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Promoting a Strategic Approach to Clinical Nurse Leader Practice Integration

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The Office of Nursing Services of the Department of Veterans Affairs (VA) piloted implementation of the clinical nurse leader (CNL) into the care delivery model and established a strategic goal in 2011 to implement the CNL role across the VA health care system. The VA Office of Nursing Services CNL Implementation and Evaluation (CNL I&E) Service was created as one mechanism to facilitate that goal in response to a need identified by facility nurse executives for consultative support for CNL practice integration. This article discusses strategies employed by the CNL I&E consultative team to help facility-level nursing leadership integrate CNLs into practice. Measures of success include steady growth in CNL practice capacity as well as positive feedback from nurse executives about the value of consultative engagement. Future steps to better integrate CNL practice into the VA include consolidation of lessons learned, collaboration to strengthen the evidence base for CNL practice, and further exploration of the transformational potential of CNL practice across the care continuum. **Key words:** *clinical nurse leader, health care delivery, models, nursing, program evaluation*

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IN RESPONSE to Institute of Medicine reports of poor quality within the health care system, the American Association of Colleges of Nursing created the Task Force on Education and Regulation for Professional Nursing Practice from 1999 to 2004,[1] from which the idea of the clinical nurse leader (CNL) role originated.[2] Senior nurse leaders from the Veterans Health Administration (VA) participated in the task force work and led early efforts to implement the role.

The CNL role was described in the 2007 *White Paper on the Role of the Clinical Nurse Leader* as a master's prepared generalist nurse providing expert clinical leadership at the level of the microsystem with accountability for outcomes of care provided in that microsystem or point of care units where teams provide care to specific groups of patients.[3,4] The CNL was envisioned to influence care delivery and outcomes through fundamental

domains of CNL practice that integrate clinical and systems expertise.[1,5,6]

Pilot adoption of the CNL role began in the VA in 2004, with promising outcomes reported from an evaluation of impact data collected in 2008.[6] Outcomes were reported across all dimensions of the evaluation framework that had been recommended by American Association of Colleges of Nursing[2] and adopted in the VA evaluation effort,[6] including financial, quality/safety, satisfaction, and innovation examples. Facility-level experimentation with this new role continued, resulting in continuing accounts of positive CNL impact, identification of system-level barriers, and significant diversity across the system in how the role was implemented. The 2010 Institute of Medicine report on the future of nursing noted the CNL as a "new role for nurses that taps their potential as innovators"(p86) and identified the VA as an adopter of the role.[7]

The initial strategic goal for CNL spread in the VA was implementing the CNL role into all areas of nursing practice across the national system by 2016. Considering that the VA health care system comprises 150 medical centers providing care at more than 1700 sites across all 50 states and US territories,[8] this goal represented a significant implementation challenge. Furthermore, CNL role implementation was not a national mandate (not a centrally funded requirement). Clinical nurse leader implementation decisions regarding alignment with the Office of Nursing Services (ONS) initiative were decentralized to facility-level leadership. Facility nurse executives were encouraged to consider and exploit the transformational potential of CNL role implementation and practice integration within their individual organizations while maintaining budget neutrality.

Adding to the challenges posed by this ambitious strategic goal was the nature of the CNL as one of many competing systemwide interventions to improve outcomes. There was general acknowledgement among the originators of the CNL role that this was not the only solution to the issues facing health care.[2] Implementation of the CNL role as a systems solution required buy-in from multiple organizational stakeholders, and nurse leaders across the VA were called upon to present the CNL business case to various leadership and disciplinary entities in their local facilities as the intervention of choice in the face of ever-tightening resource constraints. While general theoretical and empiric information supported the value of the CNL role,[2,6,9] and CNL practice exemplars existed in the VA, the data at the time were largely anecdotal. Role implementation was seen as the untested use of an innovation rather than a robustly validated system intervention. Efforts to evaluate CNL practice impact were limited by the variability in role implementation across a relatively small number of practice sites.

To realize the potential of the CNL to transform health care delivery at the microsystem level, it would be necessary to change the fabric of nursing presence at the point of care. Choosing an innovative intervention that disrupts familiar and strongly embedded processes, practices, roles, authority, and accountability remains a difficult choice over the seemingly simpler solution of adding another task-focused position to the health care landscape.[10] Nurse executives across the VA identified the need for ready access to consultative resources to support facility-level CNL role implementation. In 2011, in response to feedback and requests for additional guidance from facility nursing leadership, the VA chief nursing officer launched a collaborative portfolio of activities to promote full implementation of the CNL.

A full description of the VA ONS infrastructure supporting CNL role implementation and practice integration can be found in previously published nursing resources.[11-13] This article describes the use of a centrally supported consultative service to support nursing leadership in its efforts to integrate CNL practice into VA health care delivery.

CONSULTATIVE INFRASTRUCTURE AND ACTIONS

The VA ONS Clinical Nurse Leader Implementation and Evaluation (CNL I&E) Service was established by ONS in 2011 to address the need for consultative support. The primary CNL I&E Service team comprised 2 nurse consultants who were engaged in successful CNL programs at 2 VA facilities that were early adopters of the role: the Central Texas Veterans Health Care System and the VA Portland Health Care System.

Developing consultative support for CNL practice integration

Key findings from 2 national VA gap analyses conducted in 2010 and 2012[14] informed the design, development, and implementation of the consultative infrastructure to support CNL role implementation and practice integration efforts across the VA. Over two-thirds of VA nurse executives identified the limited supply of CNLs as a major barrier.[14] In other regions with robust CNL populations, leaders identified a relative lack of organizational knowledge and experience with this new resource. As facilities moved forward with CNL role implementation, variability across the national system became apparent in the conceptualization and operationalization of CNL roles. The challenge was to design and implement a consultative infrastructure that could support, guide, and coordinate efforts to reduce unwanted variability and increase chances of CNL success within the complexity of the national system.

An individualized approach was indicated to support facilities across multiple stages of the CNL journey. For example, facilities at the beginning of the journey needed to develop organizational knowledge in preparation for the role as well as a way to identify or establish an adequate source of CNLs. For facilities with CNLs or CNL students in their system, developing CNL practice was the more immediate need. The I&E services included activities designed to directly support the growing CNL workforce, such as monthly continuing education and special focus webinars, collaborations to support development of EBP and continuous quality improvement skills, and implementation of a virtual CNL community of practice. The following section describes in more detail 2 focus areas targeting specific needs identified by facility nurse executives: consultative site visits and increasing the supply of CNLs.

Facility-level engagement through consultative site visits

To effectively provide consultative services to meet the diversity of needs across the VA, a facility-level needs assessment was designed and implemented as the first step in active consultative engagement. Table 1 lists categories of identified facility-level needs that guided customization of consultative activities. The facility needs assessment allowed the CNL I&E Service team to exploit both virtual and face-to-face consultative strategies, leverage additional resources appropriate for specific challenges, and initiate dialogue about strategic approaches to CNL practice integration. While many needs were adequately supported through virtual consultative options, such as teleconferences and online live meetings, in-person consultative site visits were also arranged when requested by nurse executives. Facilities requesting consultative visits identified unique challenges that were best served by on-site targeted presence of expertise and guidance. The site visit option provided opportunity to impact and influence multiple stakeholders and stakeholder groups at the facility level with minimal disruption of normal clinical operations. This allowed for rich small group discussion and one-on-one real-time problem solving for diverse stakeholders.

A critical component of consultative engagement with VA facility nursing leadership was promoting a systematic approach to CNL role implementation. The initial ONS goal of a CNL in every microsystem had an unintended consequence of being interpreted as "get the

Table 1. Categories of Facility-Level Needs Identified by VA Nurse Executives During Individual Consultative Needs Assessment Activities From 2012 to 2015

Integrating CNL implementation into strategic initiatives
Developing a strategic plan/approach for implementing the CNL role
Aligning current CNL practice with a strategic plan
Revising a strategic plan/approach on the basis of prior experience with the CNL role
Readying environments for CNL role implementation and sustainment
Obtaining stakeholder buy-in/making the business case
Addressing staff and manager uncertainties regarding the CNL role
Clarifying role delineation from other roles
Developing shared concepts, values, and expectations across stakeholder groups
Developing capacity to implement CNL practice
Establishing collaborative partnership with academic CNL program
Identifying existing resource opportunities
Developing preceptors and mentors for CNLs
Designing and implementing clinical immersion experiences
Growing and sustaining CNL practice
Determining CNL role activities
Supporting new CNLs and CNL students
Managing and modifying CNL performance
Facilitating microsystem functionality of existing roles
Evaluating CNL outcomes and impact

Abbreviation: CNL, clinical nurse leader.

role in place." This contributed to wide variability in CNL practice across the system. An important accomplishment of the CNL I&E Service team was working with VA ONS senior leadership to modify the strategic goal to better communicate the intent of developing thoughtful integration of CNL practice into the delivery of VA health care across sites over time. The consulting team could guide facility-level leadership teams in a thorough examination of where and how it made the most sense to integrate the CNL role. Important considerations in facility consultations included the identification of microsystems of care where clinical leadership executed through the fundamental aspects of CNL practice[3,5] would most directly impact outcomes of care. Fundamental aspects of CNL practice of particular significance across facilities requesting consultative support included accountability for patient care outcomes, risk identification, lateral integration of care, implementation of evidence-based practices, and collaboration across the health care delivery team. Another important consideration was the examination of reasons why CNL role implementation might be the intervention of choice in a given microsystem context.

An important lesson learned early in the consultation process was the value of including experienced VA practicing CNLs as part of the consultative site visit team. These CNLs provided concrete insights about what CNLs did on a day-to-day basis in their practice and the clinical environment transformation needed for successful CNL practice integration. The CNL was able to facilitate problem solving in real-time, addressing the realities of CNL practice in the context of the sites requesting consultative services. This perspective was especially useful for facilities with limited exposure to CNL practice. Another resource that proved particularly effective for several facilities was the creation of a team comprising a nurse manager and CNL who had established a strong partnership with tangible outcomes. The importance of a high-performing partnership between the unit nurse manager and the CNL was evident in successful implementation efforts.

However, this was identified as challenging for some sites. While the CNL I&E Service consultants could provide information and facilitate thoughtful consideration across a broad range of CNL-related issues, the perspective of those who were actually working in the role making it happen at the point of care was often the most meaningful and influential component of the consultation.

The consultative service also assisted facility leadership with establishing appropriate and realistic expectations regarding the impact of CNL role implementation. Part of this challenge was the lack of clear descriptions of CNL activities in the literature, combined with the lack of aggregate empiric evidence linking CNL practice activities to clinical performance outcomes. A key component of many consultative discussions was thoughtful discourse about the educational aspects of the CNL role[15] and ways that CNLs were prepared to influence point of care functional patterns. Understanding the complexity of how functional patterns in a microsystem of care are related to outcomes, and how those patterns are influenced over time through embedded engagement of the CNL (see Table 2), helped frame discussions about how CNL practice adds value.

A growing compilation of VA CNL practice exemplars (see Table 3) over the life cycle of the service helped ground discussions in practice context and provide ongoing momentum for practice integration. External networking and participation in the annual CNL Summit sponsored by the American Association of Colleges of Nursing contributed additional examples of CNL practice impact summarized in conference proceedings[16] and published elsewhere.[17] Knowledge gained and disseminated through the experience and observations of the 2 nurse consultants and the practice experience of seasoned CNLs was particularly useful in promoting reasonable expectations for implementation of the role.

Capacity development

In 2011, there were an estimated 120 CNLs in the VA nursing workforce. Considering that the strategic goal at that time was to implement the CNL role across all care delivery areas of the national system, growing the capacity for CNL practice was a major priority. Three barriers to growing CNL practice capacity were identified by nurse executives in the gap analyses.[14] The first was the lack of certified CNLs available for recruitment at specific facilities. The second barrier, geographic in nature, was the lack of local academic programs offering the CNL master's education for many VA facilities. The third barrier was the difficulty for full-time VA staff nurses to complete the clinical immersion requirement of 300 to 400 clinical hours when their primary VA work assignment was not yet a CNL role.

Consultative activities addressing capacity development included guidance and examples of successful recruitment strategies. Facility nursing leadership was encouraged to consider serving as sites for the clinical

Table 2. Value of Embedded Engagement of the CNL at the Point of Care

CNL embeds advanced skill set and systems perspective at the point of care
CNL assesses and addresses issues in real time and within the context of the reality at the point of care
CNL observes and evaluates patterns impacting practice environment and patient outcomes
CNL fosters interprofessional team collaboration and team environment
CNL partners with the nurse manager to create conditions for clinical excellence
CNL supports point of care nurses as an available, supportive, expert resource
CNL facilitates practice and practice change driven by outcomes
CNL engages staff in evidence-based practice as a way of practice
CNL promotes culture of quality, safety, efficiency, and reliability

Abbreviation: CNL, clinical nurse leader.

Table 3. Exemplars of VA CNL Practice Presentations

CNL Summit Presentations
2011
Clinical nurse leader as coordinator of multidisciplinary rounds
Process to achieve interprofessional collaboration
2012
Patient as partner in delivering high-quality transitional care to older adults
A new practice guideline regarding mobility for patients with left atrial catheters
2013
Reducing CHF readmissions
The "Daily News": using the EMR to identify high-risk patients
2014
Meeting the needs of a geriatric-specific acute care cohort
Improved outcomes from a nurse-initiated sepsis protocol
VA CNL Monthly Webinars and Community of Practice Communications
Sustained reduction in special surface rental bed costs without increase in HAPU
Reduced cost of care and diversion through improved patient transfer process
Reduced cost through alignment of PIV maintenance with evidence-based standards
Decreased use of restraints and readmissions in acute mental health
Decreased CLABSI, CAUTI, and VAP through increased compliance with evidence based practice

Abbreviations: CAUTI, catheter associated urinary tract infection; CHF, congestive heart failure; CLABSI, central line associated blood stream infection; EMR, electronic medical record; HAPU, hospital acquired pressure ulcer; PIV, peripheral intravenous access; VA CNL, Veterans Affairs clinical nurse leader; VAP, ventilator associated pneumonia.

immersion experiences of CNL students in their geographic areas. Virtual support through teleconferences and online live meetings was provided to foster sufficient academic partnerships for this activity. Non-VA CNL students frequently contacted the CNL I&E Service team inquiring about VA opportunities for clinical experiences. These students were referred to the local VA facility contacts that had expressed interest in pursuing this option, creating efficiencies matching student immersion settings to VA sites expressing interest in CNL practice.

Guidance and templates for "grow your own CNL" initiatives was a common request. Facilities seeking assistance were connected with facilities that had successfully implemented internal workforce CNL development strategies. Assistance with establishing local and virtual infrastructure to support partnerships with distance learning and online CNL programs was particularly sought by facilities in areas without local academic partner programs. The consulting team initiated teleconferences, online live meetings, and other virtual networking activities to facilitate dissemination of successful strategies and lessons learned across sites.

Nurse executives identified the difficulty of completing 400 hours of clinical immersion for full-time VA nurses who were not yet assigned to CNL roles.[14] To address this issue, ONS collaborated with the VA Healthcare Talent Management Program Office to create an internal scholarship program that would allow VA nurses enrolled in CNL programs to complete the clinical immersion component as their primary duty assignment. Applications for this scholarship program required a commitment by the facility that the scholarship recipient would be placed in a suitable role upon graduation. The program started in 2012, and as of February 2015, a total of 124 VA nurses from 48 facilities have been able to use this program to support CNL role implementation.

MEASURES OF SUCCESS

The Figure illustrates the sustained growth in the number of CNLs in the VA nursing

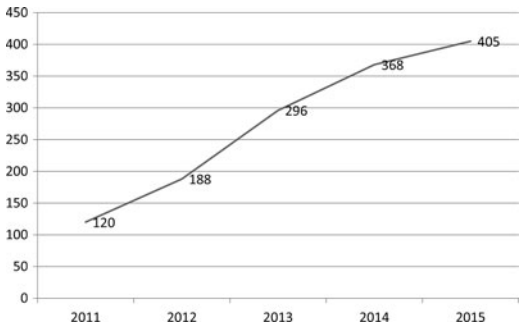

Figure. Growth in the number of certified clinical nurse leaders in the VA nursing workforce from 2011 to 2015.

workforce over the life cycle of the CNL I&E Service. The number of certified CNLs in the VA has consistently represented approximately 10% of the total certified CNL population. While the overall number of certified CNLs employed by the VA is considered to be an accurate measure, the ability to accurately determine the number of certified CNLs who are practicing in designated CNL roles remains illusive, as CNL roles are not clearly differentiated in administrative databases from other VA direct care nursing roles. Estimates based on self-report by CNLs are that at least 37% of VA-certified CNLs are in positions that are designated by their facilities as CNL roles or roles based on CNL competencies. Continued growth is anticipated with more than 120 VA nurses enrolled in CNL programs (unpublished).

Nurse executive feedback assigned a high value to consultative engagement for both virtual and in-person options. Consultative services have helped facilities across multiple phases of the CNL journey, from getting started to expanding existing programs. Several sites were able to restart their journey and move forward despite barriers created by previous unsuccessful efforts. Specific benefits of consultative engagement noted by nurse executives and other facility stakeholders in ongoing program evaluation efforts are listed in Table 4. Requests for assistance increased over the life cycle of the CNL I&E Service and are still being received.

Examples of the association of CNL practice integration with improved outcomes continue to accumulate in the VA. The examples listed in Table 3 and recorded elsewhere[16,17] include (*a*) cost reduction and cost avoidance; (*b*) reduced hospital-acquired conditions; (*c*) improvement in nurse-sensitive indicators; (*d*) improved patient flow both within and between microsystems of care; (*e*) increases in evidence-based practice; (*f*) increased efficiency in microsystem processes; (*g*) increased engagement of point of care nursing staff in professional development and continuous quality improvement activities; and (*h*) improved experience for patients and clinical staff. VA CNLs share successes and strategies through an internal community of practice network. A virtual manuscript development workshop for CNLs has been implemented[18]

Table 4. Benefits of Facility-Level Consultative Engagement With CNL I&E Service Reported by VA Nurse Executives From 2012 to 2015

Increased understanding of CNL role across departments and disciplines
Increased support for business case across stakeholders
Increased confidence in moving forward with CNL practice integration
Increased confidence in providing guidance for CNL performance management
Better understanding of alignment of CNL practice with unit performance
Ability to connect with academic and clinical partners in a meaningful way
Ability to see the potential for strategic CNL role placement in the organization
Ability to identify resource benefits and reasonable resource options
Better internal structures to support CNL practice
Ability to establish internal workforce development program for growing own CNLs

Abbreviation: CNL I&E, clinical nurse leader implementation and evaluation.

to support dissemination of more specific information about VA CNL practice outcomes to a broader nursing and health care delivery audience.

In summary, the VA CNL I&E Service was implemented in response to a need identified by VA nurse executives for consultative guidance and support. Needs assessment data were collected to build a framework for action. Virtual and in-person consultative services have been responsive to a broad range of needs and practice sites. Outcomes include new and continued interest in exploring CNL integration, steadily increasing capacity for CNL practice, and continued accumulation of examples of CNL practice impact.

FUTURE OPPORTUNITIES

There is now a critical mass of more than 500 CNL-prepared nurses and CNL students within the VA. Capacity for CNL practice provides opportunity for examination of CNL integration as a resource to embed quality and safety at the point of care. Current priorities for CNL practice integration in the VA system are to consolidate lessons learned from efforts to date, collaborate across the national health care community to strengthen the CNL evidence base, and continue to explore the transformational potential of CNL practice across the full continuum of care. While diversity across sites and practice areas provides a rich and fertile basis for discovery, it also creates challenges to meaningful evaluation of the impact of CNLs. Ongoing national nursing research efforts to validate a grounded theory-derived model of CNL practice[19] that will support development of metrics pertaining to both CNL implementation and outcomes[20] will provide opportunities to exploit practice-based knowledge embedded in the national system. A unifying framework of CNL practice integration and a set of CNL metrics will provide a strong base for future exploration of CNL practice integration across the full continuum of VA health care services.

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