The Clinical Nurse Leader: Addressing Health-Care Challenges Through Partnerships and Innovation

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Evidence demonstrates that the American health-care system is failing to meet quality, safety, and efficiency mandates. In response to the need to raise core standards, education and practice leaders have come together to create a new master’s-degree nursing role—the clinical nurse leader (CNL®). These CNL academic and clinical partnerships are producing measurable and sustainable practice outcomes that are positively affecting the quality, safety, and cost of care. The CNL initiative demonstrates the power of collaboration and the need to re-envision traditional nursing roles to meet the constantly emerging challenges of health care.

Regulatory requirements, advances in technology and scientific knowledge, workforce demographics, and consumer expectations cause constant change in health-care delivery and nursing practice. A decade of evidence demonstrates that the American health-care system is failing to deliver safe, efficient, and timely patient-centered care (American Hospital Association, 2002; Institute of Medicine, 1999, 2003; Vest & Gamm, 2009). To transform the health-care environment and re-envision roles and systems, we need visionary leadership. Besides fostering fresh thinking, leaders must balance innovation with risk management, facilitate and communicate change, and engage interprofessional stakeholders in processes that result in efficient, quality, safe, and sustainable care delivery (Porter-O’Grady & Malloch, 2009).

The role of regulation is to ensure patient safety, but this role must be balanced with the needs for innovation and organizational change. Dr. Peter Buerhaus from the Center for Interdisciplinary Health Workforce Studies at the Institute for Medicine and Public Health at Vanderbilt University Medical Center has accused oversight bodies of overregulating the health-care system and has asserted that the market can more effectively correct problems that plague the system (Saver, 2010).

As organizations implement innovative activities to address health-care reform initiatives and mandated regulations and to incentivize systems as novel sustainable enterprises, an opportunity exists for organizations and academic institutions to align their efforts. Clinical and academic partnerships create transformational avenues that result in patient-centered, forward-thinking, outcomes-driven work. Regulators have an opportunity to support or join these partnerships and recognize the importance of innovation and the growing role nurses must play in a changing health-care system.

The clinical nurse leader (CNL®), a new master’s-degree nursing role and national initiative spearheaded by the American Association of Colleges of Nursing (AACN), emerged from a national dialogue with regulatory, academic, and practice leaders on how to address the many challenges facing the health-care system (American Association of Colleges of Nursing [AACN], 2007). These conversations lead to academic-practice partnerships that are collectively reporting positive, measurable outcomes affecting the quality, safety, and cost of care. Though many of the outcomes are organization-specific because of the relative newness of the initiative, opportunities for multisystem and longitudinal inquiry exist.

This article provides an overview of CNL education, practice, and credentialing; issues related to nursing regulation; and examples of practice-academic partnerships that address quality, safety, and efficiency reform mandates.

CNL: Partnership and Vision

Global health-care dilemmas and growing technological infrastructures fuel the call for action, innovation, and revolutionary change in today’s health-care system. Health-care providers and administrators face an aging population, a growing need for health promotion and chronic-illness management across the lifespan, widening health disparities, and the need to offer more services with less human and fiscal capital. Though advancing science and meeting the needs of society require specialization, the urgency to prepare individuals to coordinate care and help patients navigate the complex health-care environment cannot be dismissed (AACN, 2007).

Health care needs unified approaches by educators and clinicians. The diversity and skill sets in academic and clini-
TABLE 1
CNL Employment Settings (N = 1,255)

This table shows where the currently certified clinical nurse specialists (CNLs) work.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute-care inpatient</td>
<td>654</td>
</tr>
<tr>
<td>Community health, public health</td>
<td>39</td>
</tr>
<tr>
<td>Home health</td>
<td>17</td>
</tr>
<tr>
<td>School health, university health</td>
<td>69</td>
</tr>
<tr>
<td>Nursing home, long-term care, sub-acute care</td>
<td>13</td>
</tr>
<tr>
<td>Hospice</td>
<td>2</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>26</td>
</tr>
<tr>
<td>Outpatient</td>
<td>37</td>
</tr>
<tr>
<td>Physician practice</td>
<td>3</td>
</tr>
<tr>
<td>Nurse-managed practice</td>
<td>5</td>
</tr>
<tr>
<td>School of nursing</td>
<td>237</td>
</tr>
<tr>
<td>Other</td>
<td>153</td>
</tr>
</tbody>
</table>

Source: Commission on Nurse Certification database, September 2010.

health clinics, home care, long-term care, emergency departments, outpatient clinics, and rehabilitation facilities. The partnerships exist in 38 states and Puerto Rico.

In the partnerships, academia with input from practice settings provides a curriculum to prepare students for the CNL role, and practice settings with input from academia redesign care delivery, maximizing the CNL role. The success of CNL partnerships hinges on academia and practice working together. Through these partnerships, stereotypes of and assumptions about each other have diminished, and the common goal of a new nursing role in the health-care system has advanced. The energy, enthusiasm, and innovation going on across the country have created a sense of excitement for nursing. The engagement of nurses at all levels—from the staff nurse to the chief nursing officer—has been critical to the success of the CNL initiative.

CNL Practice
As the CNL gains experience, his or her practice may include more advanced skills and knowledge. However, initial CNL preparation builds on entry-level nursing knowledge and skills and encompasses eight broad areas:

- Clinician
- Outcomes manager
- Client advocate
- Educator
- Information manager
- Systems analyst/risk anticipator
- Team manager
- Member of a profession/lifelong learner (AACN, 2007)

The CNL is a clinical leader-manager serving as the "air-traffic controller" on a unit or at the point of care in a health-care delivery system. CNL preparation focuses on quality improvement, interprofessional communication, care coordination, and cost-effective resource utilization. CNL practice varies depending on the setting, but the CNL's knowledge and skills are applicable and beneficial in all settings that deliver health care. Table 1 shows the practice settings of the currently certified CNLs.

The defining aspects of CNL practice include the following:

- Leadership in the care of patients and families in and across all settings
- Implementation of evidence-based practice
- Lateral integration of care for a specified group or cohort of patients
- Clinical decision making
- Oversight of the design and implementation of care plans
- Risk anticipation, specifically evaluating anticipated risks to patient safety with the aim of quality improvement and prevention of medical errors
- Participation in identifying and monitoring care outcomes
- Accountability for evaluation and improvement of point-of-care outcomes
- Client and community advocacy
- Education for individuals, families, groups, and other health-care providers
- Information management, including using information systems and technology at the point of care, to improve health-care outcomes
- Delegation and oversight of care delivery and outcomes
- Team leadership and collaboration with other health professional team members
- Interprofessional communication
- Leverage of human, environmental, and material resources
- Design and provision of health-promotion and risk-reduction services for diverse populations

The AACN 2007 White Paper on the Education and Role of the Clinical Nurse Leader provides in-depth descriptions of these aspects of CNL practice.

CNL Education: Preparation for Today's Health-Care Environment
Stakeholders engaged in extensive dialogue about the appropriate educational level to prepare CNLs. Crosswalking the essential competencies for entry-level professional nurses with those identified for the CNL showed that the additional knowledge, skills, and experiences needed for this new role could not be obtained in a 4-year baccalaureate nursing program. Based on this evaluation and input from multiple stakeholders, the AACN board decided the educational preparation must be at the graduate level in a master's- or post-master's-degree program.

The CNL curriculum must prepare the graduate with core outcome competencies expected of all master's nursing programs
of Veterans Affairs anticipates piloting it at several sites in the near future.

**Post–master’s-degree CNL Certificate Program**

The post–master’s-degree CNL certificate program is designed for those who hold a master’s degree in nursing that prepared them for a specific area of practice or an advanced nursing specialty. Demand for this program comes from nurses who are working in settings where the CNL is being implemented and who want to become CNLs. Demand also comes from employers eager to implement the CNL, using master’s-degree nurses currently practicing in the setting.

Post–master’s-degree candidates must successfully complete the graduate didactic and clinical requirements of a master’s-degree CNL program through a certificate program. Candidates are expected to achieve the same outcome competencies as master’s-degree CNL students. The content identified as critical to CNL role preparation and post–master’s-degree certificate programs can be found on the AACN website at http://www.aacn.nche.edu/cnl/pdf/PostMastersStmtnt.pdf

**CNL Regulation: Licensure and Certification**

The CNL is educated and licensed as a professional RN. If not already licensed, a CNL graduate must obtain and maintain licensure.

To use the title “clinical nurse leader” or the credential CNL, a graduate of a CNL master’s-degree or CNL post–master’s-degree certificate program must be certified by the Commission on Nurse Certification (CNC), an autonomous arm of AACN. In contrast to licensure, which validates a clinician’s minimum level of competence, certification indicates that one has achieved a higher level of competence in a more focused area of practice. To be eligible for CNL certification, an RN must graduate from a CNL master’s-degree or post–master’s-degree certificate program that is accredited by a nursing accrediting agency recognized by the U.S. Department of Education and that prepares individuals with the competencies delineated in the AACN white paper.

Twelve schools piloted the CNL Certification Examination® from November 2006 to January 2007. The first regular administration of the exam occurred in April and May 2007. Since then, over 1,200 CNLs have been certified. An elected CNC Board of Commissioners oversees all certification activities and policies. Employers and others recognize that nurses holding the CNL credential have met national education requirements and have successfully completed a rigorous examination that tests requisite knowledge and experiences. To protect the integrity of the CNL designation, the AACN has trademarked the CNL title and the CNL Certification Examination.

**CNL Value, Impact, and Sustainability**

As the CNL role continues to evolve and be adopted by healthcare organizations, the impact of CNLs will be many, measurable outcomes. The CNL’s value must be assessed by knowing stakeholder’s interest and establishing CNL outcome measures appropriate to the setting (Fitzgerald, 2004; Morris, 2010). Porter-O’Grady, Clark, and Wiggins (2010) stated that the means formerly used by nurses to value their work are now only partially meaningful. Obtaining value requires a convergence of principle, evidence, and efforts; the connection between the resources and the outcomes must be evident.

Morris (2010) identified an iterative process in which value can be determined using a series of questions. The questions can guide organizations considering the adoption of the CNL role by helping determine the overall value for the organization, the department, and the customer; the financial impact; and the risk of not adopting and using the role outlined in the AACN white paper. Answers to the questions may provide support for role sustainment for years.

As patient needs continue to change and the health-care system evolves, the CNL is in a pivotal position to introduce evidence-based interventions that produce intended effects. These effects can be aligned with activities that meet core measures, national patient safety goals, and best available practices. Popper (1945) and Campbell and Russo (1999) advocated the introduction of small interventions that deal directly with specific issues, can be practically tested and measured, and are fundamentally the same in all disciplines.

Few care settings have nurses to focus primarily on clinical-care coordination that culminates in meeting intended goals. CNLs are educated to analyze meaningful data and trends and drive improvement initiatives. They serve as coaches and mentors to other staff members and facilitate communication among staff members and patients. This focus is timely as organizations adopt the medical home model and other patient-aligned frameworks.

A CNL’s actions shift the nonaligned and siloed practice of the past to a convergence of networking and synchronized care. Examples of how CNL activities are leading improvements at public and private facilities are provided in Table 3. Sustaining these actions requires continuous alignment of activities by educators and clinicians, using the best available evidence. However, several factors can contribute to poor sustainability, such as inadequate time for educating others about practice changes, limited resources and leadership support, and absence of an evidence-based culture (Hagedorn et al., 2006; Seetler, 2003; Wallin, Profetto-McGrath, & Levers, 2005). Argote (1999) and Huber (1991) encourage care settings to learn from the basic tenets of organizational learning theory (acquisition, interpretation, storage, data retrieval, and use of knowledge) to sustain interventions and introduce a new practice role.

This new paradigm will require systematic, enduring planning and action by all stakeholders to ensure changes and prac-

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: Author.


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