Healthcare Reform? A New Role for Changing Times: Embracing the Clinical Nurse Leader Role? A Strategic Partnership to Drive Outcomes
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Embracing the Clinical Nurse Leader Role—A Strategic Partnership to Drive Outcomes

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OBSERVING AND RESPONDING TO TRENDS AND CHANGING TIMES

The first inklings of the need for a new breed of nurse arose in 1999 after several organizations released reports about high occurrences of medical errors. The Institute of Medicine issued, ‘To Err Is Human: Building a Safer Health System,’ highlighting that medical errors were not usually the result of “human recklessness,” but more commonly were caused by “faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.”

The American Association of College of Nursing (AACN) board of directors responded to these national concerns and led the efforts to investigate what nursing could do. The AACN formed a task force in 2001, composed of academic and practice leaders to review competencies a clinical nurse leader (CNL) would need. In May 2003, White Paper on the Education and Role of the Clinical Nurse Leader was published that described the new role and laid the foundation for competencies and expectations.

The AACN white paper describes the CNL, the first new nursing role in 40 years, as “a leader in the healthcare delivery system across all settings in which health care is delivered. The CNL role is not one of administration or management. The CNL functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting through the assimilation and application of systems thinking, change management, and performance improvement tools to enhance the care and outcomes for patients and organizations. The CNL is a provider and a manager of care for individuals and cohorts. The CNL designs, implements, and evaluates client care by coordinating, delegating and supervising care provided by health care team members, including licensed nurses, technicians, and assistive personnel.”

The CNL is a master’s-prepared registered nurse (RN) who has completed advanced coursework in leadership, teamwork, quality, informatics, and metrics. He/she is an advanced generalist, trained to improve quality and safety outcomes within a complex healthcare system. The Institute for Healthcare Improvement’s Triple Aim—Better Care for Individuals, Better Health for Populations, and Reduced Per Capita Costs—is ever-present in a CNL’s mind, and evidenced in their practice.

Unlike a clinical nurse specialist (CNS) who operates within an area of expertise at the organizational or macro-level, the CNL works at the point of care or the micro-level...and yet,
across the continuum of care. Most often, CNLs are embedded in a unit and interact with patients and staff at the bedside and share their experiences and findings with the CNLs across units. In other words, CNLs are the “keepers of the patient’s story,” no matter where the patient goes in a hospital system. The CNL “connects the dots” by observing patients, patterns, and problems at the unit level; they share their findings, engaging members of the healthcare team in crafting solutions for improvement. That means better health for populations and, ideally, reduced costs for everyone.

The release of the white paper was timely for us at Saint Mary’s. A team had begun to look at a new care delivery model for the new Lacks Cancer Center. As we explored the CNL option, we began a decade-long journey to develop and clinically test this role in a 364-bed Midwest teaching hospital that includes an integrated primary care and specialty physician network.

ALL JOURNEYS BEGIN WITH THE FIRST STEP
The need for a role similar to the defined CNL became evident to the Cancer Center team in spring 2004 when much work had been done to pilot a new care delivery model. The Lacks Cancer Center was being built, and the oncology medical-surgical unit had the opportunity to redesign in preparation for the move into a new $42 million facility, fully funded through community philanthropy.

Using a grant from the Trinity Health CNO Council, and facilitated by an external consultant, multiple focus groups were convened to interview RNs, patient care assistants, physicians, families, and patients. Several common themes emerged:
1. No one person "holds the patient's story" and is thereby accountable for coordination of care.
2. Lack of coordinated care could lead to poor outcomes.
3. Fragmentation in care leads to errors and poor outcomes.
4. Patient care outcomes were not at optimal levels, and in particular, mediocre patient satisfaction scores were noted.

Patients and their families indicated that they did not know the “game plan” or why they were still in the hospital. They were unclear about what still needed to be done and what the next steps would be. We concluded there was need for a consistent person to connect the dots, assist in developing and communicating the plan, and be the "keeper of the patient’s story," which allows for devising a plan to improve both clinical and service outcomes.

The AACN white paper was released just as the Cancer team described their new concept role. The white paper described a similar gap and a skill set that matched the experience and focus group results. We decided to give this role a try and began with one of our current RNs with a master’s degree, experience as a manager, CNS, and case manager, who assumed the new concept role defined at the time as a care coordinator. In 2004, the identified RN was reallocated from her role to pilot the concept prototype care coordinator role in the redesigned care delivery model.

The pilot was successful based on pre- and post-metrics for clinical outcomes, length of stay (LOS), cost, and satisfaction levels of stakeholders. The pilot compared the outcomes for the patients in the pilot model with those in a usual care model. At the end of 8 weeks, LOS was lower, cost was reduced, core clinical outcomes improved, and patient, staff, and physician satisfaction levels also improved.

The pilot results were encouraging, and the idea to implement this role more broadly across the organization began to germinate. We recognized the associated problems of increasing fragmentation driven by system issues such as 12-hour shifts, multiple specialists, and variation in skillsets, knowledge, and experience with novice to expert nurses to name just a few. In 2008, Krichbaum et al. described the work environment of nursing as chaotic with “complexity compression” supporting the need for re-evaluating the roles and skills needed to manage within our acute care hospital.

GETTING STUCK IN FIRST GEAR
Over the following few years, the leadership team for the Cancer Center continued to work to achieve the outcomes and the processes as envisioned in the original model and the pilot without success. As with many change processes, Culture ate strategy for lunch. Without a consensus-built model upon which all key stakeholders external to the Cancer Center could envision, and then gain agreement on the burning platform and need for change to a patient-focused perspective, the re-titled care coordinators were unable to make the transition.

Analysis of the drivers for not realizing the outcomes included a redefinition of a job description without concomitant redesign of training, knowledge, and mind shift, coupled with a lack of consistent support from the department of case management who saw their primary role as discharge planning and utilization review tasks, and to complicate matters, the care coordinators did not actualize the
I believe the CNL program has been a great success. I know the CNLs do their best work at the patients’ bedside, but for me, I value their input in managing populations. The CNLs are able to take their personal experience with individual patients, grouped by various subtypes, and then use that knowledge to apply to decision-making across populations. In effect, CNLs have been able to multiply the care they give to improve the support provided to many other patients.—Dr. Michael Olgren, MD, Chief Medical Informatics Officer (prior Medical Director ED)

When the manager and CNL collaborate effectively, outcomes move in a positive direction. The CNL begins looking at problems on the unit in a methodical and systems focused way, getting to the root cause of the issue. The CNL serves as an expert in systems thinking and serves as coach. We have realized significant reductions in falls, seclusion, incidents of violence, and restraints based on the work of our CNL. He is a true clinical partner for me.—Carrie Mull, BSN, RN, RN-BC, CNML, Clinical Service Manager Psychiatric Medical Unit

I view the CNL role as one vital for our future, particularly in light of how we must redesign and reform our healthcare system. CNLs possess the knowledge and skills to not only guide individual patients through their episode of care, but also, they can look at our systems, see what needs to be improved and lead those changes in service to all future patients.—Gay L. Landstrom, PhD(c), RN, NEA-BC, Senior Vice President and Chief Nursing Officer, Trinity Health

There are many moving parts in the complex care of today’s hospitalized patient. Each is vital to the care, as well as appropriate transitions out of the hospital, and when done well, assists in the avoidance of future illnesses that would require re-hospitalization. Each of these parts changes with each patient and their own unique complexities. The person with the best insight into each of these groups is the CNL. As a primary hospital physician, I value my relationship with our CNL’s greatly, as we both are aimed at the same patient goals.—Jim Passinault, MD, Medical Director Senior Care Services

With the Advanced HF Certification, there were certain processes that had to be put into place in order for the hospital to qualify for certification. As the CNS, I reviewed the requirements for the certification and the clinical practice guidelines for HF. After having an understanding of the requirements, I worked collaboratively with the CNLs to implement the processes at the point of care on their respective units. Post-discharge appointment increased from 50% in January 2013 to 91% in December 2013. Follow up phone call 0% in Jan 2013 to 91% in Dec 2013.—Kristine Todd, DNP(c), FNP-BC, RN-BC

CNLs are prepared by both education and experience to support teams in making practice changes by initiating quality improvement projects to address concerns in process flow, redundancies and gaps in care. They have knowledge and expertise in systems, quality and process-improvement strategies, measurement and advanced clinical knowledge to identify concerns. CNLs are uniquely positioned to see input, throughput and output issues that could benefit from different perspectives so solutions can be identified and implemented.—Tricia Thomas, PhD, RN, FACHE, NEA-BC, ACNS-BC, CNL, Director of Nursing Practice and Research, CHE Trinity Health

elements of the redesigned role to lead the team, address communication and coordination of care, and provide strategies to address gaps or redundancies in care.

PARTNERSHIPS TURNED THE TIDE

Early in 2007, options began to emerge. Three local academic partners showed interest in pursuing the role in spring 2007, and Trinity Health (TH) system nursing leadership engaged with University of Detroit Mercy (UDM) in a dialogue about the potential for a TH pilot. A work team, including system nursing leaders and hospital-based chief nursing officers (CNOs) worked with the UDM leaders towards a partnership to initiating a pilot CNL program. After gaining initial support from the TH executive team, the concept team and the pilot CNOs from 3 organizations came together to further define the plan with UDM.

The TH support included funding the pilot as part of a board-approved, innovative, full scholarships for the initial 2 cohorts in the pilot organizations. The first cohort began January 2008, with 17 eager and highly skilled R.Ns from Saint Mary’s who began their academic journey.

Throughout their program, as CNO, I continued to educate and present to the executive team the concepts and expected outcomes as a result of integration of the CNL in our care delivery model. Members of the executive team were invited to monthly meetings I held with the clinical service director and the CNL students. We spent time with the students helping them understand the value of storytelling, and encouraged them to share stories of how their program was changing their thinking and how they viewed problems differently. The curriculum developed with UDM included ensuring alignment of theory with organizational strategy and drive for improved outcomes. We heard through their stories and project outcomes, the impact of systems and process thinking on their current roles.
A ZERO-BASED BUDGET APPROACH

My commitment to the executive team was the redesign of our care delivery model to remain full-time equivalent (FTE) neutral or volume adjusted. Because we were in a growth mode, it allowed us to rethink roles. We had previously implemented a role of clinical leader, meant to serve on the off-shift and focused toward supporting and mentoring new nurses. The role had drifted to become administrative and hours of work had also drifted to mid-day. This role was eliminated and educator roles were transitioned from service line to a global professional development focus. This allowed us to adjust FTEs to incorporate CNLs on each of the acute care units, emergency department, and population-focused diabetes and pain management programs. In June of 2010, we deployed our redesigned models. Although the roles and titles changed, no new positions were added, and no FTEs were reduced from the budget. The CNLs were incorporated into unit budgets and within budgeted FTEs and hours per patient day targets.

OUTCOMES TELL THE STORY

The CNLs have led many internal unit-based and organizational improvement projects.

Examples of improved outcomes since 2010 include staff outcomes such as reduced RN turnover from 12% to 7%, increased RNs with professional certification from 87 to 178, and increased BSNs from 350 to 430 (Currently we are 69% with BSN and an additional 100 RNs in BSN, MSN or DNP programs).

Patient outcomes include both service and clinical outcomes. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores for Would Recommend and Rate the Hospital moved to the top quartile, Responsiveness of Staff from 77 to 80.6, and Pain Well Controlled from 61 to 73. The number of inpatient falls were reduced by 23%, psychiatric falls by 60%, immunization rates improved from 50% to more than 90%, and medical history obtained within 8 hours of admission moved from 54% to 98%, allowing medical reconciliation rates of more than 95%.

From an organizational perspective, CNLs have been integral to attaining The Joint Commission (TJC) Certification for Inpatient Diabetes (first in Michigan), TJC Advanced Heart Failure Disease Certification (silver level), and TJC Primary Stroke Certification.

Additionally they have impacted overall organizational clinical outcomes, which are measured by TH through a grade point average (GPA) based on setting the target at top-decile performance against national norms. The GPA includes 6 categories of measurement, with each section weighted as a percentage of 100 with 34 individual metrics in total (Table 1).

Table 1. Trinity Health Clinical Dashboard Metrics

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Metrics</th>
<th>Section Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical process</td>
<td>13</td>
<td>30%</td>
</tr>
<tr>
<td>Patient safety</td>
<td>13</td>
<td>30%</td>
</tr>
<tr>
<td>Patient experience of care</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>Regulatory nurse staffing</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figure 1. SMHC Clinical Weighted Grade Point Average
Some of the metrics roll up multiple indicators (e.g., perfect patient score for heart failure). Each of the measures is graded 0 to 5 (below threshold is 0, and exceptional performance is 5). Targets are set at 90th percentile of national reported outcomes or zero defects. Figure 1 demonstrates the impact of our CNL integration into the care delivery model in June 2010. We have experienced the highest GPA in the system for organizations of similar size and complexity.

SUMMARY
As I reflect on our journey, it is truly about putting your money, your heart, and your soul, where your mouth is for over a decade: It is all about trust. It was about managing uncertainty. We did not know how this would work. We were testing, trialing, and learning every day! We had to believe in the process before there were results. We had to have visible commitment to shared leadership and collaboration—we incorporated the CNLs into our shared leadership model and set organizational standards and processes. We had to recognize that each unit would implement the role within their culture, and while we worked to maintain key principles and set standard outcomes, each CNL had their own personality within that culture to impact outcomes. The CNLs could not be successful if we did not support risk taking and nurture them in their personal journey wherever it took them. We also committed internal experts to support the CNLs—LEAN process excellence consultants, clinical service directors, and CNS served as coaches throughout their educational and onboarding processes. I have constantly made myself available to coach, mentor, and serve as a sounding board, even as some identified this role was not the one for them. To date, 15 of the 17 remain within our system, and adding value every day regardless of the title they hold.

Since we implemented the CNL role, we have experienced positive outcomes for patients, staff, and our physician colleagues. Our goal of creating an environment where patients love to receive care, staff love to come to work, and physicians love to practice was realized when we received Magnet® designation in 2013. We have multiple podium and poster presentations at local, state, and national conferences along with peer-reviewed publications by CNLs.

As noted by our recently retired CEO, Phillip H. McCorkle Jr., MHA, FACHE, President and CEO (Retired), “Magnet designation represents the culmination of many great initiatives...like the creation of the Clinical Nurse Leader role at Saint Mary’s. This role made available new levels of clinical expertise that benefitted most importantly, the patient, but enhanced and reinforced everyone’s passion for quality patient care.”

Mission accomplished! 

References

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