American Association *of* Colleges *of* Nursing

ADVANCING HIGHER EDUCATION IN NURSING

Competencies and Curricular Expectations for Clinical Nurse Leader[SM] Education and Practice

October 2013

CNL Clinical Nurse Leader

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American Association of Colleges of Nursing

Competencies and Curricular Expectations for Clinical Nurse Leader℠ Education and Practice

October 2013

CLINICAL NURSE LEADER EXPERT PANEL

Pamela Abraham, MSN, RN, CNL
Clinical Nurse Leader
Hunterdon Medical Center

James Harris, DSN, RN, MBA, APRN-BC
Professor & Director of CNL Program
University of South Alabama

Marjorie M. Godfrey, PhD, RN
Co-Director, The Dartmouth Institute Microsystem
Academy & Instructor,
The Dartmouth Institute for Health Policy and Clinical Practice
Dartmouth Medical School

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

Lorraine R. Kaack, MS, RN, CNL
CNC Liaison
Clinical Nurse Leader
Bay Pines Veterans Affairs Health System

Sandra Kuntz, PhD, RN
Associate Professor
Montana State University- Bozeman

Ellen T. Kurtzman, MPH, RN, FAAN
Assistant Research Professor
School of Nursing
The George Washington University

Cathy Leahy, MSN, MEd, RN, CNL
Faculty, School of Nursing
Xavier University

Tammy Lee, MSN, RN, CNL
Clinical Nurse Leader Coordinator
Carolinas Medical Center

Nina Swan, MSN, RN, CMSRN, CNL
CNLA Liaison
Nurse Manager
Maine Medical Center

Tricia Thomas, PhD, RN, CNL
Director, Nursing Practice & Research
Trinity Health

Rita Vann, RN
Senior Vice President of Healthcare Services
Brookdale Senior Living, Inc.

Joan Stanley, PhD, RN, FAAN, FAANP, *staff liaison*
Senior Director of Education Policy

Karen S. Kesten, DNP, APRN, CCRN, PCCN, CCNS, CNE, *staff liaison*
Director of Educational Innovations

Horacio Oliveira, *staff liaison*
Education Policy and Special Projects Coordinator

INTRODUCTION

The CNL® is a master's educated nurse, prepared for practice across the continuum of care within any healthcare setting in today's changing healthcare environment. This document delineates the entry-level competencies for all Clinical Nurse Leaders (CNLs). These CNL competencies build on the American Association of Colleges of Nursing (AACN) *The Essentials of Master's Education in Nursing* (2011).

AACN, representing baccalaureate and graduate schools of nursing, in collaboration with other healthcare organizations and disciplines, first introduced the Clinical Nurse Leader (CNL) in 2003, the first new nursing role in over 35 years, to address the ardent call for change being heard in the healthcare system. The competencies deemed necessary for the CNL originally were delineated by the AACN Task Force on Education & Regulation II (TFERII) in the *Working Paper on the Clinical Nurse Leader*. In 2007, the AACN Board of Directors approved the *White Paper on the Education and Role of the Clinical Nurse Leader*. The *White Paper* provided the background, rationale, and description of the CNL role and education as well as the expected outcomes and competencies for all CNL graduates. The background, rationale, and description of CNL practice as well as the assumptions for preparing the CNL remain particularly relevant; therefore, the *White Paper* is included as an attachment to this document.

The competencies delineated here have been revised and updated to reflect CNL practice within the changing healthcare environment. Therefore, these competencies replace the competencies in the *White Paper on the Education and Role of the Clinical Nurse Leader* (February, 2007). In addition to the CNL master's level competencies, the Curriculum Framework and Clinical/Practice Expectations for CNL programs are included. These components provide the basis for the design and implementation of a master's or post-master's CNL education program and prepare the graduate to sit for the Commission on Nurse Certification (CNC) CNL Certification Examination.

CNL PRACTICE

The CNL is a leader in the healthcare delivery system in all settings in which healthcare is delivered. CNL practice will vary across settings. The CNL is not one of administration or management. The CNL assumes accountability for patient-care outcomes through the assimilation and application of evidence-based information to design, implement, and evaluate patient-care processes and models of care delivery. The CNL is a provider and manager of care at the point of care to individuals and cohorts of patients anywhere healthcare is delivered. Fundamental aspects of CNL practice include:

- Clinical leadership for patient-care practices and delivery, including the design, coordination, and evaluation of care for individuals, families, groups, and populations;
- Participation in identification and collection of care outcomes;
- Accountability for evaluation and improvement of point-of-care outcomes, including the synthesis of data and other evidence to evaluate and achieve optimal outcomes;

- Risk anticipation for individuals and cohorts of patients;
- Lateral integration of care for individuals and cohorts of patients
- Design and implementation of evidence-based practice(s);
- Team leadership, management and collaboration with other health professional team members;
- Information management or the use of information systems and technologies to improve healthcare outcomes;
- Stewardship and leveraging of human, environmental, and material resources; and,
- Advocacy for patients, communities, and the health professional team.

COMPETENCY DEVELOPMENT PROCESS

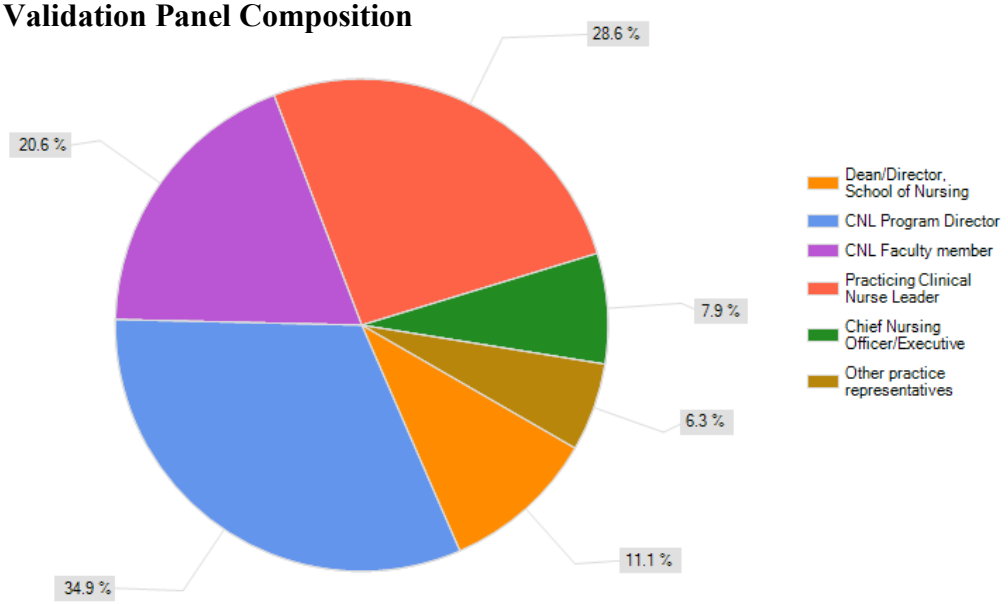
The Clinical Nurse Leader Competencies reflect a national consensus-based process. AACN facilitated the process to develop these consensus-based competencies, including the work of the national Expert Panel and external Validation Panel, both representing CNL education and practice. In addition, the Expert Panel included representation from two national stakeholder organizations: the Commission on Nurse Certification (CNC) and the Clinical Nurse Leader Association (CNLA). The process used for this project models that previously used for the development of the *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontology, Pediatric, and Women's Health (2002)* as well as a number of other nationally recognized nursing competencies.

The Expert Panel (see page 3) initially convened in April 2012 first via conference call and then face-to-face at AACN headquarters in Washington, DC. During this meeting, the panel reviewed relevant documents including the CNC Job Analysis results, AACN's *The Essentials of Master's Education in Nursing* (2011), and the *White Paper on the Education and Role of the Clinical Nurse Leader* (2007). After the face-to-face meeting, the Panel met electronically and by conference call to review and discuss the competencies. By early summer 2013 the panel reached consensus on the draft competencies and completed Phase I of the competency development process. Phase II, the validation process, was conducted in July and August 2013.

A letter of invitation to participate in the validation process was sent to 150 individuals, randomly selected from the CNL database. Invited individuals equally represented CNL education (including faculty, program directors, and deans) and practice (including chief nursing officers/nurse managers and practicing CNLs). Sixty-three individuals accepted the invitation and participated in the validation review process. The Validation Panel representation included CNOs, CNLs, faculty, and deans. Distribution and representation on the Validation Panel is shown in Figure 1. The validation tool developed originally as part of the Health Resource and Services Administration (HRSA) funded nurse practitioner primary care competencies project (2002) was adapted to a SurveyMonkey online format. The Validation Panel was asked to systematically review each CNL competency for relevance (i.e., is the competency necessary?) and specificity (i.e., is the competency stated specifically and clearly? If not, provide suggested revisions.) The Validation Panel also was asked to provide comment on the comprehensiveness of the competencies.

The validation process demonstrated overwhelming consensus with the competencies and provided valuable feedback for additional refinement. The Expert Panel met electronically four times subsequent to this process to review the validation results, revise the competencies as needed, and produce the final set of 82 competencies delineated in this document. Based on the feedback from the Validation Panel, 14 competencies were deleted, one competency was added, and 50 (61%) of the competencies underwent revision to enhance specificity or clarity. The Expert Panel also reviewed Validation Panel responses regarding required clinical expectations for CNL education programs and made final recommendations.

Figure 1: Validation Panel Composition



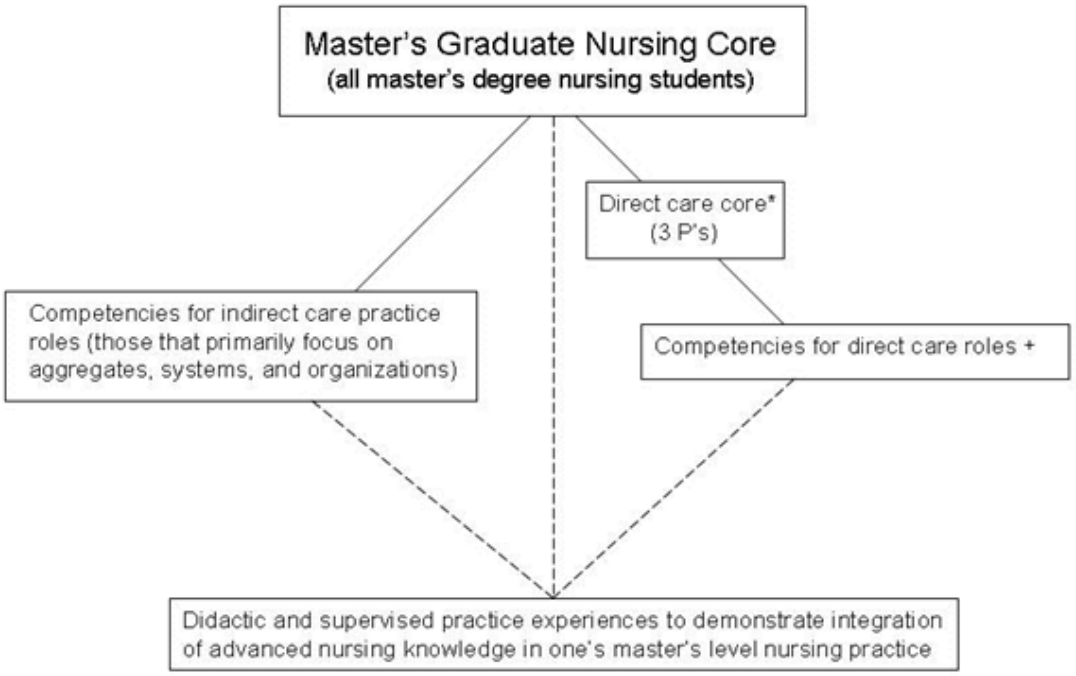
CNL CURRICULUM

The master's nursing curriculum is conceptualized in Figure 1 and includes three components (AACN, 2011, p. 7-8):

1. Graduate Nursing Core: foundational curriculum content deemed essential for all students who pursue a master's degree in nursing regardless of the functional focus.

2. Direct Care Core: essential content to provide direct patient services at an advanced level.

3. Functional Area Content: those clinical and didactic learning experiences identified and defined by the professional nursing organizations and certification bodies for specific nursing roles or functions [CNL competencies and clinical expectations].



*All master's degree programs that prepare graduates for roles that have a component of direct care practice that includes the CNL **are required to have graduate level content/coursework** in the following three areas: physiology/pathophysiology, health assessment, and pharmacology. [Although **not required**, it is recommended that the CNL curriculum include three separate graduate-level courses in these three content areas. Having CNLs at the point of care with a strong background in these three areas is seen as imperative from the practice perspective. In addition, the inclusion of these three separate courses facilitates the transition of these master's program graduates into DNP direct care (advanced practice registered nurse) programs.]

+The competencies for the CNL role are delineated in this document.

Therefore, the three components comprising the master's-level CNL curriculum include:

- Master's Graduate Nursing Core: The outcomes delineated in *The Essentials of Master's Education in Nursing*.
- Direct Care Core: Graduate level content/coursework in physiology/pathophysiology, health assessment, and pharmacology.
- CNL Role Competencies & Clinical Expectations: Delineated in this document.

These three components reflect the current knowledge base and scope of practice for entry-level CNLs. As scientific knowledge expands and the healthcare system and practice evolve in response to societal needs, CNL competencies and practice also will evolve. The periodic review and updating of these competencies will ensure their currency and reflect these changes.

The CNL master's curriculum is designed to make the graduate, if he/she chooses, eligible to matriculate to a practice- or research-focused doctoral program immediately or in the near future. It is recommended that graduate-level didactic and clinical coursework be designed to reduce duplication and repetition between the master's and doctoral-level coursework. This approach to curriculum design will allow a more seamless transition to doctoral education and career progression.

The preparation of the graduate for CNL practice assumes the previous or simultaneous attainment of the competencies delineated in *The Essentials of Baccalaureate Education for Professional Nursing Practice* (AACN, 2008). Therefore, an entry-level/2nd degree master's program preparing graduates with the CNL competencies and eligible to sit for CNL certification is expected to ensure that graduates also have attained the Baccalaureate Essentials and are prepared to sit for the national registered nurse licensure examination (NCLEX).

Table 1: Master's Essentials and Clinical Nurse Leader Competencies

The Master's Essentials and the Clinical Nurse Leader Competencies are included in this table to provide a comprehensive view of expected outcomes of CNL education. In addition, the inclusion of both sets of expected outcomes should facilitate curriculum development.

Essential 1: Background for Practice from Sciences and Humanities

Essential 1: The Essentials of Master's Education in Nursing	Essential 1: CNL Competencies
1. Integrate nursing and related sciences into the delivery of advanced nursing care to diverse populations. 2. Incorporate current and emerging genetic/genomic evidence in providing advanced nursing care to individuals, families, and communities while accounting for patient values and clinical judgment. 3. Design nursing care for a clinical or community-focused population based on biopsychosocial, public health, nursing, and organizational sciences. 4. Apply ethical analysis and clinical reasoning to assess, intervene, and evaluate advanced nursing care delivery. 5. Synthesize evidence for practice to determine appropriate application of interventions across diverse populations. 6. Use quality processes and improvement science to evaluate care and ensure patient safety for individuals and communities. 7. Integrate organizational science and informatics to make changes	1. Interpret patterns and trends in quantitative and qualitative data to evaluate outcomes of care within a microsystem and compare to other recognized benchmarks or outcomes, e.g. national, regional, state, or institutional data. 2. Articulate delivery process, outcomes, and care trends using a variety media and other communication methods to the healthcare team and others. 3. Incorporate values of social justice to address healthcare disparities and bridge cultural and linguistic barriers to improve quality outcomes. 4. Integrate knowledge about social, political, economic, environmental and historical issues into the analysis of and potential solutions to professional and healthcare issues. 5. Apply concepts of improvement science and systems theory.

in the care environment to improve health outcomes. 8. Analyze nursing history to expand thinking and provide a sense of professional heritage and identity.	

Essential 2: Organizational and Systems Leadership

Essential 2: The Essentials of Master's Education in Nursing	Essential 2: CNL Competencies
1. Apply leadership skills and decision making in the provision of culturally responsive, high-quality nursing care, healthcare team coordination, and the oversight and accountability for care delivery and outcomes. 2. Assume a leadership role in effectively implementing patient safety and quality improvement initiatives within the context of the interprofessional team using effective communication (scholarly writing, speaking, and group interaction) skills. 3. Develop an understanding of how healthcare delivery systems are organized and financed (and how this affects patient care) and identify the economic, legal, and political factors that influence health care. 4. Demonstrate the ability to use complexity science and systems	1. Demonstrate working knowledge of the healthcare system and its component parts, including sites of care, delivery models, payment models, and the roles of health care professionals, patients, caregivers, and unlicensed professionals. 2. Assume a leadership role of an interprofessional healthcare team with a focus on the delivery of patient-centered care and the evaluation of quality and cost-effectiveness across the healthcare continuum. 3. Use systems theory in the assessment, design, delivery, and evaluation of health care within complex organizations. 4. Demonstrate business and economic principles and

theory in the design, delivery, and evaluation of health care. 5. Apply business and economic principles and practices, including budgeting, cost/benefit analysis, and marketing, to develop a business plan. 6. Design and implement systems change strategies that improve the care environment. 7. Participate in the design and implementation of new models of care delivery and coordination.	practices, including cost-benefit analysis, budgeting, strategic planning, human and other resource management, marketing, and value-based purchasing. 5. Contribute to budget development at the microsystem level. 6. Evaluate the efficacy and utility of evidence-based care delivery approaches and their outcomes at the microsystem level. 7. Collaborate with healthcare professionals, including physicians, advanced practice nurses, nurse managers and others, to plan, implement and evaluate an improvement opportunity. 8. Participate in a shared leadership team to make recommendations for improvement at the micro-, meso- or macro-system level.

Essential 3: Quality Improvement and Safety

Essential 3: The Essentials of Master's Education in Nursing	Essential 3: CNL Competencies
1. Analyze information about quality initiatives recognizing the contributions of individuals and inter-professional healthcare teams to improve health outcomes across the continuum of care. 2. Implement evidence-based plans based on trend analysis and quantify the impact on quality and safety. 3. Analyze information and design systems to sustain improvements and promote transparency using high reliability and just culture principles. 4. Compare and contrast several appropriate quality improvement models. 5. Promote a professional environment that includes accountability and high-level communication skills when involved in peer review, advocacy for patients and families, reporting of errors, and professional writing. 6. Contribute to the integration of healthcare services within systems to affect safety and quality of care to improve patient outcomes and reduce fragmentation of care. 7. Direct quality improvement methods to promote culturally responsive, safe, timely, effective, efficient, equitable, and patient-centered care. 8. Lead quality improvement initiatives that integrate socio-cultural factors affecting the delivery of nursing and healthcare services.	1. Use performance measures to assess and improve the delivery of evidence-based practices and promote outcomes that demonstrate delivery of higher-value care. 2. Perform a comprehensive microsystem assessment to provide the context for problem identification and action. 3. Use evidence to design and direct system improvements that address trends in safety and quality. 4. Implement quality improvement strategies based on current evidence, analytics, and risk anticipation. 5. Promote a culture of continuous quality improvement within a system. 6. Apply just culture principles and the use of safety tools, such as Failure Mode Effects Analysis (FMEA) and root cause analysis (RCA), to anticipate, intervene and decrease risk. 7. Demonstrate professional and effective communication skills, including verbal, non-verbal, written, and virtual abilities. 8. Evaluate patient handoffs and transitions of care to improve outcomes.

	9. Evaluate medication reconciliation and administration processes, to enhance the safe use of medications across the continuum of care. 10. Demonstrate the ability to develop and present a business plan, including a budget, for the implementation of a quality improvement project/initiative. 11. Use a variety of datasets, such as Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), nurse sensitive indicators, National Data Nursing Quality Improvement (NDNQI), and population registries, appropriate for the patient population, setting, and organization to assess individual and population risks and care outcomes.

Essential 4: Translating and Integrating Scholarship into Practice

Essential 4: The Essentials of Master's Education in Nursing	**Essential 4: CNL Competencies**
1. Integrate theory, evidence, clinical judgment, research, and interprofessional perspectives using translational processes to improve practice and associated health outcomes for patient aggregates. 2. Advocate for the ethical conduct of research and translational scholarship (with particular attention to the protection of the patient as a research participant). 3. Articulate to a variety of audiences the evidence base for practice decisions, including the credibility of sources of information and	1. Facilitate practice change based on best available evidence that results in quality, safety and fiscally responsible outcomes. 2. Ensure the inclusion of an ethical decision-making framework for quality improvement. 3. Implement strategies for encouraging a culture of inquiry within the healthcare delivery team. 4. Facilitate the process of retrieval, appraisal, and synthesis of

the relevance to the practice problem confronted. 4. Participate, leading when appropriate, in collaborative teams to improve care outcomes and support policy changes through knowledge generation, knowledge dissemination, and planning and evaluating knowledge implementation. 5. Apply practice guidelines to improve practice and the care environment. 6. Perform rigorous critique of evidence derived from databases to generate meaningful evidence for nursing practice.	evidence in collaboration with healthcare team members, including patients, to improve care outcomes. 5. Communicate to the interprofessional healthcare team, patients, and caregivers current quality and safety guidelines and nurse sensitive indicators, including the endorsement and validation processes. 6. Apply improvement science theory and methods in performance measurement and quality improvement processes. 7. Lead change initiatives to decrease or eliminate discrepancies between actual practices and identified standards of care. 8. Disseminate changes in practice and improvements in care outcomes to internal and external audiences. 9. Design care based on outcome analysis and evidence to promote safe, timely, effective, efficient, equitable, and patient-centered care.

Essential 5: Informatics and Healthcare Technologies

Essential 5: The Essentials of Master's Education in Nursing	Essential 5: CNL Competencies
1. Analyze current and emerging technologies to support safe practice environments, and to optimize patient safety, cost-effectiveness, and health outcomes. 2. Evaluate outcome data using current communication technologies, information systems, and statistical principles to develop strategies to reduce risks and improve health outcomes. 3. Promote policies that incorporate ethical principles and standards for the use of health and information technologies. 4. Provide oversight and guidance in the integration of technologies to document patient care and improve patient outcomes. 5. Use information and communication technologies, resources, and principles of learning to teach patients and others. 6. Use current and emerging technologies in the care environment to support lifelong learning for self and others.	1. Use information technology, analytics, and evaluation methods to: a. collect or access appropriate and accurate data to generate evidence for nursing practice; b. provide input in the design of databases that generate meaningful evidence for practice; c. collaborate to analyze data from practice and system performance; d. design evidence-based interventions in collaboration with the health professional team; e. examine patterns of behavior and outcomes; and f. identify gaps in evidence for practice 2. Implement the use of technologies to coordinate and laterally integrate patient care within, across care settings and among healthcare providers. 3. Analyze current and proposed use of patient-care technologies, including their cost-effectiveness and appropriateness in the design and delivery of care in diverse care settings. 4. Use technologies and information systems to facilitate the

	collection, analysis, and dissemination of data including clinical, financial and operational outcomes. 5. Use information and communication technologies to document patient care, advance patient education, and enhance accessibility of care. 6. Participate in ongoing evaluation, implementation and integration of healthcare technologies, including the electronic health record (EHR). 7. Use a variety of technology modalities and media to disseminate healthcare information and communicate effectively with diverse audiences.

Essential 6: Health Policy and Advocacy

Essential 6: The Essentials of Master's Education in Nursing	**Essential 6: CNL Competencies**
1. Analyze how policies influence the structure and financing of health care, practice, and health outcomes. 2. Participate in the development and implementation of institutional, local, and state and federal policy. 3. Examine the effect of legal and regulatory processes on nursing practice, healthcare delivery, and outcomes. 4. Interpret research, bringing the nursing perspective, for policy makers and stakeholders.	1. Describe the interaction between regulatory agency requirements, (such as The Joint Commission (TJC), Centers for Medicare and Medicaid (CMS), or Healthcare Facilities Accreditation Program (HFAP)), quality, fiscal and value-based indicators. 2. Articulate the contributions and synergies of the CNL with other nursing and interprofessional team member roles, to policy makers, employers, healthcare providers, consumers,

5. Advocate for policies that improve the health of the public and the profession of nursing.	and other healthcare stakeholders. 3. Advocate for policies that leverage social change, promote wellness, improve care outcomes, and reduce costs. 4. Advocate for the integration of the CNL within care delivery systems, including new and evolving models of care.

Essential 7: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

Essential 7: The Essentials of Master's Education in Nursing	**Essential 7: CNL competencies**
1. Advocate for the value and role of the professional nurse as member and leader of interprofessional healthcare teams. 2. Understand other health professions' scopes of practice to maximize contributions within the healthcare team. 3. Employ collaborative strategies in the design, coordination, and evaluation of patient-centered care. 4. Use effective communication strategies to develop, participate, and lead interprofessional teams and partnerships. 5. Mentor and coach new and experienced nurses and other members of the healthcare team. 6. Function as an effective group leader or member based on an in-depth understanding of team dynamics and group processes.	1. Create an understanding and appreciation among healthcare team members of similarities and differences in role characteristics and contributions of nursing and other team members. 2. Advocate for the value and role of the Clinical Nurse Leader (CNL) as a leader and member of interprofessional healthcare teams. 3. Facilitate collaborative, interprofessional approaches and strategies in the design, coordination, and evaluation of patient-centered care. 4. Facilitate the lateral integration of healthcare services across the continuum of care with the overall objective of

	influencing, achieving and sustaining high quality care. 5. Demonstrate a leadership role in enhancing group dynamics and managing group conflicts. 6. Facilitate team decision making through the use of decision tools and convergent and divergent group process skills, such as SWOT, Pareto, and brainstorming. 7. Assume a leadership role, in collaboration with other interprofessional team members, to facilitate transitions across care settings to support patients and families and reduce avoidable recidivism to improve care outcomes.

Essential 8: Clinical Prevention and Population Health for Improving Health

Essential 8: The Essentials of Master's Education in Nursing	**Essential 8: CNL Competencies**
1. Synthesize broad ecological, global and social determinants of health; principles of genetics and genomics; and epidemiologic data to design and deliver evidence based, culturally relevant clinical prevention interventions and strategies. 2. Evaluate the effectiveness of clinical prevention interventions that affect individual and population-based health outcomes using health information technology and data sources. 3. Design patient-centered and culturally responsive strategies in the delivery of clinical prevention and health promotion interventions and/or services to individuals, families, communities, and aggregates/clinical populations.	1. Demonstrate the ability to engage the community and social service delivery systems that recognize new models of care and health services delivery. 2. Participate in the design, delivery, and evaluation of clinical prevention and health promotion services that are patient-centered and culturally appropriate. 3. Monitor the outcomes of comprehensive plans of care that address the health promotion and disease prevention needs of patient populations

4. Advance equitable and efficient prevention services, and promote effective population-based health policy through the application of nursing science and other scientific concepts. 5. Integrate clinical prevention and population health concepts in the development of culturally relevant and linguistically appropriate health education, communication strategies, and interventions.	4. Apply public health concepts to advance equitable and efficient preventive services and policies that promote population health 5. Engage in partnerships at multiple levels of the health system to ensure effective coordination, delivery, and evaluation of clinical prevention and health promotion interventions and services across care environments. 6. Use epidemiological, social, ecological, and environmental data from local, state, regional, and national sources to draw inferences regarding the health risks and status of populations, to promote and preserve health and healthy lifestyles. 7. Use evidence in developing and implementing teaching and coaching strategies to promote and preserve health and healthy lifestyles in patient populations. 8. Provide leadership to the healthcare team to promote health, facilitate self-care management, optimize patient engagement and prevent future decline including progression to higher levels of care and readmissions. 9. Assess organization-wide emergency preparedness plans and the coordination with the local, regional, and National Incident Management System (NIMS).

Essential 9: Master's-Level Nursing Practice

Essential 9: The Essentials of Master's Education in Nursing	Essential 9: CNL Competencies
1. Conduct a comprehensive and systematic assessment as a foundation for decision making.	1. Conduct a holistic assessment and comprehensive physical examination of individuals across the lifespan.
2. Apply the best available evidence from nursing and other sciences as the foundation for practice.	2. Assess actual and anticipated health risks to individuals and populations.
3. Advocate for patients, families, caregivers, communities and members of the healthcare team.	3. Demonstrate effective communication, collaboration, and interpersonal relationships with members of the care delivery team across the continuum of care.
4. Use information and communication technologies to advance patient education, enhance accessibility of care, analyze practice patterns, and improve healthcare outcomes, including nurse sensitive outcomes.	4. Facilitate modification of nursing interventions based on risk anticipation and other evidence to improve healthcare outcomes.
5. Use leadership skills to teach, coach, and mentor other members of the healthcare team.	5. Demonstrate the ability to coach, delegate, and supervise healthcare team members in the performance of nursing procedures and processes with a focus on safety and competence.
6. Use epidemiological, social, and environmental data in drawing inferences regarding the health status of patient populations and interventions to promote and preserve health and healthy lifestyles.	6. Demonstrate stewardship, including an awareness of global environmental, health, political, and geo-economic factors, in the design of patient care.
7. Use knowledge of illness and disease management to provide evidence-based care to populations, perform risk assessments, and design plans or programs of care.	7. Facilitate the lateral integration of evidence-based care across settings and among care providers to promote quality, safe, and coordinated care.
8. Incorporate core scientific and ethical principles in identifying potential and actual ethical issues arising from practice, including the use of technologies, and in assisting patients and other healthcare providers to address such issues.	8. Facilitate transitions of care and safe handoffs between

9. Apply advanced knowledge of the effects of global environmental, individual and population characteristics to the design, implementation, and evaluation of care. 10. Employ knowledge and skills in economics, business principles, and systems in the design, delivery, and evaluation of care. 11. Apply theories and evidence-based knowledge in leading, as appropriate, the healthcare team to design, coordinate, and evaluate the delivery of care. 12. Apply learning, and teaching principles to the design, implementation, and evaluation of health education programs for individuals or groups in a variety of settings. 13. Establish therapeutic relationships to negotiate patient-centered, culturally appropriate, evidence-based goals and modalities of care. 14. Design strategies that promote lifelong learning of self and peers and that incorporate professional nursing standards and accountability for practice. 15. Integrate an evolving personal philosophy of nursing and healthcare into one's nursing practice.	healthcare settings, providers, and levels of care. 9. Evaluate the effectiveness of health teaching by self and others. 10. Facilitate the implementation of evidence-based and innovative interventions and care strategies for diverse populations. 11. Design appropriate interventions using surveillance data and infection control principles to limit healthcare acquired infections (HAI) at all points of care. 12. Advocate for patients within the healthcare delivery system to effect quality, safe, and value-based outcomes. 13. Collaborate in the development of community partnerships to establish health promotion goals and implement strategies to address those needs. 14. Evaluate the care of at risk populations across the lifespan by identifying and implementing programs that address specialized needs. 15. Engage individuals and families to make quality of life decisions, including palliative and end-of-life decisions. 16. Assess an individual's and group's readiness and ability to make decisions, develop, comprehend, and follow a plan of care. 17. Assess the level of cultural awareness and sensitivity of healthcare providers as a component of the evaluation of care

	delivery. 18. Demonstrate coaching skills, including self-reflection, to support new and experiences interdisciplinary team members in exploring opportunities for improving care processes and outcomes. 19. Use coaching techniques to assist individuals in developing insights and skills to improve their current health status and function.

Glossary:

Care Coordination: the deliberate organization of patient care activities among two or more participants, including the patient and/or the family, to facilitate the appropriate delivery of health care services. (NTOCC, 2008)

Care Transitions: Transitions of Care refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. (NTOCC, 2008)

CURRICULAR ELEMENTS & STRUCTURE

Master's CNL Program Length

To prepare a CNL graduate with the necessary graduate-level content post attainment of the baccalaureate competencies, it is recommended that the CNL graduate-level curriculum, including the clinical immersion experience, be designed within an 18-month timeframe depending upon the institution's academic calendar (semesters or quarters.) Graduates of all master's degree CNL programs: post-baccalaureate, RN-MSN, and second-degree master's programs are expected to attain the master's and CNL competencies delineated in this document.

Post-Master's CNL Program

Post-master's CNL programs prepare individuals who hold a master's degree in nursing or related field for CNL practice and to sit for the CNL certification exam. Post-master's students must successfully complete graduate didactic and clinical requirements of a master's CNL program through a formal graduate-level certificate or master's level CNL program. Post-master's students are expected to master the same outcome competencies as master's CNL students, including the Essential master's core competencies and the CNL competencies. In addition, graduate level content or courses in pharmacotherapeutics, physiology/pathophysiology, and health assessment is required. Post-master's CNL students are required to complete a minimum of 300 hours in a supervised clinical immersion practicum that provides the opportunity to practice in the CNL role. Additional information on post-master's program expectations, including a list of the elements and content identified as critical to CNL preparation and practice, as well as a sample form for completing an analysis or previous graduate coursework, can be found in *Statement on Post-Master's CNL Certificate Program* (AACN, 2009)

Clinical/Practice Expectations for the CNL Education Program

The CNL education program provides sufficient didactic and clinical experiences to prepare the graduate with the competencies delineated in this document. It is expected that faculty assess the types of experiences, patient populations and settings, and length of experiences afforded each student to ensure that he/she is prepared to practice as a CNL with the knowledge, skills, and abilities that are applicable across the continuum of care and in any setting where healthcare is provided.

A variety of experiences should include opportunities to integrate the student's new learning into practice. The total number of clinical hours should be determined by the CNL program faculty. However, each CNL student should complete a minimum of 400 clinical/practice hours as part of the education program. In addition to the clinical/practice experiences integrated throughout the education program, an extended practice immersion experience, prior to graduation, mentored by an experienced CNL or other appropriate clinicians/professionals, is critical to the effective integration of CNL practice into the healthcare delivery system. A minimum of 300 of the 400 total practice hours should be dedicated to the immersion experience(s).

The intensive immersion into CNL practice should provide the student with the opportunity to practice in a chosen healthcare environment(s) and to integrate into one's practice the knowledge, skills, and attitudes (KSAs) acquired throughout the CNL education experience. The integrative experience(s) should occur in a practice environment that allows for the full implementation of CNL practice. In addition, a strong interprofessional practice focus should be embedded into the experience. Ideally, the student should have the opportunity, either face-to-face or virtually, to be precepted or mentored by an experienced CNL. The immersion may be completed in one setting or in several settings with different preceptors depending upon the needs of the student. To provide the opportunity for the student to more fully engage with an interprofessional team and practice environment, and to implement new knowledge and skills into one's practice, it is recommended that the immersion experience(s) be designed over a 10- to 15-week period of time. Practice is defined broadly as:

> *Any form of nursing intervention that influences health care outcomes for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and health care organization, and the development and implementation of health policy.* (AACN, 2004, p.2)

IMPORTANCE OF ACADEMIC PRACTICE PARTNERSHIPS

> *Academic/Practice Partnerships are an important mechanism to strengthen nursing practice and help nurses become well positioned to lead change and advance health. Through implementing such partnerships, both academic institutions and practice settings will formally address the recommendations of the Future of Nursing Committee (2011). Effective partnerships will create systems for nurses to achieve educational and career advancement, prepare nurses of the future to practice and lead, provide mechanisms for lifelong learning…* (AACN, 2012, p.1)

Significant impact on the healthcare system and successful outcomes will not be realized unless there is true partnership and collaboration between the education and practice arenas. Individuals educated with the new CNL competencies will be more successful in effecting change and improving care outcomes if the healthcare setting also has evolved. The rapid rate of change in healthcare knowledge and practice requires collaboration and input from both academia and practice. Therefore, schools of nursing developing a CNL program are strongly encouraged to actively engage in developing and sustaining true Academic-Practice partnerships. Successful change in both the practice environment and nursing education requires committed and active partnerships between education and practice in nursing and with other health professions. Improvement in health care outcomes, the ultimate goal, can only occur through meaningful and dedicated partnerships and a willingness to commit significant resources and energy to realizing this goal.

CNL CERTIFICATION

After successful completion of the formal CNL education program, including the total 400 practice hours with 300 hours of immersion in CNL practice, the CNL graduate will be eligible

to sit for the CNL Certification Examination offered by the Commission on Nurse Certification (CNC), an autonomous arm of AACN. Students are encouraged to sit for the CNL Certification Exam during their last term of a CNL master's or post-master's program or as soon after graduation as possible. Program directors of students sitting for the exam in the last term must attest that the student will have completed the required clinical and immersion hours prior to graduation.

Individuals in entry-level/2nd degree master's programs that prepare the graduate with the CNL competencies may sit for the CNL Certification Examination prior to sitting for the NCLEX Registered Nurse (RN) licensure exam. However, a candidate will not be granted CNL certification status until documentation of RN licensure is received by the CNC.

For additional information regarding CNL Certification go to www.aacnnursing.org/CNL-Certification

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INSTITUTIONS REPRESENTED ON CNL VALIDATION PANEL (N=53)

Carolinas Medical Center
Central Arkansas Veterans Healthcare System
Curry College
Federal Healthcare System
Georgia Regents University
Grand View University
Hunterdon Medical Center
Illinois State University
James Madison University
Jesse Brown VA Medical Center
MD Anderson Cancer Center
Mercy Health Saint Mary's
Morton Plant Mease Health Care
OSF Saint Anthony Medical Center
Otterbein University
Pacific Lutheran University
Queens University
Rush University
Saint Anthony College of Nursing
Saint Louis University
Saint Mary's Health Care
Seton Hall University
Sinai Hospital of Baltimore
South Dakota State University
South Texas Veterans Health Care System
Southern New Hampshire University
Spring Hill College
Texas Christian University
Texas Health Resources - Fort Worth
The University of Tennessee Health Science Center
The University of Texas Health Science Center at San Antonio
The University of Toledo
Trinity Health Saint Mary's
University of Alabama at Birmingham
University of Central Florida
University of Detroit Mercy
University of Florida
University of Maryland
University of Northern Colorado
University of Pittsburgh
University of San Diego
University of San Francisco
University of Toledo
University of Virginia
University of West Georgia
University of Wisconsin-Milwaukee
VA Boston Healthcare System
VA Connecticut Healthcare System
VA Palo Alto Health Care System
VA Philadelphia
VHA Network
WellStar Health System
Western New Mexico University

APPENDIX A

[Excerpts from the *White Paper on the Education and Role of the Clinical Nurse Leader* (2007) are included here. These components of the *White Paper* are considered historical and provide background information regarding the development and early implementation of the CNL.]

American Association of Colleges of Nursing

White Paper on the Education and Role of the Clinical Nurse Leader ™

February 2007
(revised and approved by AACN Board of Directors July 2007)

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PREFACE

This document delineates *both* the entry-level competencies for all professional nurses (Essentials of Baccalaureate Education for Professional Nursing Practice 1998) and those competencies of the Clinical Nurse Leader ™, an advanced generalist role. The competencies deemed necessary for the CNL role originally were delineated by the AACN Task Force on Education & Regulation II (TFERII) in the *Working Paper on the Clinical Nurse Leader* and accepted by the AACN Board (2003). Therefore, the competencies delineated here include all of the competencies deemed necessary for all graduates of a CNL education program.

In addition to the CNL graduate competencies, the Curriculum Framework which includes required curricular components, required clinical experiences, and overarching end-of-program competencies are included. These components provide the basis for the design and implementation of a master's or post-master's CNL education program and prepare the graduate to sit for the AACN CNL Certification Examination.

INTRODUCTION

Nursing education and the profession have an unparalleled opportunity and capability to address the critical issues that face the nation's current health care system. The American Association of Colleges of Nursing (AACN), representing baccalaureate and graduate schools of nursing, in collaboration with other health care organizations and disciplines, proposes a new Clinical Nurse Leader (CNL) role to address the ardent call for change being heard in today's health care system.

It is evident… that leadership in nursing . . . is of supreme importance at this time. Nursing has faced many critical situations in its long history, but probably none more critical than the situation it is now in, and none in which the possibilities, both of serious loss and of substantial advance, are greater. What the outcome will be depends in large measure on the kind of leadership the nursing profession can give in planning for the future and in solving stubborn and perplexing problems. . . if past experience is any criterion, little constructive action will be taken without intelligent and courageous leadership[1].

Isabel Maitland Stewart wrote those words over fifty years ago in her petition for education reform in nursing. Perhaps their most staggering revelation is that despite all of nursing's progress in recent decades, as a profession, nursing remains at the same 'critical' juncture where it was at the end of World War II. Despite the promise of university-based education for professional nursing, the health care system is in yet another nursing shortage with yet another call for 'intelligent and creative leadership.'

The *good* news is that nursing has the answers to the predominant health care dilemmas of the future, including

- the problems associated with normal human development, particularly aging;
- chronic illness management in all ages;

- health disparities associated with socioeconomic dislocations such as global migration, classism, sexism, and
- strategies for health promotion and disease prevention.

Each of these prevailing health problems is suited to the nursing paradigm. Their amelioration is what nursing students are educated to do. The advancement of medical science and technology has changed the landscape of health and illness. Not only are people living much longer, they are living with chronic illnesses that would have been fatal twenty years ago. This is true in adults and children, resulting in the need for providers who can manage the on-going health needs of persons of all ages. The necessity for practitioners who focus on the promotion of health and wellness and the prevention of disease has emerged as not only a good and wholesome thing to do in our society, but also as a means of addressing escalating medical costs. Whether working with older adults, children, refugees, ethnic minorities, persons with chronic illness, or whole communities, the predominant theme is the promotion and maintenance of health and the improvement of health care outcomes.

BACKGROUND

In November 1999, the Institute of Medicine (IOM) issued the comprehensive report on medical errors, *To Err is Human: Building a Safer Health System.* The report, extrapolating data from two previous studies, estimates that somewhere between 44,000 and 98,000 Americans die each year as a result of medical errors.[2] These numbers, even at the lower levels, exceed the number of people that die from motor vehicle accidents, breast cancer or AIDs. Total national costs of preventable adverse events (medical errors resulting in injury) were estimated to be between $17 billion and $29 billion, of which health care costs represented over one-half.[3] In addition, medication-related and other errors that do not result in actual harm are not only extremely costly as well but have a significant impact on the quality of care and health care outcomes. The IOM report also focused on the fragmented nature of the health care delivery system and the context in which health care is purchased as being major contributors to the high and inexcusable error rate.

In addition to the growing concern over health care outcomes, the United States is in the midst of a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows. According to a study by Dr. Peter Buerhaus[4] and colleagues, published in the *Journal of the American Medical Association*, the U.S. will experience a 20% shortage in the number of nurses needed in our nation's health care system by the year 2020. This translates into a shortage of more than 400,000 RNs nationwide. The fall 2002 survey by the American Association of Colleges of Nursing (AACN) showed that enrollment in entry-level baccalaureate programs in nursing increased by 8% nationwide since fall 2001. This represents an increase of 5,316 enrollees and only 559 more graduates than the previous year. And despite these modest increases, enrollment is still down by almost 10% or 11,584 students from 1995.[5]

Several recent, landmark reports focus on the nursing shortage, the crisis in the health care system and proposed strategies for addressing these critical issues. The IOM report, *Crossing the Quality Chasm* (2001), stresses that the health care system as currently structured does not, as a whole, make the best use of its resources. The aging population and increased client demand for new services, technologies, and drugs contribute to the increase in health care expenditures, but

also to the waste of resources. Recommendation two in the report calls on all health care organizations and professional groups to promote health care that is safe, effective, client-centered, timely, efficient, and equitable (p. 6).[6]

In a follow-up report, *Health Professions Education: A Bridge to Quality*, the Institute of Medicine[7] Committee on the Health Professions Education states, "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics (p.3)."

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*[8] urges that "the shortage of registered nurses has the potential to impact the very health and security of our society…" Recommendations include proposals for transforming the workplace, aligning nursing education and clinical experience and providing financial incentives for health care organizations to invest in high quality nursing care.

The American Hospital Association (AHA) Commission on Workforce for Hospitals and Health Systems report, *In Our Hands: How Hospital Leaders Can Build a Thriving Workforce* (2002)[9], highlights the immediate and long-term critical workforce shortages facing hospitals. Five key recommendations include the need to foster meaningful work by designing health care to center on clients and the need to collaborate with professional associations and educational institutions to attract and prepare new health professions.

The Robert Wood Johnson Foundation in its commissioned 2002 report *Health Care's Human Crisis: The American Nursing Shortage*[10] takes a broad look at the underlying factors driving the nursing shortage. One of the key recommendations made is for the reinvention of nursing education and work environments to address and appeal to the needs and values of a new generation of nurses.

While there is ample evidence for the need to produce many more nurses to meet the pressing health care needs of society, this is not just a matter of increasing the volume of the nursing workforce. The nursing profession must produce quality graduates who:

- Are prepared for clinical leadership in all health care settings;
- Are prepared to implement outcomes-based practice and quality improvement strategies;
- Will remain in and contribute to the profession, practicing at their full scope of education and ability; and
- Will create and manage microsystems of care that will be responsive to the health care needs of individuals and families. [11,12]

In addition, unless nursing is able to create a professional role that will attract the highest quality women and men into nursing, we will not be able to fulfill our covenant with the public. The Clinical Nurse Leader (CNL) addresses the call for change.

The realities of a global society, expanding technologies, and an increasingly diverse population require nurses to master complex information, to coordinate a variety of care experiences, to use technology for health care delivery and evaluation of nursing outcomes, and to assist clients with

managing an increasingly complex system of care. The extraordinary explosion of knowledge in all fields also requires an increased emphasis on lifelong learning. Nursing education must keep pace with these changes and prepare individuals to meet these challenges. Change, however cannot occur in isolation. Nursing education must collaborate and work in tandem with the health care delivery system to design and test models for education and practice that are truly client-centered, generate quality outcomes, and are cost-effective. Significant changes must occur in both education and the practice setting to produce the delivery system desired by all constituents. New ways of educating health professionals, including inter-professional education and practice, and new practice models must be developed that better use available resources and address the health care needs of a rapidly, growing, diverse population.

EDUCATING THE CLINICAL NURSE LEADER

In response to client care needs and to the health care delivery environment, the American Association of Colleges of Nursing (AACN) proposes the Clinical Nurse Leader (CNL) role. The design of this role has been done in collaboration with constituents from a broad array of expertise and leadership roles within the health care system. Participants at the Stakeholders' Reaction Panel Meeting (2003) confirmed that this role has emerged and is being further developed on an ad hoc basis. Individuals to fill this role are being recruited opportunistically based on available clinicians with appropriate experience, personal characteristics, and self-selection. Stakeholders affirmed the need to produce these clinicians through a formal degree-granting program of education.

The CNL is a leader in the health care delivery system across all settings in which health care is delivered, not just the acute care setting. The implementation of the CNL role, however, will vary across settings. The CNL role is not one of administration or management. The CNL functions within a microsystem and assumes accountability for healthcare outcomes for a specific group of clients within a unit or setting through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. The CNL is a provider and a manager of care at the point of care to individuals and cohorts. The CNL designs, implements, and evaluates client care by coordinating, delegating and supervising the care provided by the health care team, including licensed nurses, technicians, and other health professionals.

Ten Assumptions for Preparing Clinical Nurse Leaders

Assumption 1: Practice is at the microsystems level.
In addition to being direct care providers, the CNL is accountable for the care outcomes of clinical populations or a specified group of clients in a healthcare system. As clinical decision-maker and care manager, the CNL coordinates the direct care activities of other nursing staff and health professionals. The CNL provides lateral integration of care services within a microsystem of care to effect quality, client care outcomes. To prepare students for the CNL role, there must be a deliberate and integrated inclusion of leadership education and socialization that begins on the first day of the first class and continues throughout CNL education program. For example, leadership content should be incorporated in every client care plan prepared by students so that

each plan includes not only *clinical* actions for meeting the needs of the client but also an *organizational* plan for delegation of care to assisting personnel, registered nurses, and other health professionals, including the teaching and evaluation activities that would need to accompany such delegation. One leadership course taken in the last year of the CNL course of study is not sufficient to prepare the student who can perform as a beginning CNL upon graduation. Practice at the unit and systems level will require a shift in thinking on the part of faculty, with greater attention to context and the development of leadership skills throughout the curriculum. Students, as well, may have to be convinced that systems-level intervention, such as the implementation of best practices and the revision of guidelines and protocols for the management of clinical populations, is essential for professional practice and has a greater probability of generating superior and far-reaching outcomes.

Assumption 2: Client care outcomes are the measure of quality practice.
The performance of the CNL will be measured by the extent to which he or she succeeds in improving clinical and cost outcomes in individuals and groups of clients within a unit or setting, e.g. diminishing recidivism in schizophrenic clients; elimination of pressure ulcers in nursing home residents; reducing hospital length of stays for clients admitted with pneumonia; increasing participation in prenatal care and classes in a community. Professional nursing education must provide opportunities for students to isolate and describe clinical populations, e.g. adults with chronic obstructive pulmonary disease (COPD), well school-aged children or an urban neighborhood, and identify the clinical and cost outcomes that will improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client-centered. In the process, CNL students must learn how to compare desired outcomes with national and state standards and with those of other institutions. CNL education can make a significant contribution to the health of the public by emphasizing *common clinical conditions* that comprise the bulk of health care activity and cost and where professional nursing is likely to have the greatest impact on the health care system and outcomes. For example, in the past, nursing education has been dogged about assuring that every student has the opportunity to attend a birth but has never insisted that every student have the opportunity to manage a death, even though the vast majority of nurses are more likely to practice with clients who are at the end of life. Similarly, gerontology has not been a universal curriculum requirement even though persons over 65 use the lion's share of health resources nationally.

Assumption 3: Practice guidelines are based on evidence.
The preparation of the CNL must include an unrelenting demand for evidence for every aspect of practice. While most higher education programs in nursing have made the transition from ritualistic, process-based teaching to an evidence-based, outcome orientation, many graduates do not routinely read professional journals and incorporate new evidence into practice. These leadership activities require skill in knowledge acquisition, working in groups, management of change, and dissemination of new knowledge to other healthcare professionals. Most professional nursing education programs have included a course in nursing research but often have neglected the more meaningful pursuit of clinical scholarship, i.e., the application of research to the clinical setting, the resolution of clinical problems, and dissemination of results. In addition to justifying clinical actions based on evidence, the CNL student should have the opportunity, within his or her course of study, to seek and apply evidence that challenges current policies and procedures in a practice environment and to incorporate evidence into practice

situations, including the education of other health care team members. Practical experience in the dissemination of clinical knowledge such as grand rounds, case presentations and journal clubs should be intrinsic to CNL education to ensure that the implementation of new evidence becomes embedded in practice.

Assumption 4: Client-centered practice is intra- and interdisciplinary.
For care to be client-centered, the providers who comprise the health care team must discuss the client's problem and agree on a common course of action. As the health care team member who has the most comprehensive knowledge of the client, the CNL necessarily will be responsible for coordinating the variety of team members participating in the plan of care. Currently, many students complete their course of study in nursing without having had the opportunity to work closely with physicians, physical therapists, social workers, pharmacists and others who are caring for the same client. Likewise, communication with other nurses who provide care to the same client(s) in other settings is seldom stressed. This lack of communication results in discontinuous and frequently unsafe, uncoordinated, inappropriate care. Learning to advocate for clients by communicating effectively with other interdisciplinary team members, including nurses in other settings, must start in CNL education programs with real experiences. Faculty members must role model this behavior and create opportunities for students to work with the other professions as well as with nursing staff. The opportunity to learn and work in an interdisciplinary venue teaches students how to be effective client care advocates and coordinators.

Assumption 5: Information will maximize self-care and client decision-making.
Client participation traditionally has been a nursing goal; however, the stunning advances in science and technology – specifically informatics and genetics – have taken it to a new level. As participants in their own care, clients require in-depth, up-to-date knowledge about themselves, their specific health problems, and their treatment options. Health literacy is the foundation of independence, health promotion and disease prevention, all of which are hallmarks of excellence in nursing practice. CNL education requires comprehensive content in clinical genetics and clinical practice opportunities in genetics counseling, e.g. assisting clients to construct genealogies and identify family patterns of health problems. Clinical practica also must include educating clients and families – not just on how to perform a procedure at home but also the nature of the problem, and how they can acquire additional knowledge about the condition and support from others with similar problems. Teaching other direct care providers how to assist clients, families and communities to be health literate and independent managers of their own care is a system responsibility of the CNL that requires practice opportunities in the education program. In CNL education, a health literacy plan should be a component of each care plan and include family members and other care providers.

Assumption 6: Nursing assessment is the basis for theory and knowledge development.
With the explosion of knowledge, the CNL or any other health professional can not know everything that is required for a safe, high quality clinical practice. The use of information technology for decision support for all clinicians will be critical and depends on the routine collection of data that documents the characteristics, conditions and outcomes for various clinical groups or populations. Assessment has been a core activity of nursing practice. To engage clients in therapeutic partnerships, the CNL must communicate with them and must first

assess the individual, his or her health problems, and the context in which those problems are manifested in order to effectively communicate. In the future, assessment data not only will guide individual plans of care, but also will be classified (using a standardized language), stored, retrieved, analyzed and then integrated into information systems to continuously update decision support, and complete the cycle of evidence-based practice. CNL education must include an understanding of information systems and standardized languages, and how they relate to the improvement of clinical outcomes, continuous performance measures and decision support technology.

Assumption 7: Good fiscal stewardship is a condition of quality care.
Requesting more and more resources to support an essentially dysfunctional system is injudicious. However, attempting to drive costs down by withholding and rationing services is equally misguided. Accountability for the cost-effective and efficient use of human, environmental and material resources will rest with the CNL. This expectation requires an understanding of how to identify waste and manage resources within systems. For example, using a CNL to perform client care tasks that can be done as effectively by less prepared nursing personnel is poor fiscal stewardship; however, delegating certain activities to less prepared nursing personnel resulting in poorer client outcomes is also not fiscally sound management. The CNL student must understand the fiscal context in which he or she is practicing and how to identify the high cost/high volume activities, including how much procedures cost and how those costs compare nationally and across institutions. Managing the care of a clinical population or group can be compared to running a small business. The CNL needs to understand economies of scale, how to read a balance sheet, the difference between fixed and incremental costs, how to establish per unit costs, and some basic marketing strategies. Basic business skills and organizational theory must become accepted components of CNL education.

Assumption 8: Social justice is an essential nursing value.
Altruism, accountability, human dignity, integrity and social justice are the guiding values of the nursing profession. For the CNL, however, the value of social justice is particularly significant because it directly addresses disparities in health and health care. As one of only two goals of the Healthy People 2010 agenda, the elimination of health disparities requires an in-depth understanding of the impact of unequal distribution of wealth and a pluralistic health care system. As the health professional charged with the management of clinical unit or setting-based populations, the CNL will assume responsibility for addressing variations in clinical outcomes among various groups, including those most vulnerable. Although professional nursing education programs have included cultural competence and health disparities content in the curricula, such content seldom addresses the more comprehensive issue of social justice. The opportunity to work with clinical populations and even whole communities to assess and implement strategies that address health disparities is imperative in the education of the CNL and serves as a prelude to influencing policy formulation at the systems level.

Assumption 9: Communication technology will facilitate the continuity and comprehensiveness of care.
While the face-to-face clinic visit, home visit and hospital stay have been the traditional venues for provider-client interaction, technological advances in communication have made it possible for more sustained and ongoing contact with clients, families, and other caregivers. Four fifteen-

minute visits per year in a physician's office are an insufficient and costly way to manage chronic illness, often resulting in untimely and inappropriate use of the most expensive health care services. The ability to develop and sustain therapeutic relationships, monitor the course of illness and health events on a continuous basis and provide care using varied and distance technologies is a necessary component of CNL education. Students must have the opportunity to diagnose, educate, treat and evaluate the care of clients, using distance and varied technology. Communication courses will include the range of interactions from face-to-face to electronic interactions with individuals and groups, as well as with the media, policy makers and public.

Assumption 10: The CNL must assume guardianship for the nursing profession.
The ability of professional nursing to fulfill its covenant with society and protect and promote the health of citizens and communities will depend on the health care leadership of the CNL. The CNL, with additional education, will be expected to assume positions in professional, policy and regulatory organizations/agencies, leadership positions in health care facilities, practice plans, and as faculty in institutions of higher education. The assumption of the CNL's leadership in the health care system, however, begins with entry into the education program and includes a clear expectation of the more advanced generalist's clinical practice role, including delegation to other licensed nurses. This socialization and leadership role preparation may be the most difficult dimension of CNL education and requires extensive socialization and actual practice, as well as modeling by faculty members and staff nurses. Leadership development activities must become a core component of the CNL curriculum and awarded credit accordingly.

THE ROLE OF THE CLINICAL NURSE LEADER

The CNL is a leader in the health care delivery system, not just the acute care setting but in all settings in which health care is delivered. The implementation of the CNL role, however, will vary across settings. The CNL role is not one of administration or management. The CNL assumes accountability for client care outcomes through the assimilation and application of research-based information to design, implement, and evaluate client plans of care. The CNL is a provider and manager of care at the point of care to individuals and cohorts of clients within a unit or healthcare setting. The CNL designs, implements, and evaluates client care by coordinating, delegating and supervising the care provided by the health care team, including licensed nurses, technicians, and other health professionals.

Fundamental aspects of the CNL role include:

- Leadership in the care of the sick in and across all environments;
- Design and provision of health promotion and risk reduction services for diverse populations;
- Provision of evidence-based practice;
- Population-appropriate health care to individuals, clinical groups/units, and communities;
- Clinical decision-making;
- Design and implementation of plans of care;
- Risk anticipation;
- Participation in identification and collection of care outcomes;

- Accountability for evaluation and improvement of point-of-care outcomes;
- Mass customization of care;
- Client and community advocacy;
- Education and information management;
- Delegation and oversight of care delivery and outcomes;
- Team management and collaboration with other health professional team members;
- Development and leveraging of human, environmental and material resources;
- Management and use of client-care and information technology; and
- Lateral integration of care for a specified group of patients.

The CNL provides and manages care at the point of care to individuals, clinical populations and communities. In this role, the CNL is responsible for the clinical management of comprehensive client care, for individuals and clinical populations, along the continuum of care and in multiple settings, including virtual settings. The CNL is responsible for planning a client's contact with the health care system. The CNL also is responsible for the coordination and planning of team activities and functions. In order to impact care, the CNL has the knowledge and authority to *delegate* tasks to other health care personnel, as well as *supervise and evaluate* these personnel and the outcomes of care. Along with the authority, autonomy and initiative to design and implement care, the CNL is accountable for improving individual care outcomes and care processes in a quality, cost-effective manner.

As the use of technology expands and care is delivered not only across multiple settings but in virtual settings as well, the CNL has the knowledge and skills to deliver and coordinate care across settings using up-to-date technology.

Risk anticipation, the ability to critically evaluate and anticipate risks to client safety is a critical component of the CNL role. At the systems level (risk to any client) and the individual level (account for client history, co-morbidities, etc.) it is necessary to anticipate risk when new technology, equipment, treatment regimens or medication therapies are introduced. Tools for risk analysis, e.g. failure mode evaluation analysis, root cause analysis, and quality improvement methodologies, and the potential use of large data sets, are important concepts in the armamentarium of the CNL.

Mass customization, the ability to profile patterns of need and tailor interventions is a key component of the CNL role. The CNL uses an evidence-based approach by identifying patterns, and modifying interventions to meet specific needs of individuals, clinical populations, or communities within a microsystem. This approach to health care requires the CNL to collaborate with individuals in providing client-focused care.

Client and community advocacy is a hallmark of the CNL role. As a client advocate the CNL assumes accountability for the delivery of high quality care, including the evaluation of care outcomes and provision of leadership in improving care. Historically, the nursing role has emphasized partnership with clients--whether individuals, families, groups, or communities--in order to foster and support active participation in determining health care decisions. In addition,

the CNL advocates for improvement in the institution or health care system and the nursing profession.

In this role, the CNL also assumes the role of *educator*, preparing individuals, families, or cohorts of clients for self-care and a maximal level of functioning and wellness. The CNL serves as an information manager, with state-of-the art knowledge regarding research findings and health information resources. As advocates and educators with state-of-the-art knowledge, the CNL helps clients acquire, interpret, and use information related to health care, illness, and health promotion. Health information available to clients is often overwhelming or confusing; the CNL serves as an information manager, assisting clients in accessing, understanding, evaluating and applying health-related information. To maximize wellness, health promotion, and risk reduction, the CNL designs and implements education programs for cohorts of clients, with particular emphasis on those with chronic illnesses. In addition, the CNL provides education and guidance to other health professionals to whom care is delegated.

The CNL is responsible for the provision and management of care in and across all environments. The CNL focuses not only on individual-level health care, but also manages, monitors, and manipulates the environment to foster health. In addition, the CNL develops, leverages, and serves as a *steward of the environment and human and material resources* while coordinating client care. The CNL role requires knowledge and skill in biotechnology and information technology as these relate to direct nursing care, health education, and the management and coordination of care.

The CNL is a *member and leader of health care teams* that deliver treatment and services in an evolving health care system. The CNL brings a unique blend of knowledge, judgment, skills, and caring to the health care team. As a leader and partner with other members of the health care team, the CNL seeks collaboration and consultation with other health professionals as necessary in the design, coordination and evaluation of client care outcomes.

As a health care provider and leader who functions autonomously and as a member of an interdisciplinary health care team, the CNL is responsible for his/her own professional identity and practice. Self-awareness and self-evaluation are utilized to enhance professional relationships, improve communication and improve quality of care outcomes.

The role of the CNL requires strong critical thinking, communication and assessment skills, and the demonstration of a balance of intelligence, confidence, understanding, and compassion. Membership in any profession, and more specifically as a CNL, requires the development and acquisition of an appropriate set of values and an ethical framework. As advocates for high quality care for all individuals, the CNL is knowledgeable and active in the political and regulatory processes defining health care delivery and systems of care.

A defining feature of the CNL role is a strong focus on health promotion, risk reduction and population-based health care. As advances in science and technology allow us to predict future health problems, the CNL will be called upon to design and implement measures to modify risk factors and promote engagement in healthy lifestyles. While the CNL will continue to provide and coordinate care to the sick, many will engage in direct interaction with groups and

communities for the purpose of health promotion, secondary prevention, and risk reduction.

The CNL is committed to lifelong learning and willing to assume responsibility for planning one's professional career. As a professional committed to lifelong learning, the CNL is able to define his or her professional self by purposeful and structured educational experiences for the ongoing improvement of practice competence and improved practice outcomes.

In summary, the role of the beginning CNL encompasses the following broad areas:

- ***Clinician***: designer/coordinator/integrator/evaluator of care to individuals, families, groups, communities, and populations; able to understand the rationale for care and competently deliver this care to an increasingly complex and diverse population in multiple environments. The CNL provides care at the point of care to individuals across the lifespan with particular emphasis on health promotion and risk reduction services.
- ***Outcomes manager:*** synthesizes data, information and knowledge to evaluate and achieve optimal client outcomes.
- ***Client advocate***: adept at ensuring that clients, families and communities are well-informed and included in care planning and is an informed leader for improving care. The CNL also serves as an advocate for the profession and the interdisciplinary health care team.
- ***Educator:*** uses appropriate teaching principles and strategies as well as current information, materials and technologies to teach clients, groups and other health care professionals under their supervision;
- ***Information manager***: able to use information systems and technology that put knowledge at the point of care to improve health care outcomes;
- ***Systems analyst/Risk anticipator:*** able to participate in systems review to improve quality of client care delivery and at the individual level to critically evaluate and anticipate risks to client safety with the aim of preventing medical error.
- ***Team Manager***: able to properly delegate and manage the nursing team resources (human and fiscal) and serve as a leader and partner in the interdisciplinary health care team; and
- ***Member of a profession:*** accountable for the ongoing acquisition of knowledge and skills to effect change in health care practice and outcomes and in the profession.
- ***Lifelong Learner:*** recognizes the need for and actively pursues new knowledge and skills as one's role and needs of the health care system evolves.

AACN Task Force on Education and Regulation II

Chairperson
Jean Bartels, PhD, RN
Chair, School of Nursing
Georgia Southern University
Statesboro, Georgia

Members

Carol Allen, PhD, RN
Chair, Department of Nursing
Oakwood College
Huntsville, Alabama

Lauren Arnold, PhD, RN
Senior Director and Operations Analyst
Tenet Health
Dallas, Texas

Tina DeLapp, EdD, RN
Director, School of Nursing

University of Alaska—Anchorage
Anchorage, Alaska

Melanie Dreher, PhD, RN, FAAN
Dean, College of Nursing
University of Iowa
Iowa City, Iowa

Donna Hartweg, PhD, RN
Director, School of Nursing
Illinois Wesleyan University
Bloomington, Illinois

Elizabeth Lenz, PhD, RN, FAAN
Dean, College of Nursing
The Ohio State University
Columbus, Ohio

Terry Miller, PhD, RN
Dean, School of Nursing
Pacific Lutheran University
Tacoma, Washington

Roberta Olson, PhD, RN
Dean, College of Nursing
South Dakota State University
Brookings, South Dakota

Cathy Rick, RN, CNAA, CHE
Chief Nursing Officer
Department of Veterans Affairs
Washington, District of Columbia

Elias Vasquez, PhD, NNP, PNP, FAAN
Assistant Professor, School of Nursing
Department of Child, Women's and Family
Health, University of Maryland
Baltimore, Maryland

AACN Staff

Polly Bednash, PhD, RN, FAAN
Executive Director

Joan Stanley, PhD, RN, CRNP
Director of Education Policy

REACTION PANEL

Lauren Arnold, PhD, RN
Senior Director and Operations Analyst
Tenet Health
Dallas, Texas

Jean Bartels, PhD, RN (*TF Chair*)
Director, School of Nursing
Georgia Southern University
Statesboro, Georgia

Geraldine Bednash, PhD, RN, FAAN
Executive Director
American Association of Colleges of Nursing
Washington, District of Columbia

Karen N. Drenkard, RN, MSN, CNAA
Chief Nurse Executive
Inova Health System
Falls Church, Virginia

Donna Dorsey, MS, RN
President
National Council of State Boards of Nursing
Chicago, Illinois

Catherine J. Futch, MN, RN, CNAA
President-Elect
American Academy of Ambulatory Care Nursing
Pitman, New Jersey

Tim Henderson, MSPH
National Conference of State Legislatures
Primary Care Resource Center
Washington, District of Columbia

Jean Johnson, PhD, RNC, FAAN
Senior Associate Dean, Health Sciences
George Washington University
Washington, District of Columbia

Marian Osterweis, PhD
Executive Vice President and Director
Division of Global Health
Association of Academic Health Centers
Washington, District of Columbia

Joy F. Reed, EdD, RN
President
Association of State and Territorial Directors of Nursing
Raleigh, North Carolina

Cathy Rick, RN, CNAA, CHE
Chief Nursing Officer
Department of Veterans Affairs
Washington, District of

Mary Smolenski, EdD, RN, CS, FNP
Director of Certification Services
American Nurses Credentialing Center
Washington, District of Columbia

Joan Stanley, PhD, RN, CRNP
Director of Education Policy
American Association of Colleges of Nursing
Washington, District of Columbia

Jolene Tornabeni, RN, MA, FACHE, FAAN
Executive Vice President and Chief Operating Officer
Inova Health System
Falls Church, Virginia

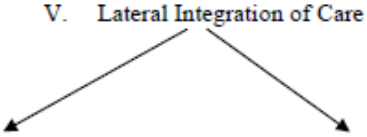
Michael Whitcomb, MD
Senior Vice President for Medical Education
Association of American Medical Colleges
Washington, District of Columbia

CONSULTANT:
Maureen K. Robinson
Bethesda, Maryland

CNL CURRICULUM FRAMEWORK FOR CLIENT-CENTERED HEALTHCARE

Nursing Leadership

I. Horizontal Leadership
II. Effective Use of Self
III. Advocacy
IV. Conceptual Analysis of the CNL Role
V. Lateral Integration of Care



Clinical Outcomes Management ⟷ **Care Environment Management**

I. Illness/Disease Management
- Care management
- Client outcomes
- Builds on and expands the baccalaureate foundation in:
  1. Pharmacology
  2. Physiology/ pathophysiology
  3. Health Assessment

II. Knowledge Management
- Epidemiology
- Biostatistics
- Measurement of client outcomes

III. Health Promotion and Disease Reduction/ Prevention Management
- Risk assessment
- Health literacy
- Health education and counseling

IV. Evidence-based Practice
- Clinical decision making
- Critical thinking
- Problem Identification
- Outcome measurement

I. Team Coordination
- Delegation
- Supervision
- Interdisciplinary care
- Group process
- Handling difficult people
- Conflict resolution

II. Healthcare Finance/Economics
- Medicare and Medicaid/ Reimbursement
- Resource allocation
- Healthcare technologies
- Healthcare Finance & Socioeconomic Principles

III. Healthcare Systems & Organizations
- Unit level healthcare Delivery/microsystems of care
- Complexity theory
- Managing change theories

IV. Healthcare Policy
V. Quality Management/Risk Reduction/Patient Safety
VI. Informatics

Major Threads integrated throughout curriculum

I. Critical Thinking/Clinical decision making
II. Communication
III. Ethics
IV. Human diversity/cultural competence
V. Global Healthcare
VI. Professional development in the CNL role
VII. Accountability
VIII. Assessment
IX. Nursing technology and resource management
X. Professional Values, including social justice

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AACN CNL IMPLEMENTATION TASK FORCE MEMBERS

Jolene Tornabeni, MA, RN, FACHE, FAAN *Task Force Chair*
Cynthia Flynn Capers, PhD, RN, University of Akron
Melanie Dreher, PhD, RN, FAAN, Rush University, *AACN Board liaison*
Karen Haase-Herrick, MN, RN, Northwest Organization of Nurse Executives, *AONE representative*
James Harris, DSN, RN, MBA, APRN, Chief Nursing Officer, VA Tennessee Valley Healthcare System, *VA representative*
Traci Hoiting, MS, RN, ACNP-C, Swedish Medical Center, Seattle, WA
Rose Marie Martin, BSN, RN, Arthur G. James Cancer Hospital, Columbus, OH
Judith Fitzgerald Miller, PhD, RN, FAAN, Marquette University
Charlene Connolly Quinn, PhD, RN, Department of Epidemiology and Medicine School of Medicine University of Maryland, *Evaluation Committee Chair*
Raelene Shippee-Rice, PhD, RN, University of New Hampshire
Marcia Stanhope, DSN, RN, FAAN, University of Kentucky, *Curriculum Committee Chair*
Marge Wiggins, MBA, RN, Maine Medical Center, *Practice Model Committee Chair*
Joan Stanley, PhD, RN, CRNP, FAAN, *AACN staff liaison*
Kathy McGuinn, MSN, RN, CPHQ, *AACN staff liaison*

CNL Curriculum Committee Members:
Marcia Stanhope, DSN, RN, FAAN, University of Kentucky, *Committee Chair*
Traci Hoiting, MS, RN, ACNP-C, Swedish Medical Center, Seattle, WA
Judith Fitzgerald Miller, PhD, RN, FAAN, Marquette University
Raelene Shippee-Rice, PhD, RN, University of New Hampshire
Joan Stanley, PhD, RN, CRNP, FAAN, *AACN staff liaison*

CNL Practice Model Committee Members:
Marge Wiggins, MBA, RN, Maine Medical Center, *Committee Chair*
Cynthia Flynn Capers, PhD, RN, University of Akron
Melanie Dreher, PhD, RN, FAAN, Rush University
Karen Haase-Herrick, MN, RN, Northwest Organization of Nurse Executives,
James Harris, DSN, RN, MBA, APRN, Chief Nursing Officer, VA Tennessee Valley Healthcare System
Rose Marie Martin, BSN, RN, Arthur G. James Cancer Hospital, Columbus, OH
Jolene Tornabeni, MA, RN, FACHE, FAAN
Kathy McGuinn, MSN, RN, CPHQ, *AACN staff liaison*
Joan Stanley, PhD, RN, CRNP, FAAN, *AACN staff liaison*

CNL Evaluation Committee Members:
Charlene Connolly Quinn, PhD, RN, Department of Epidemiology and Medicine School of Medicine University of Maryland, *Committee Chair*
Sean Clarke, PhD, RN, CRNP, CS, Center for Health Outcomes and Policy Research University of Pennsylvania, *consultant*
Sue Haddock, PhD, RN, CNAA-BC, WJB Dorn VA Hospital, *VA liaison*
Kathy Player, EdD, RN, Ken Blanchard College of Business at Grand Canyon University

Kathleen Sanford, MA, RN, DBA, FACHE, Gig Harbor Area Multicare Health System
AONE representative
Marcia Stanhope, DSN, RN, FAAN, University of Kentucky, *Implementation TF liaison*
Jolene Tornabeni, MA, RN, FACHE, FAAN, immediate-past EVP and COO, Inova Health System, *Implementation TF liaison*
Gail Wolf, DNS, RN, UPMC Health Systems, *AONE Representative*
Joan Stanley, PhD, RN, CRNP, FAAN, *AACN staff liaison*
Kathy McGuinn, MSN, RN, CPHQ, *AACN staff liaison*

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