Enacting a Vision for a Master's Entry Clinical Nurse Leader Program: Rethinking Nursing Education

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The need to educate nurses at the graduate level and provide them with a different skill set that broadens their view of health and nursing is clearly articulated by the American Association of Colleges of Nursing. Consequently, the role of the clinical nurse leader (CNL) was born. Responding to the need for providing a highly educated and credentialed professional at the bedside, Rush University College of Nursing made the bold move to phase out baccalaureate education and enact a prelicensure, master's entry CNL program. Although there is a clear need for this type of graduate, there is little in the literature to provide guidance to institutions that wish to develop this type of program. This paper describes the factors that came into play in making that decision, the process of curriculum development and implementation, the challenges encountered in implementing this type of program, and the outcomes that the program has evidenced since its inception. (Index words: Master's entry education; Graduate entry education; Clinical nurse leader; Curriculum development; Curriculum implementation)
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THE LAST DECADE in American health care has been one of uncertainty and complexity. Increasingly, there has been closer scrutiny of our health care system, particularly related to care cost and outcomes, as well as patient error and safety (Institute of Medicine, 2001). Recognizing the centrality of nurses as providers who can assume greater responsibility for improving the quality and safety of care, as well as improve care continuity and outcomes, the American Association of Colleges of Nursing (AACN; 2007) undertook several years of investigation and discussion with key stakeholders from education and practice to ascertain the type of education needed to prepare a nurse for these responsibilities. The result of this investigation was the creation of a new nursing role, the first in 40 years: clinical nurse leader (CNL). The CNL was designed to prepare a nurse at the master's degree level who had the knowledge and abilities to analyze and intervene in microsystems to improve patient care outcomes while reducing cost and improving quality and safety (AACN, 2007).

The CNL's skill set is well positioned to have a positive impact in today's health care setting from both a staff and patient perspective. Kohler (2010) found that the presence of CNLs improved a measure of happiness and reduced perceived nursing staff depression and potential turnover (as cited in Bender, 2014, p. 116). From a patient care perspective, health care organizations who have implemented the CNL role have experienced higher patient satisfaction with nursing care (Bender, Connelly, & Glaser, 2012), improved adherence to discharge instructions and decreased length of stay (Stachowiak, 2011), and reduced falls, nosocomial infections, and pressure ulcers (Hartranft, Garcia, & Adams, 2007).

Rush University College of Nursing has long been known for innovation in nursing education, with the college being one of the first to offer the clinical doctorate and graduate entry into practice. In 2007, the faculty made the bold decision to transition entry-level education from the baccalaureate to the master's degree. The purpose of this paper is to describe the process and

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outcomes of enacting a vision for educating a new kind of nurse: an entry-level, master-prepared CNL.

Setting the Stage

Current estimates suggest more than 1 million nurses will be needed to meet the expected demand in 2022 based on job openings due to growth and replacement needs (Bureau of Labor Statistics & U.S. Department of Labor, 2013). In the early 2000s, the U.S. Department of Labor began projecting the need for large numbers of new and replacement registered nurses (RNs). Accelerated degree programs for nonnurses grew dramatically as a programmatic strategy to help meet the demand to prepare baccalaureate nurses at an increased rate. The AACN (2014) reported that accelerated nursing programs exist in 46 states plus the District of Columbia and Puerto Rico. “In 2012, there were 255 accelerated baccalaureate programs and 71 accelerated master's programs available at nursing schools nationwide…with 25 new accelerated baccalaureate programs in the planning stages, and 7 new accelerated master's programs are also taking shape” (AACN, 2014, p. 1).

During this proliferation of accelerated programs over the last 15 years, a number of important studies were published, establishing a link between higher levels of nursing education and better patient outcomes. Aiken, Clarke, Cheung, Sloane, and Silber (2003) have been followed by additional studies that correlate higher levels of nursing education with a broad array of improved clinical outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Blegen, Goode, Park, Vaughn, & Spetz, 2013; Kutney-Lee, Sloane, & Aiken, 2003). These results further validated baccalaureate education as a necessary minimum educational requirement to improve health outcomes. Direct-entry master's programs were the next step in the evolution of accelerated programs; they fast-tracked nonnurses to a master's degree, elevated expectations of leadership and clinical competency, and laid the groundwork for progression to doctoral preparation.

Yale University School of Nursing began master's entry education in the 1970s (Varney, 1998). Since then, numerous master's entry programs have been developed; some terminating in specialty practice, others in generalist practice. A recent review of the literature (Pellico, Terrill, White, & Rico, 2012) indicated that master's entry graduates successfully complete these rigorous programs and develop into registered and advanced practice nurses. Similar to bachelor of science in nursing (BSN) accelerated students, these students came from varied academic backgrounds, and many were second-career students. Since 1974, Rush University College of Nursing provided traditional baccalaureate entry-level education that emphasized excellence in clinical practice. In 2001, the college began to offer a 12-month accelerated baccalaureate program for individuals who had a nonnursing baccalaureate degree. This program was very successful, and applications were robust. In 2007, Melanie Dreher, PhD, RN, FAAN, became dean of the college. In her previous deanship at the University of Iowa, she developed and implemented an entry master's program in nursing. Dr. Dreher came to Rush with a similar vision—to move from baccalaureate nursing education and offer only master's entry prelicensure education. In addition, we decided to move all of our specialty programs to the doctor of nursing practice (DNP).

There were several factors that led the faculty to unify their thinking and proceed with a transition to master's entry education. First and foremost was a commitment to the up-leveling of nursing education. “The realities of a global society, expanding technologies, and an increasingly diverse population require nurses to master complex information, to coordinate a variety of care experiences, to use technology for health care delivery and evaluation of nursing outcomes, and to assist clients with managing an increasingly complex system of care…”Nursing education must keep pace with these changes and prepare individuals to meet these challenges” (AACN, 2007, pp. 5-6). Dean Dreher espoused the firm belief that “education must lead practice.” The faculty's ability to stay steadfast in that conviction allowed for moments when a leap of faith was required; that is, change is difficult if what you are doing today has worked well in the past.

Another factor that helped the faculty make this transition was that we had already been very successful with second-degree students in the accelerated BSN program. The faculty recognized the intellectual maturity and innate curiosity of these students. Their previous academic and life experiences provided a fertile context that informed and enriched their nursing education. Further, most excelled in the program, and their attrition rate was approximately half (10%) of that in the traditional BSN program. The 1-year BSN program was tremendously time and cost-effective from the student's perspective. From the college's perspective, it was not possible to offer two entry-level programs; we had neither the human or physical resources to do so.

Because many of our second degree students were interested in continuing their education into advanced practice roles, we saw the development of a graduate prelicensure curriculum as an opportunity to create a seamless and accelerated progression into advanced practice study. This meant we could create a “graduate core” of courses that all graduate students would share. This early recognition of the need to facilitate a transition to the DNP has been tremendously helpful in streamlining the educational progression of those students interested in advanced practice roles. The graduate core also made conceptual sense as we were offering a prelicensure program at the graduate level, so content in courses such as biostatistics, health promotion, or epidemiology needed to be at a sufficiently high level.

Finally, the fiscal impact of a master's entry program addressed the issue of stabilizing the revenue stream of the college. Because of the greater attrition experienced in the traditional BSN program (20%), the college could not make up for lost seats, and therefore revenue, in a cohort. This is generally true for any program in which courses follow in sequence and one term of instruction builds upon the next. The accelerated BSN program did have a

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