challenges facing health care institutions today. In addition, many of the smaller nontraditional settings are not able to provide funds for continuing nursing education. Apprising students of available local and external scholarships sources, as well as grant funds through the Alabama Board of Nursing, has been part of the solution to this problem. The CCN development office is diligently working to secure new graduate nursing scholarship funds; however, assisting students with the cost of graduate education remains an ongoing need of the CNL program.

### What's Next?

The students initially recruited into the CNL program at the CCN have recently graduated and successfully completed the CNL certification examination. Students representing five different clinical settings (large urban hospital, VA hospital, small rural hospital, public health department, and home-based home care agency) participated in a monthly CNL teleconference (August 20, 2008) hosted by the AACN. This teleconference titled "CNL Practice Across Diverse Care Settings" featured a discussion of the CNL role in each clinical setting, as well as a description of the clinical immersion project completed in each area (Stanton et al., 2008).

What's next as we continue our development of the CNL in diverse settings? We plan to examine other health care settings for the development of the CNL role, such as rehabilitation, subacute, emergent, psychiatric, rural primary, and long-term care. Concurrently, we intend to examine how the CNL can effectively interface with other interdisciplinary roles, that is, counselors, case managers that have prescribed role in these new health care venues. An examination to determine how the CNL can effectively participate in transitions of care is planned in conjunction with several community partners. A longitudinal study of CNL role development in each setting as these CNLs implement the CNL role in their respective agencies will be conducted. The research question to be answered with this study is "Has the CNL role confirmed to what the institution, the educational agency, and the AACN envisioned?" A series of case studies describing the role development of the CNL in each diverse clinical setting will be the published outcome of this project.

### Conclusion

We believe that the CNL role is flexible and can be adapted to fit into a variety of settings. Clearly defining outcomes for the organization and where the CNL will focus efforts is important, as is remembering that the CNL is a point of service coordinator of care rather than the direct provider of care. The ultimate measure of successful implementation of the CNL role in diverse settings will be improvement in services and outcomes. With academia and practice working in partnership, the goal of transforming health care and improving patient outcomes can be achieved.

### References

- American Association of Colleges of Nursing. (2003). *Working white paper on the role of the Clinical Nurse Leader*. Available from AACN website <http://www.aacn.nche.edu/publications/whitepapers/clinicalnurseleader.htm>.
- American Association of Colleges of Nursing. (2007). *White paper on the education and role of the Clinical Nurse Leader*. Available from AACN website <http://www.aacn.nche.edu/publications/whitepapers/clinicalnurseleader.htm>.
- American Association of Colleges of Nursing. CNL Tool Kit. Available from AACN website <http://www.aacn.nche.edu/CNL/toolkit.htm>.
- American Hospital Association Commission on Workforce for Hospitals and health systems. (2002). *In our hands, how hospital leaders can build a thriving workforce*. Chicago, IL: American Hospital Association.
- Institute of Medicine. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Institute of Medicine. (2001). *Crossing the quality chasm*. Washington, DC: National Academy Press.
- Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academy Press.
- Joint Commission of Accreditation of Healthcare Organizations. (2002). *Healthcare at the crossroads: Strategies for addressing the evolving nursing crisis*. Chicago: The Joint Commission.
- Koloroutis, M. (Ed.). (2004). *Relationship-based care: A model for transforming practice*. Minneapolis: Creative Health Care Management.
- Nelson, E. C., Batalden, P. B., & Godfrey, M. M. (2007). *Quality by design: A clinical microsystems approach*. San Francisco: Josey-Bass.
- Robert Wood Johnson Foundation. (2002). *Health care's human crisis: The American nursing shortage*. Princeton. Available from <http://www.rwjf.org/files/newsroom/NursingReport.pdf>.
- Stanley, J., Hoitling, T., Burton, D., Harris, J., & Norman, L. (2007). Implementing innovation through education-practice partnerships. *Nursing Outlook*, 55, 67-73.
- Stanton, M., Lammon, C., Tolbert, S., Beasley, J., McCullough, P., Cash, S., et al. (2008). CNL practice across diverse care settings. Presented August 20, 2008 at the Clinical Nurse Leader Network Teleconference. Available from AACN website <http://www.aacn.nche.edu/CNL/teleconf.htm>.