
UNIT 1

Introduction

ONE

Introducing the Clinical Nurse Leader: Past, Present, and Future

■ Joan M. Stanley

www

Learning Objectives

© Arenacreative/Dreamstime.com

- Discuss how the clinical nurse leader (CNL) contributes to care coordination within the evolving and constantly changing healthcare environment
- Describe the CNL role evolution—past, present, and future

Introduction

Health care is at a critical junction. Economic uncertainty, mushrooming costs, rapid growth in biomedical advances, workforce shortages, changing population demographics, and demands for better outcomes all call for new ways of delivering health care and educating future health professionals. Despite the many ways the profession has evolved over the past decade, nursing continues to be faced with unique challenges, including the fragmentation of care, retention of nurses in the profession, opportunities for

“I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything new that might improve the past.”

Clara Barton

career advancement, utilization of nurses to the full scope of practice, and equipping clinicians with the knowledge and skills needed to address the competing demands of a complex healthcare system. Inter- and intraprofessional collaboration are key to meeting these challenges. Innovative partnering between the practice and education arenas is even more critical to address and sustain effective solutions for the long term. Within this environment, the American Association of Colleges of Nursing (AACN), in partnership with practice leaders, created the clinical nurse leader (CNL) role—the first new nursing role in over 40 years. The CNL is prepared to respond to today’s challenges and readily adapt to meet the needs of the rapidly changing healthcare environment.

The Healthcare Environment

In 1999, the Institute of Medicine (IOM) released its landmark report, *To Err is Human: Building a Safer Health System*, which estimated that up to 98,000 Americans die each year as a result of medical errors (IOM, 1999). Subsequent estimates indicated that these numbers could be even higher (Leape & Berwick, 2005). The estimated national costs of preventable adverse events (medical errors resulting in injury) are in the billions. Medication-related errors and mistakes that do not result in actual harm are also extremely costly and have a significant impact on quality of care and healthcare outcomes. Over the past two decades, the IOM (2003) and others, including the American Hospital Association (AHA, 2002), The Joint Commission (2002), and the Robert Wood Johnson Foundation (Kimball & O’Neil, 2002), have all called on healthcare systems to refocus their efforts to reduce medical errors, improve patient safety, and reevaluate how future health professionals will be educated.

A report released by the U.S. Department of Labor in February 2012 reported that the growth in nursing jobs was the largest among all professions. The report projected that the number of employed nurses would increase from 2.74 million in 2010 to 3.45

million in 2020, an unprecedented increase of 26% (U.S. Department of Labor, 2012). Buerhaus and coauthors projected that the nursing shortage will increase to 260,000 nurses by 2025, twice the size of any previous shortage (Buerhaus, 2009). The nursing shortage will have dire consequences for quality of care and nursing outcomes if it is not addressed. Needleman and associates demonstrated that lower nurse staffing levels were associated with adverse patient outcomes, including higher rates of pneumonia, urinary tract infections, length of stay, and “failure to rescue” (Needleman et al., 2002). Aiken and colleagues (2002) found that low nurse-to-patient ratios were related to higher risk-adjusted 30-day mortality and “failure to rescue” rates. In addition, nurses practicing in settings with lower nurse-to-patient ratios were more likely to experience burnout and job dissatisfaction (Aiken et al., 2002).

In addition to the predictions of a long-lasting nursing shortage and the universal calls from outside nursing to change the way health professionals are educated and practice, several studies have demonstrated that nurses educated at baccalaureate or higher degree levels produce better patient outcomes, specifically reduced mortality and failure-to-rescue rates (Aiken et al., 2003; Estabrooks et al., 2005). In its report, *The Future of Nursing*, the Institute of Nursing called for 80% of the nursing workforce to hold a minimum of a baccalaureate degree by 2020 and recommended that all nurses be allowed to work to the full scope of their education in order to address and face the challenges of the country’s healthcare system (Institute of Nursing, 2010).

Leading the Profession to a New Vision for Nursing Education

In direct response to the changing global demographics, the turmoil of the healthcare system, and the drastic shortage of nursing professionals, the AACN began a dialogue to examine and shape nursing education. For over a decade, this dialogue, which is participated in by a broad representation of stakeholders both inside and outside of the nursing profession, focused on the knowledge, skills, and competencies needed by professional nurses to address the demands of an evolving healthcare system. From this dialogue emerged a preferred vision of the future of nursing, as well as new models for nursing education. This vision encompasses all levels of nursing education, from the baccalaureate degree to the doctorate (Stanley, 2008). The CNL— prepared at the master’s-degree level to practice in any healthcare

setting, with a focus on quality improvement, interprofessional communication, evidence-based practice, and care coordination—is its linchpin.

In 1999, the AACN board of directors formed the Task Force on Education and Regulation for Professional Nursing Practice (TFER). The task force developed new education models, including a model for the “New Nurse” graduate, a clinician educated beyond the 4-year baccalaureate degree with a new license and legal scope of practice. After consultation with nurse executives, regulators, and other key stakeholders, the TFER determined that a new role was needed to differentiate professional nursing’s scope of practice. At the same time, the National Council of State Boards of Nursing (NCSBN) indicated it was not possible to create a separate license for entry-level nurses educated at the associate and baccalaureate-degree levels unless the roles were well differentiated.

In 2002, in response to the recommendations from the TFER, the AACN board created TFER II, which was charged with examining what competencies were needed in the current and future healthcare system to improve patient care outcomes. A wide array of stakeholders, representing nursing education and practice, medicine, healthcare administration, pharmacology, public health, and others, were invited to provide input about what this “new nurse” role might look like. Their work resulted in the 2007 publication of the *White Paper on the Role of the Clinical Nurse Leader*. Prior to its publication, in addition to discussing the competencies needed for this new role, many discussions were held within AACN and with external groups about a possible name for the new role and the kind of education that would be needed to prepare someone to practice at this level.

The CNL Initiative Is Born

Since the early stages of the conception of the new role, the AACN board has remained committed to the implementation of the CNL and the involvement of both education and practice. In 2003, the Implementation Task Force (ITF), composed of representatives from both the education and practice arenas, was appointed to oversee the development of the new role. Modeling the importance of education–practice partnerships, the American Organization of Nurse Executives (AONE) was invited to appoint a representative to serve on the ITF. Another extremely important partner in this initiative was the Department of Veterans Affairs (DVA). Cathy Rick, chief nursing officer and an early stakeholder, has been a proponent of the CNL from its earliest stages, and the DVA has participated at all levels in collaborating

on the design and implementation of the CNL role. This joint participation by education and practice has been a key factor in the success of the initiative. In January 2007, the ITF submitted its final report and recommendations to the AACN board. Tremendous strides had been made in moving the CNL initiative forward; however, continued support and leadership by AACN was critical to sustaining the early momentum and ensuring continued growth. Responding to the ITF's recommendation, in March 2007, the AACN board appointed the CNL steering committee, composed also of education and practice representatives, whose primary charge was to elevate the visibility and sustainability of the CNL role and support the measurement of the CNL's impact on patient care outcomes and costs.

Key Steps and Landmarks Along the Way

In October 2003, the AACN sent an open invitation to all deans of schools of nursing inviting them to participate in an exploratory meeting about the CNL role, which included exploring the implications and expectations for education programs and the transformation of care delivery models. The only requirement of participants was that they attend with at least one nurse leader from a practice institution. Over 280 individuals representing 100 potential partnerships attended this exploratory meeting. By March 2004, a request for proposals (RFP) was sent to all AACN member schools inviting schools and their practice partners to commit to implementing the CNL role, including the design of a master's-level CNL curriculum and integration of the CNL role within at least one unit in the practice setting. In June 2004, the ITF sponsored a CNL implementation conference for all education practice partners participating in the initiative. Representatives from 79 schools of nursing and 136 practice organizations participated with the goal of advancing the CNL movement.

By fall 2006, the number of partnerships had grown to 87, representing 93 schools of nursing and 191 healthcare practice settings. This number has continued to grow and now includes 98 schools and well over 200 practice settings, including a number of large healthcare systems. In a recent survey of the AACN member schools, 124 respondents indicated they had in place or were planning to institute a CNL program.

Numerous forums and conferences, including annual CNL conferences, have been held since the initial CNL implementation conference in June 2004. Over 400 faculty, deans, chief nursing officers, CNLs, students, healthcare administrators, and physicians attended the Fourth National CNL Summit, jointly sponsored by the AACN and the DVA, highlighting the success and continued growth of the

CNL initiative. The Fifth National CNL Summit occurred in January 2013 in New Orleans, Louisiana, and was widely attended by multiple stakeholders.

The CNL Association (CNLA), open to all CNLs and students, held its inaugural meeting during the First AACN–DVA National Summit in 2009. The CNLA has continued to grow its membership, supporting a regional conference annually and providing online education offerings, including a newly designed website.

Another landmark decision was the development of a CNL certification examination and designation. (See *“The CNL: Past, Present, and Future”* at the end of this chapter, for more detail). CNL certification provides a unique credential for graduates of the master’s and post-master’s CNL programs. The CNL Certification Examination was tested by 12 schools during the period from November 2006 to January 2007. The first regular administration of the CNL Certification Examination occurred in April and May 2007. Since that time, nearly 2,500 CNLs have been certified and may use the credential and title CNL. The Commission on Nurse Certification (CNC) was formed in 2007. An elected board and staff oversee all certification related activities and policies.

The AACN was also successful in trademarking the CNL title and the CNL Certification Examination in an effort to protect the integrity of this new designation. Only individuals who are successful in obtaining CNL certification may use the title CNL. In addition, the trademark symbol is to be used along with the CNL title, any reference to the title, or when citing the CNL Certification Examination.

The CNL Role

The CNL role was designed in collaboration with a broad array of stakeholders within the healthcare system. As the role emerged, it became evident that many leaders in practice had already identified the need for a nurse with these skill and knowledge sets. Similar roles were being developed and emerging on an ad hoc basis in settings across the country. Nurses were being recruited to fill these roles based on availability, clinical experiences, and self-selection. In many instances these nurses were completing classroom and clinical work without receiving academic credit or recognition of the advanced competencies being acquired. In addition, there was no standardization of the competencies and experiences required, and the utilization of these nurses varied from site to site. All of these factors prevented these CNL forerunners from moving from one care setting to another, discouraged the duplication of care models, and made it difficult to assess the impact these clinicians were having on care outcomes.

The patient care facilitator (PCF) role was designed by cardiovascular nursing staff in response to a challenge to describe the ideal unit staffing pattern. We piloted the PCF position, and it was so successful that we continued to implement the role across other areas and units. When the CNL role was first described we developed an academic practice partnership model and began to educate our PCFs to become CNLs.

Joan Shinkus Clark, DNP, RN, NEA-BC, CENP, FACHE, FAAN, Senior Vice President and System Chief Nurse Executive, Texas Health Resources

Assumptions About the CNL

Ten assumptions about the CNL were articulated early on by the AACN as role competencies were delineated and curricula designed. These assumptions included:

1. Practice is at the microsystem level.
2. Client care outcomes are the measure of quality practice.
3. Practice guidelines are based on evidence.
4. Client-centered practice is intra- and interdisciplinary.
5. Information will maximize self-care and client decision making.
6. Nursing assessment is the basis for theory and knowledge development.
7. Good fiscal stewardship is a condition of quality care.
8. Social justice is an essential nursing value.
9. Communication technology will facilitate the continuity and comprehensiveness of care.
10. The CNL must assume guardianship for the nursing profession (AACN, 2007).

The impact of the CNL has been even greater than expected. Nurses influence all of the critical metrics for our health system: quality and safety, patient experiences, finance, growth, employee engagement. The CNL plays a critical role in all of these.

**MaryLou Wesley,
MSN, RN, Senior VP &
Chief Nurse Executive,
WellStar Health System
Inc., Marietta, GA**

Key Components of the CNL Role

The CNL is seen as a leader in the healthcare delivery system—not just in the acute care setting, but in all settings in which health care is delivered. The implementation of the CNL role, however, varies across settings. The CNL is not an administrative or management role. The CNL assumes accountability for patient care trends and outcomes through the assimilation and application of evidence-based information to design, implement, and evaluate plans and processes of care. The CNL is a provider and manager of care at the point of care to individuals and cohorts of patients within a unit or healthcare setting. The CNL designs, implements, and evaluates patient care by coordinating, delegating, and supervising the care provided by the healthcare team, including licensed nurses, technicians, and other health professionals.

The defining aspects of CNL practice include:

- Leadership in the care of patients in and across all settings;
- Implementation of evidence-based practice in all healthcare settings for diverse and complex patients;
- Coordination of care;
- Lateral integration of care for a cohort of patients;
- Clinical decision making;
- Risk anticipation, specifically evaluating anticipated risks to patient safety with the aim of quality improvement and preventing medical errors;
- Participation in identification and collection of care outcomes;
- Accountability for evaluation and improvement of point-of-care outcomes;
- Mass customization of care;
- Interprofessional communication;
- Leveraging human, environmental, and material resources;
- Client and community advocacy;
- Education for individuals, families, groups, and other healthcare providers;
- Information management, including using information systems and technology at the point of care to improve healthcare outcomes;
- Oversight of care delivery and outcomes; and
- Team leadership and collaboration with other health professional team members (AANC, 2007).

An in-depth description of each of these practice components can be found in the AACN 2007 white paper, *The Role of the Clinical Nurse Leader* (AACN, 2007).

An expert panel representing CNL education, practice, and certification has been charged with the review and revision of the outcomes expected of all CNL graduates as currently delineated in the AACN 2007 white paper. This review and revision will be based on a 2011 job analysis conducted by CNC, a review of the CNL literature, and the lived experience of panel members. The process used to identify the new set of expected outcomes and competencies will be a national consensus-based process used previously to develop competencies for nurse practitioner and clinical nurse specialist competencies (Department of Health and Human Services, 2002).

The biggest impact the CNL has had in our healthcare system is how lateral integration and continuity of care has improved interdisciplinary communication and patient care outcomes.

Patricia Steingall, MS,
RN, NE-BC, Chief Nursing
Officer, VP Patient Care
Services, Hunterdon
Medical Center, NJ

Educating the CNL

As the CNL evolved, extensive dialogue occurred about the appropriate level of education to prepare someone with this unique set of competencies and to practice in this new role. Crosswalking the essential competencies for entry-level professional nurses (AACN, 1998) with those identified for the CNL (Stanley, 2008) clearly showed that the additional knowledge, skills, and experiences needed to practice in this new role could not be obtained within the confines of a 4-year baccalaureate nursing program. Based on this evaluation and input from multiple stakeholders, the decision was made by the AACN board that the educational preparation of the CNL should be at the graduate level, in a master's or post-master's degree program.

In fall 2007, 1,270 students were enrolled in 70 CNL programs, and in the 2006–2007 academic year, 265 students graduated from these CNL programs (Fang, Li, & Bednash, 2008). By fall 2011, these numbers increased to 2,817 students enrolled in 97 programs with 926 graduates in the 2010–2011 academic year (APRN Consensus, 2008). In addition, over 2,300 graduates of the CNL programs were certified by CNC by fall 2012.

After only 6 months of rolling out the CNLs on two pilot units, there were so many changes occurring in health care that I knew that nursing needed to take the lead in working with our physician colleagues in making these changes. These included pay for performance associated with core measures and the Hospital Consumer Assessment of Healthcare Providers and Systems Survey and decreasing hospital-acquired conditions. I quickly discovered that the new CNL role was the perfect fit to meet or exceed all of the goals for these new initiatives. The CNL now serves as the liaison between physicians, patients, families, and nursing staff.

Nancy Hilton, MN, RN, Chief Nursing Officer, HCA St. Lucie Medical Center, Port St. Lucie, FL

The CNL Curriculum Framework

Assumptions about CNL graduate education programs include:

1. The education program culminates in a master's degree or post-master's degree in nursing.
2. The CNL graduate is prepared as an advanced generalist with an emphasis on quality improvement and care coordination in any care setting.
3. The CNL graduate will be competent to provide care at the point of care.
4. The CNL graduate will be prepared in clinical leadership for practice throughout the healthcare delivery system.
5. The CNL graduate is eligible to matriculate to a practice- or research-focused doctoral program.
6. The CNL graduate is prepared with advanced nursing knowledge and skills but does not meet the criteria for advanced practice registered nursing (APRN) scope of practice (Institute of Nursing, 2010).
7. The CNL graduate is eligible to sit for the CNL Certification Examination.

The CNL curriculum framework encompasses three foci: nursing leadership, clinical outcomes management, and care environment management. Under each focus are major areas of emphasis, as shown in **Figure 1-1**. Ten threads that should be integrated throughout the curriculum in didactic and clinical experiences are also

Figure 1-1 CNL curriculum framework.



Major Threads Integrated Throughout Curriculum

- | | |
|---|--|
| I. Critical thinking/clinical decision making | VII. Accountability |
| II. Communication | VIII. Assessment |
| III. Ethics | IX. Nursing technology and resource management |
| IV. Human diversity/cultural competence | X. Professional values, including social justice |
| V. Global health care | |
| VI. Professional development in the CNL role | |

Source: AACN. (2007). *White paper on the role of the clinical nurse leader* (p. 32). Washington, DC: Author.

identified. The actual design of the curriculum rests with the faculty at the schools of nursing. However, the expectation is that the graduate will be prepared with the competencies delineated in the AACN *White Paper on the Role of the Clinical Nurse Leader*, as well as the required clinical experiences. The immersion experience is a critical component of the CNL curriculum. In addition to other clinical experiences integrated throughout the program, the immersion includes a minimum of 300 hours in practice in the CNL role with a designated clinical preceptor and a faculty partner. Many education programs partner with a clinical practice site and designate a single preceptor but also involve a variety of other individuals, including human resources personnel, financial officers, quality improvement personnel, patient safety officers, and nursing educators in the teaching of the CNL student.

CNL Curriculum Models

Five curriculum models for graduate CNL education programs have emerged. These five models are described in **Table 1-1**. The percentages of schools that have implemented each type of model are shown in **Figure 1-2**.

Where CNLs Are Practicing

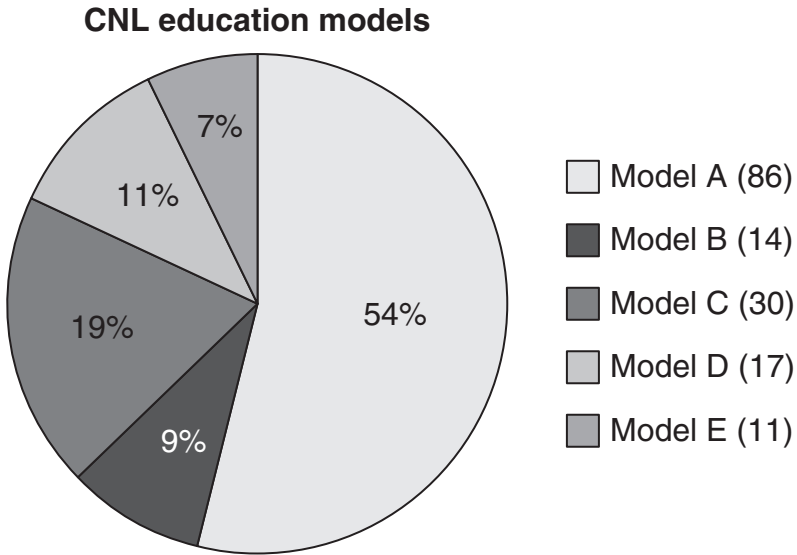
The CNL competencies delineated in the AACN's *White Paper on the Role of the Clinical Nurse Leader* are meant to prepare nurses to practice as leaders in any healthcare setting. Stakeholders who were asked to review early documents describing the CNL

Table 1-1 CNL Curriculum Models

Model	Program Description
Model A	Program designed for BSN graduates
Model B	Program designed for BSN graduates; includes a post-BSN residency that awards master's credit toward the CNL degree
Model C	Program for individuals with a baccalaureate degree in another discipline; also known as a second-degree or generic master's
Model D	Program designed for ADN graduates; also known as an RN-MSN program
Model E	Post-master's certificate program

BSN, bachelor's of nursing science; AND, associate's degree in nursing; RN-MS, registered nurse with a master's of science in nursing

Figure 1-2 Percentage of schools offering CNL curriculum models (n = 99).



Source: AACN CNL database 10/2012.

role and competencies unanimously stated that a nurse prepared with this set of competencies would be a valuable asset to their area of nursing practice or practice setting. The implementation of the CNL competencies, however, does vary across settings, and the CNLs day-to-day activities differ depending upon the setting, patient population, and care delivery model. To be most successful in any setting, however, the care delivery should be reshaped, and the CNL integrated into this revised model to fully use the unique skill and knowledge set brought to the point of care by this new nurse.

CNLs are practicing and making a significant impact in a variety of practice sites. A majority of the early graduates are practicing in acute care hospitals, where demands for improved outcomes and better ways of delivering care have been well documented. CNLs are also migrating to other employment settings including school health, long-term care, rehabilitation settings, outpatient clinics, home care, emergency departments, and state health departments. The employment settings for the early certified CNLs are displayed in **Table 1-2**.

Table 1-2 Employment Sites for Certified CNLs**CNL(r) Employment Settings (N = 535)**

Acute care inpatient	304
Community/public health	11
Home health	6
School/university health	24
Nursing home/long-term care/subacute care	7
Hospice	1
Hospital outpatient	7
Outpatient clinic/or surgery center	22
Physician practice	2
Nurse-managed practice	2
School of nursing	89
Other	60

Source: CNC Certification Database, 3/09.

I hope the CNL stays focused on the microsystem, either at the bedside or in an outpatient setting. We often move experienced nurses away from the point of care delivery and lose the effectiveness and impact.

**MaryLou Wesley,
MSN, RN, Senior VP &
Chief Nurse Executive,
WellStar Health System,
Inc., Marietta, GA**

Impact of the CNL Role on Care Outcomes

As the number of CNLs in practice increases, the impact on patient care outcomes is becoming apparent. Although many of the reports on the impacts, costs, and benefits are anecdotal, outcomes are increasingly being reported in lay and professional publications and at professional conferences. Stanley and colleagues reported outcomes of care at three healthcare settings located in one state (Stanley et al., 2008). These outcomes included improvement in the Center for Medicare and Medicaid Services (CMS) core measures (e.g. pain management, acute myocardial infarction [MI], congestive heart failure [CHF], and pneumonia indicators), improved care coordination, improved

physician–nurse collaboration, improved patient satisfaction, and decreased nurse turnover.

Gabuat and colleagues (2008) reported on a CNL pilot initiative that was conducted on a progressive care unit and medical/surgical unit at a for-profit hospital. Initially designed to be budget neutral, outcomes pre- and post-CNL implementation on these units also included decreased nursing turnover, increased patient and physician satisfaction, and improved core measures (acute MI, CHF, and pneumonia). Hartranft and colleagues reported significant patient safety improvements that included zero falls with injury and nosocomial infections and pressure ulcers, improved patient satisfaction, and 100% achievement of CMS core measures after implementation of the CNL role on several units (Hartranft, Garcia, & Adams, 2007). In addition, Hartranft notes that many of the outcomes achieved by the CNL are not captured in hard data.

For that reason, the CNLs at this facility keep a daily journal of “saves” and qualitative accomplishments, for example identifying the need for early intervention and ability to stabilize a patient without moving to a higher level of care (a savings of approximately \$1,150 per day just for the bed) (Stanley et al., 2008, p. 263). Other identified outcomes have been improvement in goal setting, greater engagement of staff nurses in projects, and improved nurse and physician satisfaction.

The DVA was involved in the early implementation of the CNL role, and the Veterans Health Administration is moving to fully implement the CNL role across all VA settings by the year 2016 (James Harris, verbal communication, March 6, 2009). One of the first VA settings where the CNL role was implemented was the Tennessee Valley Healthcare System (TVHS). AACN and TVHS collaborated on a pilot of an evaluation tool to capture clinical outcomes pre- and post-assignment of unit-based CNLs (Harris et al., 2006). Preliminary findings from this pilot were positive and encouraging, including decreased readmission rates for patients discharged with CHF, decreased length of stay for patients with CHF, increased discharge instructions for patients with CHF on an acute medical unit, and decreased patient falls

In the future, I see the CNL as the link between acute care and the outpatient settings, which is critically important with the current and impending changes in the healthcare environment.

Patricia Steingall,
MS, RN, NE-BC, Chief
Nursing Officer, VP
Patient Care Services,
Hunterdon Medical
Center, NJ

The biggest impact the CNLs have had is in “just in time” training for the nursing staff. The CNLs have raised the level of nursing care on the units, including implementing evidence-based care processes, Core Measure compliance, and decreasing hospital-acquired conditions.

**Nancy Hilton, MN, RN,
Chief Nursing Officer,
HCA St. Lucie Medical
Center, Port St. Lucie, FL**

and surgical infection rates 30 days postoperative on an acute surgical unit. Since these early outcomes were reported, evaluation at TVHS of the outcomes on five care units (microsystems of care) have also been reported. Significant demonstrated outcomes included a 20% decrease in patients receiving a blood transfusion following total knee arthroplasty (TKA) on a surgical inpatient unit, a 28.6% increase in venous thromboembolism prophylaxis implementation for critically ill intubated patients, and an 8% increase in participation in a restorative dining program on a transitional care unit (Hix, McKeon, & Walters, 2009).

Other reported outcomes linked to CNL practice include an 18.2% decrease in critical care days and a 40% decrease in returns to the critical care unit netting \$800,000 in savings over a 14-month period after a CNL implemented multidisciplinary rounds on long-term ventilator patients. Another CNL collaborated with a team of orthopedic surgeons and blood bank personnel to evaluate and then eliminate retransfusion of blood cells in TKA patients, which led to decreased opportunities for infection

and netted an estimated \$100,000 savings in time and equipment. At another facility, a CNL was able to decrease peripherally inserted central catheter (PICC) line infections from 179 blood stream infections (40 were related to the PICC line) to 0 infections, netting an estimated \$500,000 savings over a 12-month period (Wiggins, 2008). These projects and their impact on patient safety and quality of care do not represent the entire impact that these 3 CNLs made in that particular setting. Rather, they represent 3 documented examples of the impact the CNL had in just 3 care settings. Increasingly, positive outcomes for quality of care and the related cost benefits are being reported in healthcare settings where the CNL role has been implemented. Although most of these examples are from acute care units, similar benefits and outcomes are being reported in a variety of other care settings.

Future of CNL Education and Role

Admittedly the CNL initiative is not the sole answer to the many issues that plague the healthcare delivery system; however it is one very promising strategy that is demonstrating a significant and sustained impact across settings. Calls for major changes in the way health care is delivered and the way health professionals are educated have prompted nursing education and practice, under the AACN's leadership, to develop a preferred vision for nursing education with the CNL at the center. The CNL, an advanced generalist with a focus on quality improvement and care coordination, is not a replacement for other nursing roles, such as the clinical nurse specialist, nurse practitioner, nurse manager, or the staff nurse. Rather the CNL is complementary to other nursing roles (Spross et al., 2004; Ott & Haase-Herrick, 2006) and works in tandem with these providers to deliver high quality, patient-centered nursing care. Healthcare leaders have identified the CNL as the future leader of quality improvement in the microsystem and at the point of care. The CNL initiative complements other quality improvement initiatives, such as those spearheaded by the Institute for Healthcare Improvement (IHI, 2013) and the Robert Wood Johnson Foundation's (RWJF's) Transforming Care at the Bedside (TCAB), which have greatly impacted the quality of care available in hospitals (RWJF, 2013). CNLs are taking a lead in these initiatives at multiple sites to implement quality improvement projects and improve patient safety. Partnering between education and practice has been identified as critical; collaboration and combining efforts are also crucial to making a lasting impact on enhancing care delivery.

The CNL initiative has grown considerably in the 9 years since the publication of the AACN "Working Paper," which is now the white paper, *The Role of the Clinical Nurse Leader*. The number of schools implementing CNL master's or post-master's

In 10 years CNLs will be in every area of health care improving outcomes. The CNL has the expertise to provide insight and change as health care changes. As the lateral integrator and coordinator of care, I envision the CNL taking a leadership role in transitions of care, particularly from acute to post-acute care.

Patricia Steingall, MS,
RN, NE-BC, Chief Nursing
Officer, VP Patient Care
Services, Hunterdon
Medical Center, NJ

In the near future, the CNL will be the primary nurse interfacing with patients at critical junctures through the continuum of care. We are seeing a proliferation of roles like coaches and navigators to address smooth transitions for patients through the levels of care. Although these new roles may have functional worth for discreet tasks, we will still need someone (the CNL) who understands complexity and can help create systems and processes that promote seamless care, health, and well-being. The CNL will provide this leadership at all levels while staying patient focused in the day to day management of patients.

Joan Shinkus Clark, DNP, RN, NEA-BC, CENP, FACHE, FAAN, Senior Vice President and System Chief Nurse Executive, Texas Health Resources, Dallas-Forth Worth, TX

programs has increased, and more schools are exploring the possibility of launching a CNL master's or post-master's program. For a number of schools, the CNL master's program represents the first graduate program offered at that institution. For others, the CNL master's program is a part of their evolution as advanced specialty nursing programs are transitioned to the doctor of nursing practice (DNP) degree. The number and type of healthcare institutions partnering with schools to implement the CNL also has expanded. Major healthcare systems across the country, including those providing acute and long-term care, are integrating the CNL into their care delivery models. As the impact of the CNL role on patient safety, quality care outcomes, care coordination, and cost benefits is more widely disseminated, it is anticipated that this expansion will occur exponentially. Particularly in this era of healthcare reform, cost containment, and changing reimbursement policies, the integration of the CNL into care delivery across settings offers a positive means of addressing these system-wide priorities.

The AACN remains steadfast in its support for the CNL initiative. However, to sustain the momentum and ensure that the CNL becomes embedded within the healthcare delivery infrastructure, ongoing networking and expansion of national and local partnerships are critical. Documentation and broad dissemination of the CNL's impact on patient safety, quality improvement, care coordination, transitions of care, and the related cost benefits across a variety of healthcare settings also will be vitally important to sustaining this movement and embracing the CNL as a catalyst for quality care.

I see the CNLs, working with other CNLs across settings, taking a leading role in overseeing care transitions from unit to unit and from acute care to home or other settings to decrease readmissions and improve other care outcomes. We are already working to implement this and have made significant changes in our Length of Stay (LOS) hospital wide and also our readmission rates. Introducing the CNL role at St. Lucie Medical Center is the most progressive and innovative strategy that I have implemented in my 17 years as a chief nursing officer. This will be my legacy to this hospital and nursing in general.

Nancy Hilton, MN, RN, Chief Nursing Officer, HCA St. Lucie Medical Center, Port St. Lucie, FL

References

- AHA Commission on Workforce for Hospitals and Health Systems. (2002). *In our hands: How hospital leaders can build a thriving workforce*. Chicago, IL: American Hospital Association.
- Aiken L. H., Clarke S. P., Cheung R. B., Sloane D. M., & Silber J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association*, 290(12), 1617–1623.
- Aiken, L. H., Clarke, S. P., Sloane D. M., Sochalski J., & Silber J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, 288(16), 1987–1993.
- American Association of Colleges of Nursing. (1998). *The essentials of baccalaureate education for professional nursing practice*. Washington, DC: Author.
- American Association of Colleges of Nursing. (2007). *White paper on the role of the clinical nurse leader* (pp. 6–11). Washington, DC: Author. Retrieved from <http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader07.pdf>
- APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee. (2008). Consensus model for APRN regulation: Licensure, accreditation, certification & education. Retrieved from http://www.aacn.nche.edu/Education/pdf/APRN_Report.pdf
- Buerhaus, P. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs*, 28(4), 657–668.
- Department of Health and Human Services, HRSA, BHP, DON. (2002). *Nurse practitioner primary care competencies in specialty areas: Adult, family, gerontological, pediatric, and women's health*. Washington, DC: Author.

- Estabrooks, C. A., Midodzi, W. K., Cummings, G. C., Ricker, K. L., & Giovannetti, P. (2005). The impact of hospital nursing characteristics on 30-day mortality. *Nursing Research, 54*(2), 74–84.
- Fang, D., Htut, A. M., & Bednash, G. D. (2008). *2007–2008 enrollment and graduations in baccalaureate and graduate programs in nursing*. Washington, DC: American Association of Colleges of Nursing.
- Fang, D., Li, Y., & Bednash, G. D. (2012). *2010–2011 enrollment and graduations in baccalaureate and graduate programs in nursing*. Washington, DC: American Association of Colleges of Nursing.
- Gabuat, J., Hilton, N., Kinnaird, L. S., & Sherman, R. O. (2008). Implementing the clinical nurse leader role in a for-profit environment. *Journal of Nursing Administration, 38*(6), 302–307.
- Harris, J. L., Walters, S. E., Quinn, C., Stanley, J., & McGuinn, K. (2006). The clinical nurse leader role: A pilot evaluation by an early adopter. Retrieved from <http://www.aacn.nche.edu/CNL/pdf/tk/VAEvalSynopsis.pdf>
- Hartranft, S. R., Garcia, T., & Adams, N. (2007). Realizing the anticipated effects of the clinical nurse leader. *Journal of Nursing Administration, 37*(6), 261–263.
- Hix, C., McKeon, L., & Walters, S. (2009). Clinical nurse leader impact on clinical microsystems outcomes. *Journal of Nursing Administration, 39*(2), 71–76.
- Institute for Health Care Improvement. (2013). Homepage. Retrieved from <http://www.ihc.org/Pages/default.aspx>
- Institute of Medicine. (1999). *To err is human: Building a safer health system* (p. 1). Washington, DC: National Academy Press.
- Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academies Press.
- Institute of Nursing. (2010). *The future of nursing*. Washington, DC: National Academies of Science.
- Joint Commission on Accreditation of Healthcare Organizations. (2002). *Health care at the crossroads, strategies for addressing the evolving nursing crisis*. Chicago, IL: Author.
- Kimball, B., & O'Neil, E. (2002). *Health care's human crisis: The American nursing shortage*. Princeton, NJ: The Robert Wood Johnson Foundation.
- Leape, L. L., & Berwick, D. M. (2005). Five years after to err is human. *Journal of the American Medical Association, 293*(19), 2384–2390.
- Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine, 346*(22), 1715–1722.
- Ott, K. M., & Haase-Herrick, K. (2006). *Working statement comparing the clinical nurse leader and nurse manager roles: Similarities, differences and complementarities*. Washington, DC: AACN. Retrieved from <http://www.aacn.nche.edu/CNL/pdf/tk/roles3-06.pdf>
- Robert Wood Johnson Foundation. Transforming care at the bedside (TCAB) tool kit. Retrieved from <http://www.rwjf.org/en/grants/national-program-offices/T/transforming-care-at-the-bedside.html>

- Spross, J. A., Hamric, A. B., Hall, G., Minarik, P. A., Sparacino, P. A., & Stanley, J. M. (2004). *Working statement comparing the clinical nurse leader and clinical nurse specialist roles: Similarities, differences and complementarities*. Washington, DC: AACN. Retrieved from <http://www.aacn.nche.edu/CNL/pdf/CNLCNSComparisonTable.pdf>
- Stanley, J. M. (2008). AACN shaping a future vision for nursing education. In B. A. Moyer & R. A. Wittmann-Price (Eds.). *Nursing education: Foundations for practice excellence*, Philadelphia, PA.
- Stanley, J. M., Gannon, J., Gabuat, J., Hartranft, S., Adams, N., Mayes, C., . . . Burch, D. (2008). The clinical nurse leader: A catalyst for improving quality and patient safety. *Journal of Nursing Management*, 16(5), 614–622.
- U.S. Department of Labor, Bureau of Labor Statistics. (2012). Economic news release. Retrieved from <http://www.bls.gov/news.release/ecopro.t06.htm>
- Wiggins, M. (2008, June 8). The clinical nurse leader demands in healthcare require new innovation. Presentation made to the Joint Commission-Nursing Advisory Council. Oakbrook, IL.

The CNL: Past, Present, and Future

■ Tracy Lofty

Director, Commission on Nurse Certification

The Commission on Nurse Certification (CNC), an autonomous arm of the American Association of Colleges of Nursing (AACN), is responsible for the administration of the Clinical Nurse Leader (CNL) Certification Program. CNL certification is awarded to individuals who meet the certification eligibility criteria (registered nurse [RN] licensure and graduation from a CNL education program) and who successfully complete a comprehensive exam.

The first official testing period of the CNL Certification Exam was launched in May 2007. By working with subject matter experts, key stakeholders, and a highly reputable testing agency, the AACN developed the exam blueprint based upon a model curriculum that was prepared by other subject matter experts and leading authorities. At that time, the CNL was a new role, and no formally trained CNLs were practicing. Therefore, the exam had to be developed based upon a very comprehensive model curriculum. Based upon feedback from examinees completing CNC's certification program evaluations, the model curriculum served as one of the resources for certification exam preparation.

By 2011, more than 1,500 individuals had earned the CNL credential. To maintain the quality of the exam and to adhere to certification accreditation standards, the board of commissioners (BOC) began to explore conducting a job analysis. What were the CNLs doing in practice—what were their specific tasks? More importantly, what common ground did all CNLs share? Did the AACN's model curriculum support the knowledge, skills, and abilities (KSAs) required of a novice CNL in practice?

The job analysis is a critical element of a valid certification exam. Knowing that CNLs were being employed in the role and that there were testimonies of positive outcomes linked to CNL practice, the BOC decided that it was an appropriate time to conduct a formal job analysis study. The greatest challenge and concern identified by the BOC related to conducting this study was identifying shared KSAs as CNLs were employed in a variety of settings.

In the spring of 2011, the CNC posted a call for volunteers to recruit CNLs to serve on the CNL Job Analysis Committee. In May 2011, 10 CNLs, along with CNC staff, met with the staff of the current testing agency, Schroeder Measurement Technologies, Inc. (SMT) to identify CNL tasks—specifically, knowledge, skills, and

abilities of a novice, practicing CNL regardless of setting. This was an intense two-day meeting. Various publications related to the CNL role were reviewed prior to the meeting, and a list of more than 200 KSAs were considered to establish a CNL body of knowledge.

Discussion with the committee continued into the evening—clear evidence for just how passionate they were about the CNL role. Committee members could see the future of the CNL role and the critical importance of the work at hand. They believed that the CNL role was just at the cusp of being fully accepted and integrated; they viewed the CNL role as the most fundamental position in healthcare innovation. From their explanations, the CNC developed the brochure *Why Hire a CNL?*, which is currently posted on the AACN's website.

Following the meeting, SMT developed and emailed a survey based upon the KSAs to all CNLs. The survey would serve as the measuring tool to determine the significance of each KSA. Nearly 300 CNLs participated in the survey in the summer of 2011. By September 2011, SMT, along with the CNL Job Analysis Committee, completed the job analysis study, which was approved by the BOC in October 2011.

In April 2012, the CNC launched a completely new multiple choice exam based upon the job analysis study. During the first testing period of the new exam from April to May 2012, more than 300 individuals registered for the exam nationwide. This was a record number of examinees for any CNL testing period (four testing periods are offered throughout the year). This testing period also resulted in a 75% pass rate on the exam, an increase from the previous 2 years.

The CNL certification exam has evolved to reflect the practice of CNLs. The CNC offers a psychometrically sound exam with exam specifications based upon the job analysis study. The exam meets national standards that were determined by practicing CNLs. The past CNL certification exam reflected the curriculum; the present exam reflects the job analysis study. Although very similar to the past exam content outline, the exam blueprint now includes subdomains in advanced clinical assessment and ethics.

The job analysis was critical in the evolution of the CNL Certification Program. The job analysis study will undoubtedly impact the CNL curriculum and also provide an overview of CNL practice to those healthcare leaders who may still seek clarity on the role.

Following initial certification, CNLs, regardless of when they earned the CNL credential, must demonstrate continuous learning to maintain their credentials.

CNLs are required to renew once every 5 years, and the renewal criteria emphasizes enhancing competency.

What is the future of the CNL Certification Program? The BOC understands that the role continues to evolve and that the assessment must be relevant to practice. The CNC is committed to conducting a job analysis study every 5–7 years. However, exam items will be reviewed annually with new exam items developed and incorporated on a continual basis. The CNC will continue to collect feedback from examinees as well as from CNL faculty to maintain a quality certification program.

Go to www.aacn.nche.edu/CNL for information about the CNL Certification Program and the CNC.