Implementing the Clinical Nurse Leader Role in a Large Hospital Network

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In 2011, the Institute of Medicine (IOM) provided statistics regarding the future of health care based on legislative changes during 2010. According to the IOM's report,[1] an additional 32 million Americans would receive health care benefits by 2012. Additionally, it is estimated that by the year 2025, health care will face a shortage of more than 350,000 nurses.[2,3] The influx of new lives in America requiring medical care and the estimated lack of resources provide multiple challenges for hospitals, including organizing new models of care at the bedside to improve care coordination and to enhance interprofessional collaboration.[4,5]

Models that improve care coordination and interprofessional collaboration should have an impact on one of the most troubling problems in acute care hospitals: readmissions. Health care in the United States is suffering from high rates of readmissions that impact hospital reimbursement.[6] According to Commonwealth Fund's Hospital Scorecard,[7] the 2013 national average for Medicare patients' hospital readmissions was 30 per 1000, and this can be linked to multiple factors including poor care coordination. Burke and Coleman[8] indicated better care coordination can improve patient outcomes and decrease patient readmissions, which improves hospital profitability.

Redesigning care to improve care coordination and enhance interprofessional collaboration is critical in improving patient outcomes; however, multiple barriers to using such models exist within organizations. These barriers include skill mix imbalances; inefficient use of nurses; resistance to collaboration; lack of enabling environment; quality of care issues; lack of synergies among stakeholders; and workforce retention challenges.[3,4,9] Solutions must be found to these organizational challenges if the health care industry and the nurses within it are to remain viable providers of quality health care for all.

In 2003, the American Association of Colleges of Nursing introduced a new masters-prepared and certified nursing role called the clinical nurse leader (CNL). The CNL role was designed to respond to health care issues faced by the nation's hospitals, to address care coordination challenges such as

readmissions, and design new ways to collaboratively provide care that improves patient outcomes at the point of care.[5] As population needs steadily become more complicated and reimbursement models become more difficult to navigate,[4] the CNL has the potential to mitigate challenges by transforming the way care is provided.

Since 2003, there are more than 4000 licensed CNLs in the United States, and college admission rates for CNL students continue to climb.[10] The CNLs influence cost savings by reducing infections, decreasing readmissions, and decreasing indwelling catheter days.[11] For example, a successful CNL-led program to decrease emergency room utilization at one hospital estimated savings at $325,000.[12] As a result of CNL-led initiatives, another hospital reported savings of over $2 million in a 6-year period.[13] In addition, the Agency for Healthcare Research and Quality[4] supported the idea that care coordination can make a difference in transforming health care for the future and that a major focus of the CNL role is care coordination.

Despite the clear need for health care change and the potential impact that CNLs can have in reducing costs and improving patient outcomes, implementation of the CNL role has been challenged by roadblocks related to standardization, collaboration, and stakeholder acceptance.[13–16] This article describes the challenges associated with implementing the CNL role at a large health care system and suggest solutions based on administrative successes and lessons learned.

IMPLEMENTING THE CNL ROLE

Standardization of the CNL role is varied and can impact a smooth implementation process. Several studies show that successful implementation is linked to definitive role clarification, a robust communication plan, and strong leadership involvement.[13,17] An important step is for hospital leaders to clearly define the role of the CNL in the organization. The role is designed to complement and enhance patient outcomes at the point of care and is not designed to be an additional direct care nurse position.[5,18] Additionally, a clear CNL role delineation prior to implementation ensures that the interprofessional team understands how the role functions on a day-to-day basis with the care team.[13,19,20]

The CNL role was established in 2003; however, there is considerable variation with how the CNL is utilized across organizations.[18] Variation is often dependent upon the interpretation of the role or preference of how the manager implements the role on the unit.[14] Also, implementing the role out of scope diminishes the purpose of why the CNL role was developed and impacts the patient outcomes that the CNL oversees.[19,20] Examples of variation and standardization seen in studies from different organizations include: CNLs were expected to relieve nurses during breaks, CNLs being pulled from their duties to perform administrative functions, and organizations that pulled the CNL into staffing when needed.[13,21,22] Controlling variation and implementing the role in a standardized way across units and organizations are key to the success of the CNL role.[15]

Creating and sustaining a collaborative environment where disciplines work together to provide patient care that is outcome driven, safe, and improves quality is a common theme found in several descriptions of the CNL role; however, multiple qualitative and quantitative studies indicated hospital units that include a CNL have challenges with creating collaborative teams.[13–15,17] The results of a year-long experimental study of patient satisfaction surveys in a 26-bed CNL-led high acuity unit showed that there was not a significant difference made by the CNL to improve collaboration pertaining to physician's care and discharges compared to the unit that did not have a CNL.[21] By contrast, 2 organizations that struggled with collaboration conducted studies that did show an improvement in interprofessional collaboration, and one of these organizations implemented the CNL role permanently at the conclusion of the pilot study.[13,15] Similar to the importance of role delineation and standardization, the preparation and communication that precedes the implementation of the CNL role is crucial to collaborative success.

Organizational change is dynamic and, if not strategically approached, leads to disruption at all levels of the organization.[23,24] The implementation of a new role in the hospital setting that is primarily at the bedside, but does not take the traditional staff RN patient assignment, can be especially disruptive to the culture if not handled appropriately. Studies have shown that implementation of the CNL role caused significant problems when support from all members of the team prior to introducing the new role was not coordinated.[14,15,18] To ensure success when implementing the CNL role, the support of leadership, the interprofessional team, physicians, nursing, and support staff is necessary.[13,19] Organizations have utilized multiple communication methods to solicit support and clarify the CNL role, including creating implementation teams, using pilots prior to implementation, and utilizing change agents.[17,18] Education about how the role interacts with the team, the duties of the role, and how the role impacts patient outcomes are a few of the components needed in a solid education plan.[14,15] Studies have shown there are organizations that did a good job with stakeholder involvement prior to implementation[17,19] and organizations that did not adequately prepare and involve appropriate members of the team to ensure success prior to implementation.[18,21,22] More work is needed to prepare teams to accept the CNL role.

BACKGROUND

Texas Health Resources, located in north Texas, is the largest faith-based nonprofit healthcare system, in terms of patients served. Texas Health has 14 wholly owned hospitals and various joint ventures. In 2009, Joan Shinkus Clark, DNP, RN, NEA-BC, CENP, FACHE, FAAN, senior vice president and system chief nursing executive for Texas Health, led the CNL implementation plan to incorporate CNLs in various medical-surgical and intensive care units at all 14 wholly owned Texas Health hospitals. The implementation plan included a collaborative agreement between Texas Health and Texas Christian University (TCU) to work together to establish an academic program that would meet the educational requirements for preparing CNLs. The majority of initial Texas

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