



Implementing a New Nursing Role — the Clinical Nurse Leader — for Improved Patient Care Outcomes

Final Report of the CNL Implementation Task Force February 2007

Background

Over the last decade, numerous organizations and commissions have challenged health professionals and others to transform the healthcare system and dramatically reform the preparation of healthcare professionals. In 2000, the Institute of Medicine (IOM) released its landmark report, *To Err is Human: Building a Safer Health System*, which focused on the emerging data regarding safety and errors in health care systems and challenged both health care organizations and professionals to reduce medical errors and improve patient safety. In its third report of the Chasm series—*Health Professions Education: A Bridge to Quality (2003)*—the IOM detailed the five core competencies that all health professionals should obtain to meet the needs of patients in the 21st century health care system.

These reports regarding safety and quality in health care emerged at the same time that numerous organizations reported a growing shortage of professional nursing personnel. In a report released in 2006, the American Hospital Association (AHA) estimated that U.S. hospitals faced a shortage of approximately 118,000 registered nurses (RNs) to fill vacant positions nationwide. This translated into a national RN vacancy rate of 8.5 per cent. The AHA also reported that difficulties with recruitment of registered nurses (RNs) had increased dramatically over the two years preceding their report. A number of federal agencies and health policy analysts also released dramatic projections regarding potential future shortfalls of professional nursing personnel. The Health Resources and Services Administration (HRSA) projects that the nation's nursing shortage will intensify over the next decade, with more than one million new nurses needed by 2020 (HRSA, 2002). In addition, HRSA reports that by the year 2015, this shortage will encompass the entire country with all 50 states experiencing a shortage of nurses to varying degrees.

Emerging studies on the relationship of nursing personnel shortages to the quality of care provide evidence that the mandate to improve care delivery quality and safety cannot be accomplished in the face of a dramatic nursing shortage. Needleman, Buerhaus, and Mattke (2001) documented that lower professional nurse staffing levels are associated with adverse patient outcomes including higher rates of pneumonia, urinary tract infections, length of stay and “failure to rescue.” Aiken et al. (2001) reported that low nurse-to-patient ratios are related to higher risk-adjusted 30-day mortality and “failure to rescue” rates. In addition, Aiken et al. (2001) reported that nurses practicing in settings with lower nurse-to-patient ratios were more likely to experience burnout and job dissatisfaction.

Recently, several additional studies have demonstrated that the educational level of professional nurses is directly related to the quality of patient care outcomes. Aiken, Clarke, Cheung, Sloane, and Silber (2003) reported that patients cared for in institutions with the highest percentage of nurses educated at baccalaureate or higher levels experienced lower mortality and failure-to-rescue rates. Aiken et al. (2003) also studied the quality of patient care outcomes associated with varying staffing levels of varying educational composition. In this assessment, they also found that fewer, better educated nurses achieve the same level of quality in care outcomes as a larger number of less well educated nurses. This last assessment gives an indication that a better educated nursing workforce could, in fact, decrease the demand for nursing workforce personnel.

Clearly, ample evidence exists regarding the need to expand the supply of professional nurses to meet the pressing health care needs of society. However, a growing number of experiments with health care delivery provides evidence that simply increasing the supply is an inadequate answer to the current situation. In response to concerns regarding the supply of nursing personnel and the quality of care, a number of health care systems began experimentation with different nursing roles and configurations of the nursing role characteristics. These uncoordinated, yet markedly similar experiments gave evidence that by deconstructing the work roles, and inserting a better prepared nurse for oversight and coordination of the care delivery process, greater accountability was inserted into the care process and better outcomes were achieved. Nurse executives in these systems also indicated an interest in seeing a more controlled and predictable approach to developing this new role and urged nurse educators to address this need for more skilled and competent graduates who can lead the care of patients with complex and critical care needs. These nurses would be:

- prepared for clinical leadership in all health care settings;
- prepared to implement outcomes-based practice and quality improvement strategies;
- remain in and contribute to the profession, practicing at their full scope of education and ability; and
- educated to practice within micro-systems of care responsive to the health care needs of individuals and families.

Evolution of the CNL Role

In a parallel effort to address the calls to transform professional nursing care and nursing education for the future, the American Association of Colleges of Nursing (AACN) Board of Directors launched a decision process that spanned six years and included the work of four separate AACN task forces. Through this work, the AACN Board sought to fulfill the association's mission to lead in the development of educational programs designed to address the health system's current and future needs while maintaining a strong commitment to the value of education in creating solutions to the complex health care system needs. AACN

initiated this process with the first Task Force on Education and Regulation for Professional Nursing Practice (TFER I). TFER I began its work in an effort to distinguish the significant differences in practice that could be accomplished by nurses with varying levels of education and to recommend a differentiated process of regulation for these. The final report of TFER I produced an array of models for the future of nursing education, but ended with the conclusion that a differentiation of nursing based on current models was not likely to be an achievable option. Consequently, TFER I recommended to the AACN Board that a second initiative be implemented to identify the competencies that should be achieved to deliver high quality, safe, and effective professional nursing care.

TFER II was charged in July 2002 to re-conceptualize the nursing roles and competencies needed for high quality patient care to meet the needs of society now and in the future. In addition, this task force was asked to develop a plan for the future of nursing education and regulation that will effectively meet these patient care needs. Many of the recommendations in the report of TFER II came as a result of collaboration with nurse executives who urged the development of a more highly educated, and skilled, professional nurse to model the roles with which they had experimented. The final product of this task force was the *Working Paper on the Clinical Nurse Leader*, which recommended that AACN support the initiation of master's level advanced generalist nursing education and which detailed the competencies expected for this new level of professional practice. The AACN Board accepted the final recommendations of TFER II as validation of AACN's mission to lead innovation in professional nursing education and thus committed the association to support the initiation of a national pilot effort to test interest in development of this new nursing clinician in both the academic and practice communities. TFER II also was charged in spring 2003 to explore the interest and feasibility of academic and practice partners implementing this new nursing role. In October of the same year, 284 individuals representing 100 potential partnerships attended an open exploratory meeting for all interested members and practice partners to learn about and discuss this new role, the possible implications and expectations.

At a special meeting in January 2004, the AACN Board reviewed the recommendations and experience of TFER II and the future of the CNL initiative. The Board agreed that AACN would assume leadership and engage appropriate stakeholders to ensure development of a new legal scope of practice and credential for the new nursing professional described in the CNL working paper produced by TFER II. The Board also approved establishment of the CNL Implementation Task Force (ITF) to lead the effort to launch a demonstration/pilot initiative to prepare CNLs at the master's degree level. The task force was created to include a wide array of perspectives and to assure representation from practice and education. Jolene Tornabeni, executive vice president and chief operating officer of the INOVA Health System (Virginia) agreed to chair the ITF. The full charge to the CNL Implementation TF is included below.

Work of the CNL Implementation Task Force

Charge to the CNL Implementation Task Force

The CNL Implementation Task Force (ITF) was charged by the AACN Board of Directors to:

- create parameters, develop an application and screening process, and recruit partnerships for pilot/demonstration education practice partnerships to test the CNL role;
- develop guidelines for observers attending meetings regarding the CNL implementation process;
- develop curricular parameters based on the CNL Working Paper and solicit input from the participating partners;
- develop a draft of the practice environment parameters including role expectations for CNL and solicit input from the partnerships;
- orient the education and practice partners to the evaluation expectations;
- develop and implement a monitoring process to ensure accountability to project goals;
- recommend approaches for a long term steering committee to continue implementation and evaluation of pilot/demonstration projects; and
- provide ongoing reports to the AACN Board and membership.

CNL Implementation Processes

The ITF was established as a model partnership with equal representation from education and practice. Over the course of the ITF work, representatives of several nursing organizations were added to the task force to assure the opportunity for wide spread dialogue and feedback on the process. These included representatives of the American Organization of Nurse Executives (AONE), the American Nurses Association, and the Department of Veteran's Affairs Health Administration. In addition, the ITF sought consultation and participation from other stakeholders, including the Plexus Association, the National Council of State Boards of Nursing (NCSBN), National Association of Clinical Nurse Specialists (NACNS), the United American Nurses (UAN), individual state boards of nursing, and other professional nursing organizations.

In March 2004, the ITF issued a Request for Proposal (RFP) to all AACN member schools, inviting interested schools and their practice partners to participate in the pilot project to implement the CNL role. The RFP provided guidance regarding the elements to which participating partnerships would commit, including the design of a master's 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.

In fall 2004, a second call for RFPs from interested partnerships was sent to all AACN members and the number of participating partnerships has continued to grow. Currently, 87 partnerships, representing 93 schools of nursing and 191 health care practice settings participate in the pilot. These partnerships cover 35 states plus one territory (Puerto Rico).

Between January 2005 and April 2005, a series of five regional meetings were held for all CNL education and practice partners. Three hundred eighty-eight representatives from the partnerships participated in these meetings. In addition to the education and practice representatives, 12 state boards of nursing sent representatives to the regional meetings; and representatives from the American Nurses Association, American Nurses Credentialing Center (ANCC), and the National Council of State Boards of Nursing (NCSBN) attended.

The CNL Faculty Development Workshop, hosted by the Kansas University School of Nursing, and co-sponsored with the Plexus Institute, was held in Kansas City, KS in August 2005. Over 115 faculty and clinical partners attended the one-day workshop. The CNL Faculty Development Workshop focused on designing the CNL master's curriculum, selecting and orienting preceptors, creating effective clinical experiences, and developing strategies for teaching risk assessment and quality management.

In November 2005, two listservs were implemented for all CNL partners and for all CNL students/graduates. Currently, 477 individuals participate on the partnership listserv and 180 students/graduates participate on the respective listserv. Each of these listservs has provided opportunities for those working to implement the CNL role to share ideas, ask questions, diffuse learning, and seek support. As CNL students near the end of the academic year and prepare to enter into the practice setting, the student listserv has become very active and has provided opportunities for these new or soon-to-be graduates to share experiences and offer advice.

Monthly CNL Network teleconferences were instituted in January 2006. These teleconferences are open to any of the education or practice sites participating in the CNL initiative. Topics have included the Evaluation Framework and Results of the Pilot Study, Identifying, and Orienting CNL Preceptors; and the Role and Successes of a CNO in Implementing the CNL Role. The number of partnership sites on the teleconferences ranged from 38 to 96 sites with multiple individuals present at each participating site.

Two conferences, open to all individuals participating at any of the CNL partnership sites, were held in June 2006 (in Denver and Cleveland). Attendees included faculty, chief nursing officers, nurse managers, practicing CNLs, and students. These conferences focused primarily on the implementation of the CNL in the practice setting.

Outcomes/Products of the Implementation Task Force

The ITF produced a number of major products. These products and the outcomes of the ITF work are delineated in Addendum A. This diverse range of products was developed to inform

and support efforts of the academic and practice partners to implement the CNL program in the academic setting and the role in the practice setting. One major product of the ITF is a CNL Tool Kit, which serves as a resource for practice and education as the pilot partnerships work to implement the CNL in the curriculum and in the care delivery system. The entire CNL Tool Kit can be accessed at <http://www.aacn.nche.edu/CNL/toolkit.htm>.

Dissemination

Beginning in spring 2004, the ITF has maintained a section on the AACN Web site designed to provide resources for the academic and practice partnerships including PowerPoint presentations and other materials from all conferences and presentations. In addition, all documents and materials developed by the ITF are updated regularly on the AACN Web site.

Forums and presentations have been scheduled regularly at AACN fall and spring meetings and other venues, including AACN Master's Conferences (2005 and 2006), ANA Convention (2004), Plexus Institute Conference (September 2004 and June 2006), Summer Institute for Tobacco Control Practices in Nursing Education (June 2004), the American Association of Critical Care Nurses NTI (May 2005), American Organization of Nurse Executives Annual Meeting (April 2005 and 2006), Sigma Theta Tau International meeting (November 2005), Massachusetts Organization of Nurse Executives (December 2005), the NW Organization of Nurse Executives (September 2004, March 2005, September 2005, and March 2006), the Alabama Organization of Nursing Educators (March 2006), the National Council of State Boards of Nursing APRN Roundtable (April 2006), the National Organization of Veterans Affairs Nurses (2006), and the Nebraska Nursing Leadership Coalition (2006).

Multiple updates on the CNL initiative have been highlighted in AACN's publications *NewsWatch* and *Syllabus* over the past two years. Since 2006, a bimonthly department column, entitled "Clinical Nurse Leader: The Evolution of a Revolution," edited by Jolene Tornabeni, ITF Chair, has been published in the *Journal of Nursing Administration*. In addition, a number of articles/publications on the CNL initiative have been produced by ITF members. A list of articles and other publications produced by the ITF members is included in Addendum B. ITF members also have engaged in a wide range of other dissemination activities, including numerous presentations and consultations with individual schools and professional groups.

CNL Certification

The AACN Board also recognized the need for a unique credential for graduates of the master's and post-master's CNL programs and has supported the work to develop the CNL Certification Examination. In June 2006, AACN contracted with Applied Measurement Professionals, Inc (AMP) to develop and support a Web-based CNL certification program for

AACN. In accordance with the criteria established by national certification accrediting bodies, a CNL Certification Advisory Committee (see Addendum C) oversaw the development and implementation of the certification examination, processes and eligibility criteria. AMP also hosted simultaneous item writer panel workshops in May 2006 for development of the multiple choice and the simulation/case-based examinations. In addition, two Examination Committee meetings were held in June 2006 and August 2006 to finalize the test questions and establish a cut score for passing the examination. The CNL Certification Examination was piloted from November 2006 to January 2007 by 12 schools. One hundred twenty-three candidates registered for the pilot examination. The results of the pilot examination will not be available until March 2007 (will ass results when available). The first regular administration of the CNL Certification Examination is planned for April-May 2007.

CNL Trademark/Service mark

In an effort to ensure that the title for the CNL role was protected and not applied to individuals who have not completed the appropriate master's level advanced generalist program, the AACN agreed to seek to trademark the Clinical Nurse Leader and CNL titles. Legal counsel on behalf of AACN has filed appropriate documentation and supporting materials to trademark these titles. Currently, based on recommendations from legal counsel, applications have been submitted to trademark the CNL Certification Examination and title "CNL" for those individuals who successfully complete the certification process. AACN's legal counsel has indicated that these applications have a high degree of probability of being successful.

Evaluation

Although these CNL master's programs are designed to address the issues of quality and patient safety exacerbated by professional and workforce issues of education and retention, it is important to examine the outcomes of such programs and the career progression of the graduates. Also, the impact of this innovation in clinical and leadership knowledge and skills on the practice settings and care outcomes should be documented and disseminated widely.

The first step of the CNL evaluation plan was to conduct a survey of the education/practice partners in Summer 2005. These Education and Practice Partner Surveys provided information on educational models, communication and planning processes being implemented by the partnerships; numbers and types of partnership institutions; and patient outcomes data being collected by the healthcare institutions participating in the initiative. Results from these surveys are posted on the AACN Web site under CNL Partnership Resources.

Early in their effort to design an evaluation process, the ITF and the Evaluation Committee recognized the need for CNL partnerships to use a standardized evaluation framework. Using the 2005 Education and Practice Survey results, the Evaluation Committee identified sources

and types of patient outcome data, as well as specific data collection tools, in use by the practice partners. Additionally, the Evaluation Committee, with input from the ITF, designed an evaluation framework using Norton's Balanced Scorecard model for examining the CNL role. The framework includes four evaluation domains: financial, patient satisfaction, quality/internal processes, and innovations. Specific variables under each domain, including variable name, data sources, and definitions are delineated. The CNL Evaluation Framework can be accessed at <http://www.aacn.nche.edu/CNL/pdf/tk/EvalFrmwrk.pdf>.

With oversight from the Evaluation Committee, a pilot study using the Framework was conducted at the Veterans Affairs Tennessee Valley Healthcare System (VA TVHS) located in Nashville, Tennessee. The purposes of this first pilot were to 1) test the effectiveness of the CNL; and 2) discover any obstacles in using the tool and to refine the tool, definitions, and data collection processes as necessary. Based on the results of the pilot, the Framework was revised prior to its use by additional practice partners. In addition to refining variable definitions and data collection processes, results of the pilot, which included outcomes data over a three-month period prior to and after implementing the CNL role on four separate units, demonstrated that the CNL role was having a positive impact on patient care. These early outcomes included a decrease in the readmission rates of patients discharged with the diagnosis of heart failure, decreased length of stay in patients diagnosed with heart failure, decreased patient falls, and lowered surgical infection rates 30 days post-operatively. The summary of the pilot study can be accessed at <http://www.aacn.nche.edu/CNL/pdf/tk/VAEvalSynopsis.pdf>.

In the next phase of evaluation, three practice partners—identified as early adopters—accepted an invitation to replicate the revised pilot evaluation process. These three partners included eight separate healthcare facilities, in addition to the VA Health System, comprised of acute care community hospitals, a for-profit hospital, and academic medical centers. Each site was asked to identify at least one variable from each of the four domains appropriate to the specific setting and patient care unit(s). Using a retrospective approach, data are collected from existing institutional data sources, for a minimum of three months prior to the implementation of the CNL role on the unit and for three months following the implementation of the CNL role. If possible, data also will be collected on the same outcome measures on a comparison unit at the same institution. Each site is at a slightly different point in the implementation of the CNL role; therefore, the timeline for data collection at each site varies.

To systematically describe the career progression of graduates, the Evaluation Committee created a Student-Graduate Database. Each participating school was asked to submit information on all students and graduates enrolled in CNL master's programs using a unique identifier assigned to each student. The purpose of this database is to track students during and following graduation from the CNL program. The Evaluation Committee has drafted Graduate and Employer Surveys to be administered to all CNL graduates and their immediate supervisors 6-9 months post-graduation. Data from these surveys will provide information regarding the educational programs of the CNL graduates and describe their contributions to care delivery.

A number of obstacles have impeded the development of the Student–Graduate Database. Some schools have indicated that they are not permitted to release the names and contact information for students. Other schools indicated they could only release the information after going through institutional IRB procedures. Due to these concerns, the Evaluation Committee and ITF agreed that the Student-Graduate Database should be developed but will be part of the CNL Certification application process. As a result of this procedural change, only students who graduate and register for the certification exam will be included in the database. Future evaluation efforts will continue efforts to obtain the information from CNL education programs regarding the numbers of students enrolled in the education programs and expected graduation dates.

In related work, Rose Sherman, assistant professor of nursing at Florida Atlantic University and a 2006 Robert Wood Johnson (RWJ) Executive Nurse Fellow, will conduct a research study entitled “Development of a Clinical Nurse Leader Professional Practice Model in Acute Care Settings.” The project, approved by the RWJ Nurse Executive Program staff, is to be conducted with guidance from the AACN CNL Project Team and oversight by an advisory committee comprised of education/practice partners. The primary focus of the study, using interviews with a sampling of CNL graduates, is to design a conceptual model of CNL Professional Practice in acute care settings with recommendations about best practices in role implementation.

A future, major step for the CNL evaluation initiative is to secure external funding to support a larger, national evaluation, particularly focusing on patient care outcomes. This formal evaluation would involve the use of agreed-upon measures, defined in the CNL Evaluation Framework, to examine the impact of CNLs in a national sample of health care settings. Many design approaches are possible (historical controls, national benchmarking, quasi-experimental designs). A national evaluation that focused on the impact on patient safety, improved outcomes of care, and nurse retention would address the original purposes for which the CNL pilot initiative was instituted.

Lessons Learned

This national, experimental pilot project grew to a magnitude that was unexpected but which created enormous opportunity for innovation and change. The CNL pilot is, perhaps, the largest national joint education/practice initiative designed to improve the quality and safety of patient care. The purposeful and explicit partnership of nursing education and practice is radically different than previous efforts to address significant practice issues in the past. In the view of the ITF, this unique approach holds the promise of putting nursing at the forefront of making lasting changes, which will advance the role played by the nursing profession in revolutionizing patient care delivery.

The need to establish milestones, clear yet flexible expectations, and communication channels for all initiative participants at various stages of evolution—while creating a sustainable

momentum—is key to the success of these initiatives. The size and scope of the project has grown much more rapidly than originally predicted. Although the project has not been free of challenges, many of the pilot’s early outcomes have been positive. Although many of the reported positives are not yet quantifiable, numerous stories have been shared by both academic and practice partners that can inform the ongoing work of the existing partnerships and the efforts of those interested in joining this exciting initiative.

A systematic analysis of the education and practice outcomes will be necessary in the next phase of the initiative. However, a series of anecdotes and thoughts both positive and negative are included here to highlight some of the lessons learned from both academia and practice.

- Improving patient care outcomes is the critical message and goal of this initiative. Establishing a sense of urgency, developing a common vision and communicating this vision are essential. Ongoing participation by faculty members, preceptors, and practice agency personnel is necessary at all stages. Orientation of these individuals with ongoing reinforcement about this new educational program and the new role also is necessary. Faculty development is critical to meeting the program outcomes and graduating CNLs with a new vision of professional practice and enhancing patient outcomes.
- Partnerships between academia and practice have enriched the initiative and are essential for its success. Effective bilateral communication and learning in the development and implementation process of the partnership is critical to keep the initiative moving forward. Communication forums must include the practice, academic, professional organizational, and consumer domains.
- Much of the passion and leadership needs to come from the nursing position at the highest level in the organization. Early, active, and consistent involvement of the chief nursing officer (CNO) is critical. The strongest partnerships are those in which the nursing leadership from both practice and academia are actively involved, regularly meet, maintain an open dialogue and collaborate on decisions from the initial planning through the evaluation phases of the initiative. Early adopters have the CNO leading and highly visible in the CNL initiative. At one practice institution, the CNO meets monthly with “her” CNL students to discuss how they are doing, arrange clinical opportunities, and share leadership experiences.
- Long-term evaluative assessment of the quality of patient care outcomes is an important next step. However, gathering and disseminating CNL “success stories” told by a variety of practice stakeholders, including faculty, students, CNOs, nurse managers, and staff nurses are essential for maintaining positive momentum. Student clinical portfolios created throughout the clinical immersion provide an excellent means for documenting and disseminating practice outcomes. Stories from early adopters as well as evidence of positive impact of the CNL on clinical and care environment outcomes are needed to support the implementation by practice partners. Successful implementation of the CNL role must include staff nurse buy-in and efforts to help staff nurses learn how implementation of this role will facilitate their work and help them meet mutually desirable outcomes. Practice sites should include staff nurses

and advanced practice nurses in the orientation processes for the CNL transition in efforts to explore patient care needs and gaps and in collaborative efforts to design the CNL role descriptions. Education programs must prepare graduates who can team build and engage staff in these processes.

- Practice partners need ongoing support and guidance in identifying and orienting preceptors. Preceptor/mentoring orientation programs to provide CNL role clarity are important. Students need a preceptor who will serve as an advocate for him/her in the role and collaborate with other agency leaders to ensure he/she has access to data and other clinical resources needed to gain the necessary clinical experiences.
- Success with recruitment of students to these new programs has varied among the education programs. Some academic partners report uncertainty among potential students due to the lack of clear employment availability. Several schools have initiated their first programs with a small number (2-5) of students, using this first class to successfully market the role and program to the nursing and practice communities. As the outcomes of the project are disseminated, practice settings are expressing greater interest in the education programs and the role itself. Other schools have had an abundance of applications, creating a highly competitive application process for the programs. Several programs have admitted their third cohort of students.
- The CNL Curriculum Framework, developed by the Implementation Task Force, states that graduate-level content in health assessment, pharmacology, and physiology/pathophysiology is required in the CNL education program. Although not yet documented by certification and other program outcomes, schools are urged by their practice partners to include three separate graduate-level courses in these content areas in the education program. Practice partners report that nursing leaders at the point of care must have a strong background in these three areas. Other partners and students are encouraging the inclusion of these three courses to facilitate future transition of these master's program graduates into the DNP specialty programs.
- Finally and most importantly, students and newly certified graduates need ongoing support from each other, faculty and from practice mentors when embarking on this new professional role. The CNL student-graduate listserv has provided an avenue for networking and sharing of stories regarding clinical immersion experiences, writing job descriptions, role expectations, and balancing work and study. The interactions and communications among the CNL students and new graduates reflect the support they are able to provide their colleagues:
 - “The CNL should never be short-changed on clinical education experience-- this is what has made my program so valuable to me. XXXX's curriculum is right on target with what a new or experienced nurse needs. Clinical rotations are a wealth of information and being able to work in other facilities with other leaders in case management or other roles has really enhanced my knowledge base and I can tell has already made me a better CNL.
 - “My program graduates at the end of this month. I did my CNL clinical working at XXXX on their rollout of the NDNQI RN Job Satisfaction Survey to their RNs. I've learned so much, but I've been fortunate to have wonderful preceptors.

- Seize the moment. This is your time to learn. No one will expect you to be an expert...if they do, don't be afraid to set them straight. The process will continue with or without you. Don't get to the end of your program and find that you haven't taken advantage of every experience.
- "I am curious as to the role that is being defined for students (soon to be CNLs) that have never worked as an RN. How do you think your role will be defined (if differently) and how do you think you will be accepted? I know that as a nurse with 10 years experience, it is my passion to teach nurses, but stay at the bedside. I am very interested to know your view of the role."
- "We were the first CNL class in this area, so we forged (and are still forging) our own path. We based a lot on a CNL draft job description and were evaluated midway through the residency and at the end. We did a daily unit assessment and included that and daily journal entries online to help us analyze our process. Our evaluation was based on five major concepts with subcategories in each section.
 1. Provides leadership and accountability
 2. Initiates, manages, and evaluates projects
 3. Establishes and maintains high level of collegiality
 4. Develops and effectively manages human, environmental, and material resources
 5. Advocates for patients and families, the organization, community, and the profession.
- "We each ended up developing a routine that worked in our particular area. My big focus seemed to be on patient safety issues and resource for the staff. I love the role and could spend more time on describing it but need to go for now."
- "I still had to 'prove' my worth to the staff for them to buy in to what I was trying to do which was to improve patient care. At first, they didn't want me in their charts, but as they saw how I could improve the care and documentation, they became strong supporters."
- "Two of us developed our role description as part of our course requirements during our first clinical rotation. We first gathered every nursing position's job description at our practice site and started comparing them with AACN's role description (found in CNL toolkit). We met monthly with our CNO and nurse managers to go over specifics of new role. The project really helped clarify for us what a CNL is. The position ended up being a salaried position (which we advocated for), unit-based, report to nurse manager and it addresses every component as identified in the AACN Working Paper. By having copies of other roles in the hospital, we were able to identify overlap. We utilize CNS's and a position called clinical coordinator that is comparable to an assistant nurse manager...It was really helpful actually having all job descriptions, it was a learning experience to see what the expectations for each role were ...When we transitioned from clinicals to actually working we made available all of the nursing job descriptions to all nursing staff and had a nursing grand rounds presentation."

- “I am happy to report that XXX cohort is about to finish their first semester in this program. I have a better understanding of how the role is going to apply to acute care. I know a lot of my classmates read this listserv and I hope they feel they have a better understanding about the CNL program too. I remain very excited about the role. I also feel lucky to be involved in this new role available to registered nurses. I wish everyone luck in developing this role and will look forward to reading about everyone's experiences.”
- “The first semester is drawing to a close. ...as I develop this new role in my own mind and explain it to others, I get a sense of mixed emotions. The patients and family I talk to are receptive; they will have one more health care professional helping them. It is my coworkers that are not as receptive as I would expect. Many seem to view this as just another layer of management. We will not have an easy road to travel but if we, as CNLs, can advocate for our patients, build an effective healthcare team, and improve the health of our patients then we can improve our healthcare system a little at a time.”
- “Your coworkers will learn to appreciate you and fairly quickly at that. I found that to be how it was on my unit. You are their extra set of hands and eyes. One of the newer RNs this week said to me that I ‘help her be a better nurse’ by my example and my diligence towards my patients. This whole role seems intimidating until you start doing it. You do need your health organization totally behind you to support you. P.S. I like your ‘Blaze the trail, so we can pave the road’.”
- “While I work at one of the local hospitals, I am working my CNL clinical hours for a combined project with the department of public health and the XXX fire department. The project involves coordinating such services as substance abuse support, psych resources, social services, or housing outreach for a group of persons who are frequently using the emergency departments. One of my roles is trying to figure out who is involved with each patient, such as case manager and linking everyone together. The other part is actually composing care plans for each patient with a history and potential interventions. The hardest part was putting together the proposal. Although I have a pretty good grasp (after four semesters) of the CNL role, it is so varied in different scenarios.”

Recommendations

Four broad-based recommendations have been made and accepted by the AACN Board for the next phase of the CNL initiative. The recommendations are framed to ensure continued development and assessment of the advanced generalist CNL role within the health care delivery system.

- 1) Creation of a CNL steering or oversight group with representation from education and practice: The next CNL oversight group should continue the facilitation of the initiative and maintain momentum through a variety of processes and activities. One of the key activities will be expanding the dissemination of outcomes and communication efforts and

seeking active support for the CNL initiative and outcomes from a broader audience of stakeholders. This audience of stakeholders should include presidents and provosts of the academic institutions, chief executive officers of healthcare systems and healthcare organizations, accrediting bodies, payors, and the public.

- 2) Undertake a systematic evaluation of the education and patient care outcomes realized by the CNL initiative including outcomes of the new advanced generalist master's degree curricula and the impact on patient care outcomes and nurse retention in a variety of healthcare delivery settings. Evaluation efforts should include:
 - a. AACN Institutional Data System activities to collect data on the number of CNL programs, enrollees, and graduates.
 - b. Development of a national repository of data on all CNL implementation sites, both education and practice, to include the numbers of schools/programs, number and types of practice settings.
 - c. Creation of a comprehensive graduate CNL education program database.
 - d. Post-graduation survey of all graduates focused on the positions they are filling, their educational preparation to fill these roles, and the impact they are making in the practice settings.
 - e. Survey of graduate's immediate supervisor focused on the graduate's educational preparation and impact or changes made within the practice setting.
 - f. Collection of qualitative data from the academic and practice CNL champions.
 - g. A data repository on patient care outcomes from CNL practice sites.
 - h. Expanded use of pilot evaluations, using the CNL Evaluation Framework.
 - i. A systematic national study of the patient care outcomes using a comparative methodology.
- 3) Provide consultation to those academic sites seeking to implement a new CNL, advanced-generalist graduate education program and to healthcare settings seeking to implement a new health care delivery model integrating the CNL role.
- 4) Maintain and expand the CNL Certification™ to provide a unique credential for graduates of the graduate CNL programs. Activities of the CNL Certification should include certification, recertification, and related support services.

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ADDENDUM A: CNL Implementation Task Force Products

1. Education/Curriculum Resources

- a. *Working Paper on the Role of the Clinical Nurse Leader 5/03, revised 6/04*: The Working Paper describes the new role of the Clinical Nurse Leader. AACN, in collaboration with a broad array of leaders from the practice environment, called for the creation of a new nursing role to better meet client care need within the health care delivery system. The Clinical Nurse Leader assumes accountability for client care outcomes through application of research-based information to design, implement, and evaluate plans of care.
- b. *CNL Curriculum Framework for Client-Centered Healthcare*: The curriculum framework outlines the master's level curriculum for the advanced generalist, the CNL. Some of the elements of the framework include: Nursing Leadership, Clinical Outcomes Management and Care Environment Management.
- c. *End-of-Program Competencies/Required Clinical Experiences*: This document delineates the competencies expected of every graduate of a CNL master's education program. A minimum set of clinical experiences required to attain end-of-program competencies also is included.
- d. *End-of Program Competencies & Required Clinical Experiences Checklist*: This is a checklist that can be used by faculty to document that the CNL graduate has attained the end-of program competencies and the required clinical experiences of the CNL Curriculum.
- e. *CNL Preceptor Guidelines*: This document describes the preceptor's role. The preceptor's role is to facilitate the CNL students' achievement of the end-of-program competencies. The preceptor should have a clear understanding of the CNL role functions delineated in the AACN *Working Paper on the Role of the Clinical Nurse Leader*. Although several individuals or preceptors may be identified to provide the breadth of clinical experiences necessary for the students to attain the expected competencies, one individual should be designated the preceptor of record. The document also outlines the characteristics of highly effective preceptors.
- f. *Post-master's Statement*: The CNL Implementation Task Force supports the concept of post-master's CNL programs for individuals who hold a master's degree in nursing that has prepared them for practice in another advanced generalist role or in an advanced nursing specialty. This document outlines the educational policies related to the post-master's CNL program.

2. Practice Resources

- a. *Example of a CNL Job Description for an Acute Care Setting*: This job description was developed using the broad areas of the role and required competencies identified in the working paper on the Role of the Clinical Nurse Leader. Role responsibilities were identified by focus groups of clinical staff to identify the work of the CNL in the care delivery process in an acute care setting. This job description is only one example of how the role can be actualized. Adaptation of the role will vary in different settings.

- b. *Working Statement Comparing the Clinical Nurse Leader and Clinical Nurse Specialist: Similarities, Differences, and Complementarities:* A group of Clinical Nurse Specialist (CNS) leaders were asked to work with AACN to address questions that have been raised by the nursing community related to the CNL and CNS roles.
- c. *Working Statement Comparing the Clinical Nurse Leader and Nurse Manager Roles: Similarities, Differences, and Complementarities:* A group of nurse manager leaders were asked to work with AACN to answer questions that have been raised by the nursing community related to the CNL and Nurse Manager roles.
- d. *Performance Evaluation Tool for the Practice Setting: Cross-setting Expectations for the CNL Graduate (How will you know one when you see one?)*
It is the expectation that the performance of nurses prepared at the advanced generalist master's level and certified as a CNL will meet the following criteria outlined in this document. It is suggested that performance assessment includes systematic peer evaluation, intervention team evaluations, client evaluations, supervisor evaluations, and, when appropriate, faculty/learner evaluations.
- e. *AONE Nurse of the Future/CNL Comparison Grid:* This grid attempts to answer the question: How does AONE's work on the Nurse of the Future and AACN's work on the development of the Clinical Nurse Leader role "partner"? The grid demonstrates that the AACN CNL role embodies many of the key points within the AONE Guiding Principles for the Nurse of the Future. The CNL is clearly a knowledge worker and the role aligns with AONE's Guiding Principles.
- f. *Template for CNL Implementation in the Practice Setting:* The CNL Implementation Template has been designed as a guideline to assist practice partners prepare for the successful implementation of the CNL role. This template is designed using the five areas of concentration in the change or transformation process—organizational culture, pre-implementation work, implementation, outcome evaluation, and sustaining the change. This template is designed as a resource to assist, recommend, give examples or help in thinking through the change process and to provide guidelines for strategies that leaders might consider. Partners are encouraged to select those strategies that would be of value or would assist in leading patient care delivery model changes needed to assure the successful implementation of the CNL role.
- g. *CNL and Healthcare Quality Initiatives Grid:* This grid analyzes the CNL End of Program Competencies in relation to the National Quality Initiatives, i.e., JCAHO's Patient Safety Goals, NQF's Nurse Sensitive Indicators, ANA's Magnet Status, IHI's 100K Lives Campaign, and IOM's Redesign of Care.

3. Evaluation Resources & Ongoing Projects

- a. *AACN Clinical Nurse Leader Pilot Project Evaluation Framework & Indicators:* In an effort to measure early outcomes of the CNL in a variety of practice settings, the AACN CNL Evaluation and Implementation Committees developed an evaluation framework. Based on Norton's Balanced Scorecard, four

evaluation domains (financial, patient satisfaction, quality/internal processes, and innovations) were identified. These four domains or areas for evaluation are based on an exploration of clinical and academic experiences and literature reviews. Specific measures under each domain, data sources, definitions and methods for each indicator are delineated.

- b. *The Clinical Nurse Leader Role: A Pilot Evaluation by an Early Adopter:* As an early adopter and active participant in the CNL ITF, the CNL Veterans Affairs Tennessee Valley Healthcare System (VA TVHS) partnered with the CNL Evaluation Committee to pilot the evaluation framework, variable definitions and data collection processes. Early outcomes from this pilot study are presented in this report and were presented on a CNL Teleconference..
- c. *Replication of CNL Pilot:* Four sites in addition to the VA TVHS are implementing the pilot evaluation. Each site has selected at least one measure in each of the four evaluation domains and has identified a timeframe and processes for collecting outcome. A critical step in sustaining the CNL initiative and goal of the ITF is to get evidence in front of the public that demonstrates positive outcomes.
- d. *Student/Graduate Database:* A CNL student/graduate database has been created. Individual schools were requested to submit information on all enrolled CNL students and graduates. The purpose of this database is to track students and keep up-to-date national records.
- e. *Post-graduate & Employer Survey:* The Evaluation Committee has drafted a survey for CNL graduates 6-9 months post-graduation and for immediate supervisors of the CNL graduates.

4. CNL Tool Kit

- a. *CNL Tool Kit:* This tool kit serves as a resource for practice and educational institutions/organizations implementing the CNL. Elements of the tool kit are organized around Kotter's "eight stages of change."

ADDENDUM B: ITF Generated Publications and Articles on the CNL Initiative

Dreher, M.C., & Miller, J. F. (2007). Information technology: The foundation for educating nurses as clinical leaders. In C. Weaver, C. Delaney, P. Weber, & R. Carr (eds.) *Nursing and Informatics for the 21st Century*. Chicago, Illinois: HIMSS

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