CLINICAL NURSE LEADER: KEY TO MICROSYSTEM OUTCOMES

Evidenced-Based Practice / Nursing Research Conference
Kennesaw State University Conference Center

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WellStar Health System
Objectives

The learner will:

- Describe the Clinical Nurse Leader role in relation to other nursing roles
- Identify how the CNL role can enhance care experience and outcomes
- Describe the WellStar CNL Implementation Plan
“The Clinical Nurse Leader Role is the first new role introduced in Nursing in forty years since the Nurse Practitioner Role was introduced with a great deal of professional resistance in the mid-1960s”

Loretta Ford, PHD, RN, PNP, FAAN
June 2004 AACN Meeting
CNL & CNS Roles

- **CNL** - micro systems; bedside; process focused; generalist; outcomes for individual patients at point of care; environmental assessment at point of care and unit level; creating plan for making improvements at patient level and until; use evidence to drive practice; educating and implementing policy and protocols at the bedside.

- **CNS** - macro system focused; specialists and expert clinicians in their specialty; outcomes for patient populations across units and continuum; creates and analyzes and translates evidence; policy and protocol development; creating plan for making improvements at organizational or patient population level;
The Clinical Nurse Leader™ (CNL) is:

- Advanced generalist prepared at the master’s level who oversees a cohort of patients on any nursing unit or outpatient population.

- Clinical leadership at the point of care delivery – not administration
Driving Forces for the CNL Project from the Nursing Leadership Perspective as Reported by AACN

- Patient demand exceeds nursing supply
- More complex, high risk patients who require exquisite nursing expertise
- Need for improved continuity across the continuum
- Numerous “broken systems” that require clinical leadership and intervention
- Competency levels of new graduates
- Lack of nursing leadership at the point of care
- Future reimbursement for performance on nursing sensitive indicators.
- The need to drive Evidence-Based Practice to the point of care.
Background

- Unprecedented pressure to change
- Demand – altering demographic pressures
- Demand to curb health care spending
- Shift from fee-for-service to value-based payments
- Demand to reduce care fragmentation
- Recognition and challenge to variations in care provision and, as a result, cost
Must – Do Strategies

1. Align hospitals, physicians, and other providers across the continuum of care
2. Utilize evidence-based practices to improve quality and patient safety
3. Improve efficiency through productivity and financial management
4. Develop integrated information systems
Nurses should practice to the full extent of their education and training.

Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.

Effective workforce planning and policymaking, require better data collection and an improved information infrastructure.

Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.

Ensure that nurses engage in lifelong learning.

Prepare and enable nurses to lead change to advance health.
Leadership – Advocate and Professional
Clinical Care Environment Manager – Team Manager, Information Manager, Risk Anticipator
Clinical Outcomes Manager – Clinician, Outcomes Manager, Educator
Connector and Communication facilitator
The antidote to task-oriented nursing
Model A: Master’s degree for BSN graduates (40%)
Model B: Master’s degree for BSN graduates that includes a post-BSN residency that awards master’s credit (0.5%)
Model C: Second degree Master’s degree program (55%)
Model D: ADN to Master’s degree (4%)
Model E: Post-Master’s certificate with a master’s degree in nursing in another area of study (0.5%)
117 CNL degree programs

2220 certified CNLs

2150 CNLs in practice – 31% in South/32% in West
A clinical micro-system is a small group of people who work together to provide care to discrete sub-population of patients.

It has shared clinical and business aims, linked processes, shared informational environment, and produces services which can be measured as outcomes.
Clinical Nurse Leader

The focus is:
- At the beside
- One patient unit
- Patient population specific
- Processes and patterns surrounding the patient’s care
- Patient care approach
- Team centered
- To embrace continuous improvement
- Patient outcomes

The focus is not:
- From an office
- Multiple units
- Multiple patient populations
- Large systems
- Provider focused

Clinical Team Member
Personnel Manager
The CNL in the Clinical Microsystem

- Horizontal leadership
- Support the beside staff to improve care
- Neutral, expert Clinician at point of care
- Familiar with Evidence-Based Practices
- Eliminate fragmentation
- Clinical focus rather than staffing
- Improve patient outcomes
- Improves patient and physician satisfaction
1. Lateral Integration
2. Value
3. Key Stakeholder partnerships
Lateral Integration Outcomes

- fragmentation and complexity in care
- Improve effectiveness and efficiency of multidisciplinary rounds and hand-offs
- Improve workflows and clinical processes
Value Outcomes

- **HACs and HAIs**
- **LOS in ICUs, Med-Surg units, EDs**
- **Readmission rates for high risk chronic conditions**
- **Improved pain management**
- **Core measure compliance**
- **Patient and family satisfaction**
Key Stakeholder Partnership Outcomes

- ↑ staff satisfaction and engagement
- ↑ physician satisfaction and engagement
- Improved relationships with healthcare team
- Improved continuity of care
Model A Program
1st Cohort – 17 students Fall 2011
2nd Cohort – 23 students Fall 2012
4 Semester program
Fully funded program with 3 year commitment required
Robust selection process
Why Did WellStar Decide to Implement the CNL Role?

Strategic goals:

- Provide excellence in the patient’s care experience
  - Confusing healthcare system
  - Many care providers on the team
  - Poor connections, information, and communication
- Coordination of care resulting in a streamlined, efficient inpatient process
- Nursing workforce – need for mentoring, retention and raising the level of critical and systems thinking
- Implement evidence-based practice
- Improve patient outcomes and associate satisfaction
Integrating the CNL role into the Care Model

- CNL – Led teams
- Modifies the mental models of the RN
- Brings accountability practices to life
- Fosters a Patient and Family Centered culture
Comprehensive patient and family assessment
Can identify unique health needs
Uses EBP research to act and plan care needs and mentor staff
Has responsibility, accountability, and authority to manage the care of the patient
Determine, prioritize and encourage collaboration among all providers
Communicate and coordinate those needs with other members of health care team
WellStar’s Current Status

- 1 CNL in practice at WellStar Douglas Hospital
- 17 CNL students completing clinical immersions on assigned units
- 2nd cohort of 23 began Fall 2012
- 3 CNL students from WellStar Medical Group in 2nd cohort
- CNL Scorecard developed and implemented
- CNL Staff Satisfaction Survey under development
No appropriate instruments were identified that accurately assessed staff satisfaction related to the Clinical Nurse Leader (CNL) role. A 22-item survey was developed to measure staff satisfaction related to the CNL role.

Face validity was assessed by a panel of clinical experts ($N = 5$) with experience with the CNL role. Content validity was assessed against journal articles and the American Association of Colleges of Nursing describing the CNL role. A content validity index was calculated at 0.92 indicating excellent content validity.

The items are rated on a Likert response scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores indicating greater satisfaction with the CNL role. Values above 2.5 indicate general satisfaction and values below 2.5 indicate general dissatisfaction with the CNL role. The responses to all items on the survey are averaged to obtain a mean score.

Internal consistency reliability has been demonstrated in a small sample with Cronbach’s alpha of 0.98.
The baseline survey was administered to Douglas Hospital (DH) Staff working on 2 North and 2 South from March to April 2012.

Education introducing the CNL role was conducted with staff mid-April and May 2012. Additional education provided in July to staff.

Future plans to re-administer the CNL survey mid-August to DH Staff.

Plans to administer the CNL survey in December/January to nursing units that are assigned a CNL to be able to conduct additional psychometric testing.

A majority of the staff rated the responses as “neutral” indicating staff having little to no knowledge of the CNL role.
### CNL Staff Satisfaction Pre-Survey

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<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Neutral % (N)</th>
<th>Agree % (N)</th>
<th>Strongly Agree % (N)</th>
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<tbody>
<tr>
<td>The CNL coordinates interdisciplinary care for patients</td>
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<td>The CNL functions as a teacher/educator of patients</td>
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<td>The CNL analyzes and utilizes data to guide practice</td>
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<td>The CNL plans and implements health promotion and disease prevention measures</td>
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<td>The CNL is involved in creating an organizational culture that respects human diversity</td>
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<td>The CNL allows me to spend time with my patients</td>
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<td>The CNL is highly visible and accessible to staff</td>
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<td>High standards of nursing care are expected by the CNL</td>
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“Embed innovation in the culture to see the light of opportunity”
References

Clinical Nurse Leader Outcome's Literature Review

Article


Important Points from Article

- A 26 bed Progressive Care Unit (PCU) in a metropolitan, 119-bed medical teaching hospital in California (RN-patient ratios 1:3). 2 CNLs accountable for 13 patients each and worked a 40-hour work week. After 4 months, customer services scores improved, physician rounding was solidified, and nurses felt more support.
Clinical Nurse Leader Outcome's Literature Review

Article

Important Points from Article

- **2007 pilot project** at seven VA Medical Centers implemented the CNL role. Each CNL selected one to two indicators (financial, quality processes, satisfaction, and innovations - through journaling) and collected data for a scorecard. Nursing hours per patient day pre-CNL was 6.09 and post-CNL 6.74 hours.
- RN hours per patient day increased from 3.76 to 4.07. Changes were attributed to CNL facilitation with problem solving, decision making, and improvement in patient flow. CNL role was incorporated into the nurse staffing pattern.
- Cancellations in perioperative and GI scheduling procedures - cancelation rate pre was 14.4% and post 11.4% for total cost savings of $461,775.00. Sitter hours significantly reduced from 676 hours per month to 24 hours per month - cost savings $10,243 (CNL developed and initiated a clinical decision protocol for patients with dementia).
- Pressure ulcer prevalence was 12.5% and decreased to 4.2%. Falls decreased from 1.93 to 1.37. Discharge teaching compliance pre-CNL was 13% and improved to 100% compliance. VAP was 28 and decreased to 9.
- Multiple innovative stories were obtained through journaling and included collaborations with teams to reduce care fragmentation, customizing care at the microsystems level, and engaging physicians who embraced the role and became advocates for shifting resources to attain additional CNLs. A majority of the CNLs published and presented at national conferences.
Clinical Nurse Leader Outcome's Literature Review

Article

Important Points from Article

- 2 nurses and 2 techs for a 12 hour shift on 43 bed cardiac pulmonary unit. Staffing ratios included 1:5 nurse patient ratio, one unit secretary, and 1:8 tech patient ratio. The CNL role consisted of reviewing issues related to continuity of care, providing patient education, assisting staff with patient care issues, resolving issues involving all diagnostic procedures and tests, mentoring staff, and providing on the job training to staff. Measures included NDNQI data, nurse job satisfaction, nurse recruitment and retention, patient and physician satisfaction, contract labor usage, and length of stay.

- Patient's satisfaction with nursing care was 83.1% and increased to 85%. Skill of the nurse was 83% and increased to 89.5%. Physicians did not have confidence in the quality of nursing care provided (pre-pilot) and post-pilot physicians felt confident in quality nursing care (improved 95%).

- Length of stay (LOS) decreased by 9% (0.41 days) cost savings of $416,150.00. Agency staff was decreased by $120,165.00 38% reduction in restraint usage and no codes occurred during the pilot.
Clinical Nurse Leader Outcome's Literature Review


Important Points from Article

- Case studies presented that evaluated the impact the CNL role had on care outcomes. Improvements in core measures were noted. The CNL evaluation scorecard (similar to Otts et al. study) partnered after the Kaplan and Norton (1992) Balanced Scorecard was used and included four domains: quality internal processes, satisfaction, financial outcomes, and innovation.
- 733 bed academic center in Northeast Florida piloted the CNL role on a 17 bed oncology unit with 12 RNs, one LPN, and five techs. CNL used journaling, to document innovation and themes identified included: communication, risk assessment, care coordination, outcome management, and patient education. Pain management improved from 82% to 88%, fall rate 3.04 to 2.55, and nurse's response to call lights went from 58% to 72%.
- 4-hospital 1200 bed health system Clearwater, Florida implemented the CNL role on two units: 45 bed oncology unit and 43 bed medical surgical unit with 15 remote telemetry beds. The CNL was responsible for 14 patients and the other CNL was responsible for the 15 remote telemetry patients.
- Two year findings: Retention of three nurses were identified (possible cost savings of $150,000), 100% compliance with pneumonia and flu vaccine, no pressure ulcer development, one fall with injury on the oncology and zero on the remote telemetry unit. LOS decreased by 0.87 days for the oncology unit.
- 194 bed Port St Lucie, Florida piloted the CNL role on 36 bed PCU and 45 bed medical surgical unit for one year. The CNL was assigned 18 to 23 patients and worked with 3 RNs and 2 techs. Nurse turnover went from 11.2% to 2.6%, patient satisfaction from 3.25 to 3.64, physician satisfaction from 2.96 to 3.13, core measures AMI from 90% to 97%, CHF from 91% to 96%, and pneumonia from 80% to 85%.