Proposal on Closing the Communication Gaps with the Clinical Nurse Leader Role

A Problem Solving Proposal

Presented to the faculty of the School of Nursing

California State University, San Marcos

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Nursing

Clinical Nurse Leader

by

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SPRING

2012
CALIFORNIA STATE UNIVERSITY SAN MARCOS

THESIS SIGNATURE PAGE

THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE

MASTER OF SCIENCE

IN

NURSING

THESIS TITLE: Proposal on Closing the Communication Gaps with the Clinical Nurse Leader Role

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DATE OF SUCCESSFUL DEFENSE: May 18, 2012

THE THESIS HAS BEEN ACCEPTED BY THE THESIS COMMITTEE IN
PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
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Abstract

of

Proposal on Closing the Communication Gaps with the Clinical Nurse Leader Role

by

Joseph A. Parker

Communication is an important part of the human experience. Communication is ever more vital in this ever changing landscape of healthcare. With an estimated 98,000 deaths annually attributed to medical errors, the healthcare industry is more under the microscope by an increasingly more intelligent public who are demanding a safer health system (Institute of Medicine, 2000). Palomar Pomerado Health (PPH) is determined to decrease the fragmentation of care issues with the advent of implementing a new role of Clinical Nurse Leader (CNL). The purpose of this paper is to present and discuss a proposal of the CNL role at PPH in North Inland San Diego County, California. This proposal is based on an extensive literature review and evaluation of several healthcare organizations implementation of the CNL role. The success of the role is dependent on its ability to be able to communicate with frontline staff as well as with other departments by bridging gaps. Improved coordination of care is the goal of the CNL while serving as the communication hub for the intradisciplinary team. This paper proposes some recommended evaluation metrics to determine the efficacy of communication by the CNL in the clinical setting.

Pamela Kohlby

committee Chair

5/18/2012

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Closing the Communication Gaps

Introduction

Communication is an important part of the human experience. Communication is ever more vital in this ever changing landscape of healthcare. With an estimated 98,000 deaths annually attributed to medical errors, the healthcare industry is more under the microscope by an increasingly more intelligent public who are demanding a safer health system (Institute of Medicine, 2000). Medical errors lead to increased healthcare costs. Preventable medical errors are estimated to have added anywhere between $17-$29 billion dollars annually to hospitals nationwide (Institute of Medicine, 2000). Healthcare costs are projected to continue this astronomical rise with the Baby Boomer generation reaching sixty five years of age this year, the numbers of people who will require medical care will increase. These numbers will skyrocket as President Barrack Obama’s Patient Protection and Affordable Care Act of 2010 (PPACA) continues to be phased in within the coming years and guaranteed coverage is expanded to an additional 30 million more Americans (Goldsmith, 2010). This dramatic influx into the system will also come in the form of government subsidized healthcare with an increase in both Medicare and Medical patients (Goldsmith, 2010). The rapidly rising cost of healthcare also comes on the heels of the landmark studies “To Err is Human” and “Crossing the Quality Chasm” which has highlighted the need for healthcare quality (Institute of Medicine, 2000). Hospitals, now more than ever, need to be focused on controlling outcome costs attributed to poor care coordination, medical errors, and increased length of stays (Goldsmith, 2010). While
many factors may be attributed to these outcome costs, one major factor is the issue of communication and its impact on care coordination and ultimately quality healthcare.

The word “communication” has multiple definitions as noted in the Merriam-Webster’s Dictionary. Communication can be: “1. an act or instance of transmitting; 2a. information transmitted or conveyed. 2b. a verbal or written message; 3a. a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior. 3b. personal rapport” (Merriam-Webster website). Essentially, communication involves the action of conveying meaningful information. Communication is often complex and involves multiple components such as: “verbal and nonverbal exchanges, active listening, assertiveness, conflict management, and issues unique to individuals and situations” (Antai-Otong, 2010, p. 94). Communication can occur in multiple instances and interactions. It can occur face to face or via technology (e.g. computer, phone, text messages, emails, and phone or video conference call).

Irrespective of the format, communication occurs at many levels and requires specific skill sets in order to facilitate healthy work relationships, share information, carry respect, and address consumer and organizational needs (Antai-Otong, 2010).

Effective communication is a fundamental process with regards to providing quality patient care (Institute of Medicine, 2001). There is tremendous amount of patient information that is being collected and shared daily. Information such as patient history, lab results, diagnostic exams, medication regimens, treatment regimens, procedures, insurance information, demographic data, and outcome results are all pieces of information that are collected, analyzed, synthesized and shared between healthcare
providers. Yet with all of this information that is being collected and shared, there still
remains an issue with regards to communication and assurance that patients have a
smooth transition through the health care system. As noted in the Institute of Medicine
(IOM) report Crossing the Quality Chasm, “health care today harms too frequently and
routinely fails to deliver its potential benefits” (2001). Furthermore, the report stated that
tens of thousands of people die each year in America due to medical errors that could
possibly be prevented (Institute of Medicine, 2001). This is due to the fact that today’s
healthcare systems are made of large, complex networks that often miss the important
link of closing the communication gaps.

**Problem and its Environmental Context**

The communication gaps and its effects on outcomes were some of the driving
factors that the American Association of the Colleges of Nursing (AACN) recognized as
they convened in 2004 to discuss the changes needed in nursing education to address
issues in healthcare quality (Gabuat, Hilton, Kinnaird, & Sherman, 2008). These
discussions led AACN in the development of task forces that were aimed to identify ways
to improve the quality of patient care as well as ensure that nurses develop the skill sets
needed to thrive in the healthcare. One task force dealt with the model for nursing
education and regulation, while the second task force worked on a new nursing role that
seemed to be glaringly needed to help identify and address the gaps in quality care
(Porter-O’Grady, Clark, & Wiggins, 2010). This new role emerged as the Clinical Nurse
Leader (CNL). According to the White Paper by the AACN (2007), the CNL is the leader
in the health care delivery system throughout all health care settings, not just in the hospital setting (American Association of Colleges of Nursing, 2007).

The CNL role is centered on the importance of communication. The CNL works within the microsystem and assumes accountability for the healthcare outcomes for a specific group of patients on a unit or setting. This occurs through assimilation and implementation of evidence based practice. The role of the CNL, as described in the White Paper (2007), is to design, implement, and evaluate patient care through coordination, delegation, and supervision of the interdisciplinary health care team (American Association of Colleges of Nursing, 2007). The CNL role is described by Harris, Tornabeni and Walters (2006) as one who coordinates and facilitates care amongst multiple disciplines (Harris, Tornabeni, & Walters, 2006). These same authors’ described the CNL as a “lateral integrator” for the clinical units (Harris et al., 2006). The descriptor of a lateral integrator helps to visualize the function of a CNL as a person who identifies and addresses gaps in communication, minimizes silos, and views the patient holistically (Harris et al., 2006). While the word “leader” is used in the title, the CNL role is not an administrative or a managerial position. Rather, it is frontline connection between quality and practice at the bedside utilizing communication with frontline staff members to help improve quality outcomes by affecting patient care.

The CNL role is the first new role in nursing in over 35 years. The concept of the CNL role is to have a master’s prepared clinical nurse at the patient’s bedside that would assist to educate nurses on the understanding of how to provide care and improve the quality of such care in today’s complex healthcare system (Porter-O’Grady et al., 2010).
These networks or systems include “frontline Microsystems, mesosystems, and overarching macrosystems” (Nelson et al., 2007, p. 5). The clinical microsystem is the actual point at which patient care is delivered. The clinical microsystem is often a smaller group of people who work together regularly with the aim of delivering care to a more specific patient subpopulation. These Microsystems often have both clinical and business foci with defined processes and specific performance outcomes. The development of Microsystems happen over time and are often implanted within a larger organization (Nelson et al., 2007). The CNL’s live and function within the microsystem. The CNL is considered to be an advanced generalist at the microsystem level that helps to manage and coordinate patient care at the point of care (Smith, Manfredi, Hagos, Drummond-Huth, & Moore, 2006). The CNL is able to accomplish this by rounding on a select group of patients with frontline nursing personnel to ensure that appropriate care is being delivered and documented. The CNL is also constantly looking to identify trouble spots where care is fragmented and to improve communication exchanges, otherwise known as “hand offs”, to ensure that the patient care is not interrupted.

Clarity of Problem

Deficiencies in consistent communication were identified as plaguing issues that impacted care coordination at Palomar Pomerado Health (PPH). In the fall of 2004, voters in Northern San Diego County approved Proposition BB which secured funding for the expansion of Palomar Pomerado Health (PPH) facilities (Palomar Pomerado Health, 2010). The largest of the expansion projects include the building of a brand new eleven story 289 bed hospital with an ability to eventually expand to 600 inpatient beds
PPH identified that there was great opportunity to improve the quality of care that was being delivered to patients and to improve the patients overall experience. With the new hospital scheduled to open in the summer of 2012, PPH felt that there was an opportunity to change the care delivery model and the culture of the entire organization.

PPH leaders held multiple town hall meetings with community members in 2009. These community members were people who had previous interactions with PPH and the healthcare system. The meetings focused on obtaining information about the community members’ healthcare experience when visiting PPH and gave valuable feedback with regards to the care they received at PPH as well as areas that would benefit from improvement. One of the areas noted by community members is consistent with the research found in the literature that current health systems are “complex, fragmented, and arcane” (Sofaer, 2009, p. 75). Many patients had confusion with regards to which patient care providers they were eligible to see and what benefits were covered under their insurance. This made it very difficult for patients to navigate the system. The impact on patient care is that it is “less timely, safe, effective, and efficient” (Sofaer, 2009, p. 75).

This information gathered from the meetings was evaluated by the executive leadership team at PPH who then decided that it was important to make a change regarding the care delivery model for patients and the importance of changing the culture the organization with regards to patient care. Four guiding principles for patient care were established which include: quality and safety, patient centered care, efficient and effective care, and work environment.
The first guiding principle addressed the idea of quality and safety. It was decided that all patients will receive safe care that is individualized and evidence-based. Patient care decisions were to be made with the patients by having the right information at the right time, in the right format, in the right place and with the right people. Another guiding principle was the importance of patient centered care. Patient centered care as defined by PPH is that the patient’s perspective is at the heart of all of the patient care interactions. With compassion and respect, PPH staff is to honor the cultural and spiritual preferences of the patient and family. Efficient, effective care was also an important guiding principle. The goal set by PPH for patient care was to leverage innovation to deliver cost-effective, ideal patient care that provides patients exactly what they need, when and where they need it, without waste, and in an environment that is safe for all. The goal set for the work environment was to establish a health work environment in which innovation, learning, communication, accountability, recognition, and honest and open relationships are embraced.

The results from these meetings were a set of patient deliverables. Patient deliverables were identified as goals that were to be obtained that were non-negotiable. Due to the identified issue with fragmentation and complexity of care, one of the deliverables that was identified by the community members was the need of a “patient navigator” who would act as a patient advocate and help a patient navigate through the complexities of the health system. Patients felt that there was a definite gap with regards to communication of care from the care providers. This lack of communication resulted in additional unneeded and unwanted increase in anxiety levels for patients. This
identified issue allowed PPH to focus efforts on improving patient care, thus improving the patient’s overall experience.

In 2010, PPH embarked on the journey of expanding services for orthopedic spine surgery. The vision of the service included the ability of providing high quality, highly specialized care with high customer service. The executive sponsor and the manager of business development were tasked with the creation of a coordinated service line for patients suffering from back and neck pain. This was an area of service that PPH identified as an opportunity to increase market share and create a unique experience for patients. One of the major focal points of this new experience was the importance of implementing the idea of a “patient care coordinator” role.

The patient care coordinator role, according to the draft job description, is a role that embodies the functional qualities of a CNL role without the title. Just as the body of evidence with regards to quality and safety is growing with the CNL role, it is presumed that the same results will be shared with the patient care coordinator role. The patient care coordinator will be the frontline clinical outcomes manager with regards to patient care while acting as the leader for the team to ensure that the team is all on the right page and that the care is seamless.

Characteristics of the Environment

With the development and implementation of the CNL role growing nationally since its inception in 2004, it is still in its initial stages with regards to implementation in the San Diego County region. The University of California San Diego, Thornton Hospital was the first hospital in San Diego County to implement the role of the CNL with the
visionary leadership of Kathy Ryan, RN, MSN Nurse Manager on the Intermediate Unit in 2008. At the time of the implementation trial in 2008, there was only one nursing school in San Diego County that had a Clinical Nurse Leader program. California State University, San Marcos (CSUSM) launched a traditional Master’s in Science program with several concentrations, including a Clinical Nurse Leader concentration in the fall of 2009.

Currently, Palomar Pomerado Health does not have any formal CNL positions. PPH currently is committed to the utilization of Nursing Supervisors and Clinical Nurse Specialists for front line staff support. Each inpatient nursing unit has on average a minimum of four Nursing Supervisors and one Clinical Nurse Specialist. The majority of Nursing Supervisors at PPH are working Supervisors. This entails that apart from the administrative responsibilities of coaching and counseling staff, they also have the responsibility of daily staffing and patient flow. Similarly, the Clinical Nurse Specialists have both unit and organizational wide responsibilities. Some of these include: tracking and maintaining competency of staff, education of staff at the unit and district level, evaluation of the standards of care, project implementation and tracking, core measure follow up and research. The current structure still allows for opportunities for improvement with regards to care coordination and quality outcomes.

Joy Gorzeman, RN, MBA was the director of Clinical Transformation at the time when PPH identified the need for a patient care coordinator role. The patient care coordinator was a new role for PPH. Joy Gorzeman had previous experience of implementing a patient care coordinator role in her prior work experiences and was also
involved with the implementation of the Clinical Nurse Leader role while working for Trinity Health, a Catholic health care system that includes 49 acute care hospitals and 432 outpatient facilities in ten states (Trinity Health, 2012). Gorzeman believed that the setting at PPH was fertile ground with regards to the idea of introducing the CNL role. Aware that the CNL role may be met with some skepticism, Gorzeman believed that the infusion of CNL role functions into the patient care coordinator role presented an opportunity to improve communication and care coordination at the patient’s bedside.

In 2009, two employees within the PPH organization began the Masters in Science of Nursing program with a CNL concentration. Both employees possessed an extensive Intensive Care Unit practice background with over 20 years of practicing nursing experience between them. In 2010, Gorzeman was asked to serve as an adjunct faculty for CSUSM’s CNL program. Gorzeman’s experience and support of the CNL role was apparent and consistent with the goals of improving care coordination, improving patient safety, and improving staff engagement at the bedside by providing strong nursing leadership (Gabuat, Hilton, Kinnaird, & Sherman, 2008).

**Stakeholders**

Multiple stakeholders have been identified within the PPH system as being affected by the new role. There are many collaborative partnerships at the microsystem level that the new role will need to establish in order to be effective. Just as the CNL, the patient care coordinator is expected to work laterally to integrate patient care by interacting with the key stakeholders at the bedside which include: staff nurses, ancillary staff, case managers, front line managers, healthcare administrators, physicians,
respiratory care practitioners, nursing assistants, pharmacists, and rehabilitation therapists (Begun et al., 2006). While many of the relationships have the potential of a synergistic effect, there is still the possibility of role confusion. This is evident with some of the perceivable overlapping responsibilities between case managers, Clinical Nurse Specialists (CNS) and the CNL. The title of patient care coordinator was utilized in lieu of CNL to help foster adoption of the role into the organization.

Case managers at PPH are generally utilized to assist with some aspects of lateral integration function concerning transitioning patients from the inpatient setting to the most suitable level of care as proficiently as possible. Case managers are commonly assigned to individual patients as opposed to nursing units and do not have oversight with regards to care delivery.

Clinical Nurse Specialists are another subgroup that shares some overlapping functions with the CNL. Much of the role confusion between CNS’s and CNL’s occur due to unfamiliarity of the CNL role. This is evident within the PPH system. At PPH, the organization has committed to the CNS role with the goal of staffing a CNS on every nursing unit. The CNS’s are utilized as clinical experts and mentors for staff. The CNSs are unit based and help to promote continuity and quality of care through the use of metrics and the integration of performance improvement philosophies (PPH, 2012).

While there may be some similarities between the CNL and CNS functions, there are also many differences that distinguish the roles (table 1). Differentiation between the roles of the CNL and CNS are important to make in order to establish role delineation and minimize role confusion. Some of the main points from the table is the fact that
CNS’s are traditionally system based while CNL’s tend to be microsystem based at the unit level. CNS’s are charged with generating research while the CNL’s helped to act as a catalyst for change to implement the research. CNS’s are usually specialized to a very specific patient population or subspecialty while the CNL’s efforts are focused at the point of care delivery (AACN, 2004).

Table 1: Differentiation between CNL and CNS roles

<table>
<thead>
<tr>
<th>CNL:</th>
<th>CNS:</th>
</tr>
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<tbody>
<tr>
<td>Advanced Generalist</td>
<td>Advanced Specialist</td>
</tr>
<tr>
<td>MSN</td>
<td>APN</td>
</tr>
<tr>
<td>Not Management</td>
<td>Management</td>
</tr>
<tr>
<td>Microsystem Based</td>
<td>System Based</td>
</tr>
<tr>
<td>Point of Care Focus</td>
<td>Specialty/Subspecialty</td>
</tr>
<tr>
<td>Individual/Cohort Care Planning</td>
<td>Coordinate Population Based Programs</td>
</tr>
<tr>
<td>High Level Care</td>
<td>Expert Care</td>
</tr>
<tr>
<td>Implement EBP</td>
<td>Generate EBP</td>
</tr>
<tr>
<td>Assist with Data Collection/Research</td>
<td>Design/ Oversee Research Projects</td>
</tr>
<tr>
<td>Point of Care Education</td>
<td>Unit/System Wide Formal Education</td>
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</table>

**Literature Review**

A review of the literature was conducted in 2012 using the online search engine, CINAHL Plus with Full Text. The original search for the words “Clinical Nurse Leader” resulted in 149 listed articles. Another search with the words “CNL” and “communication” listed six articles, while a search with the words “CNL” and “lateral integration” only yielded two articles.

A very common theme that was noted in the literature was the importance of communication and the ability of the CNL to help mend gaps in communication. An article by Bowcutt and Goolsby (2006), examined a pilot of the CNL role within a 551
bed non-profit University Hospital in Augusta, Georgia. This particular pilot described the need for improvising when filling the CNL role, “as no actual CNL graduates existed.” The title of the role was designated as a “care coordinator.” The care coordinator responsibilities were made consistent to the AACN recommendations. The care coordinator served as a “communication hub” between staff, physicians, patients and family members to ensure that a comprehensive patient care plan was established for hospital care and that the patient/family were involved in care planning (Bowcutt and Goolsby, 2006).

The importance of communication is paramount with the CNL role. The idea of communication is interwoven within the multiple roles that the CNL performs. One such example is that of the role as a clinician. The CNL is the designer, coordinator, integrator, and evaluator of patient care that is provided to patients, families and groups of people (AACN, 2007). As a client advocate, the CNL uses communication to ensure that patients and families are kept informed and are included in the plan of care (AACN, 2007). As an educator, the CNL utilizes communication when teaching patients and other members of the health care team with regards to care strategies and health education (AACN, 2007).

One article described the CNL role as one who coordinates and facilitates care amongst multiple disciplines. These same authors’ described the CNL as a “lateral integrator” for the clinical units (Harris, Tornabeni, & Walters, 2006). The descriptor of a lateral integrator helps to visualize the function of a CNL as a person who identifies and addresses gaps in communication, minimizes silos, and views the patient holistically
(Harris, Tornabeni, & Walters, 2006). This pilot study was conducted in the VA Tennessee Valley Health System. The authors utilized the Joint Commission’s tracer methodology to present a patient scenario with the goal to delineate the differing roles of the registered nurse, CNL, CNS, nurse practitioner and other members of the health care team (Harris, Tornabeni, & Walters, 2006). This same study also identified that the role of the CNL could be evaluated using financial, patient and staff satisfaction, and quality indicators (Harris, Tornabeni, & Walters, 2006).

Another case study by Gabuat et. al. (2008) was conducted at St. Lucie Medical Center (SLMC). SLMC is a 194 bed for-profit health system located in Florida. This particular case study delineated the process steps to implementing a CNL role within their organization from building a business case through the planning and implementation phases up till evaluation. This study reported with the CNL implementation, some of the positive metrics included a decrease in nursing turnover with an increase in patient and physician satisfaction. This study also demonstrated huge improvement in the Centers for Medicare and Medicaid Services (CMS) core measure data with the implementation of the CNL role (Gabuat et al., 2008). This case study stressed the Chief Nursing Officer’s belief that “improvement in care coordination, patient safety, and staff engagement” were dependent on the presence of strong nursing leadership at the bedside (Gabuat et al., 2008). While another article by Sherman, listed numerous other outcome measures that can be addressed by the CNL, which include: NDNQI measures, length of stay, hospital-acquired pressure ulcers, falls, throughput, VAP, BSI, medical errors and readmission rates just to name a few (Sherman, 2008). The outcome measures that were found in the
literature matched closely to the reality of the role when an interview was conducted with a CNL, Rebecca Pombreke RN, MSN, CNL from the University of South Alabama. Some of the measures that the CNL focused on were incremental overtime, regulatory issues, falls, time wasted paging residents, looking for supplies, bedside handoff, pain assessment and patient emergencies (Pombreke, 2010). Pombreke was able to create a standardized hand off format that help to streamline shift report for nursing staff so that crucial information was passed on while less important information was filtered out (Pombreke, 2010).

The body of evidence in support of a CNL role continues to grow. According to the White Paper by the AACN (2007), the CNL is the leader in the health care delivery system throughout all health care settings, not just in the hospital setting. While the CNL role may vary is different settings, the CNL role is not an administrative or management position. A literature review was conducted to identify and evaluate the effectiveness of the CNL role. Much of the research that was ascertained detailed the varying journeys that education and practice partners undertook as part of the pilot groups that implemented the CNL role. In June 2004, 79 schools of nursing partnered with 143 practice sites to launch the implementation of the CNL role (Tornabeni, 2006).

While the CNL role is still in its initial stages, it has shown tremendous potential with regards to the positive impact on quality care, customer service scores, patient outcomes and bridging communication gaps. These client care focused outcomes will soon be the standard measure for quality practice. With a tremendous amount of money to be at stake, hospitals will continue to look for ways to set themselves apart from
competitors while trying to maintain high quality standards. This rush to quality places
the role of the CNL right at the forefront.

**Theoretical Constructs Underlying the Resolution of the Problem**

Innovation diffusion theory has been selected to help explain the theoretical
constructs that underlie the CNL role as being a feasible resolution to the issue of
communication gaps and helping to improve patient care through lateral integration.
Diffusion of Innovations is a theory utilized to explain how, why and at what rate
innovation spreads through cultures (Rogers, 2003). This theory was popularized by
Everett Rogers in 1962 when he published a book titled, *Diffusion of Innovations*. In this
book, Rogers evaluated and analyzed research from over 508 diffusion studies and
formulated a theory with regards to the adoption of innovations among organizations and
individuals (Rogers, 2003). Rogers described diffusion as the “process in which an
innovation is communicated through certain channels over time among the members of a
social system” (Rogers, 2003). Rogers further explains that the idea of diffusion
comprises four main elements which can have impact on the spread of new ideas. These
elements include: innovation, communication channels, time, and social systems (Shirey,
2006).

Rogers defines an innovation as an “idea, practice, or object that is perceived as
new by an individual or other unit of adoption” (Rogers, 2003). The idea of implementing
the CNL role for PPH would be considered an innovative idea due to the fact that the
role would be new to the organizations that is currently fused to the idea of utilizing
Clinical Nurse Specialists. The concept of reinvention comes into play with the idea of
accepting or rejecting the initial innovation (Shirey, 2006). Reinvention allows the innovation to be modified or adjusted with the goal of improving the chance of initial adoption or with the goal of obtaining ongoing acceptance (Shirey, 2006).

Communication channels refer to the methods used to deliver information from one individual to another (Rogers, 2003). In this instance, communication channels refer more to the social processes used to deliver messages as opposed to the scientific empirical evidence (Rogers, 2003). Different examples of communication channels include “mass media or interpersonal channels” (Rogers, 2003). The efficacy of these channels is dependent upon the perspective of time (Shirey, 2006). Communication channels are vital to help to communicate and delineate role expectations and to minimize role confusion.

The next element in the innovation diffusion theory is the element of time. Time is the actual time period of time in which the innovation-decision process occurs. Roger’s stated that the diffusion of an innovation, otherwise known as the adoption process, occurs in a series of five consecutive stages (Rogers, 2003). These stages are: knowledge, persuasion, decision, implementation, and confirmation (Rogers, 2003). Knowledge is the stage where an individual is first exposed to an innovation or idea but does not have all the information about it. At this stage, the individual has not exhibited a desire to inquire more information about the innovation. Persuasion is the next stage where the individual actually becomes interested in the innovation and pursues information about the innovation. Persuasion leads to decision where the individual weighs the pros and cons of using the new innovation and makes a decision to adopt or reject the innovation. If a
decision to adopt the innovation occurs, then the next step of the process is the implementation phase whereby the individual incorporates the innovation into practice. The last stage is confirmation when the individual makes a final decision on whether to commit to the use of the innovation (Rogers, 2003).

The last element of the innovation defusing theory refers to the social system. The social system refers to the “interrelated units that are engaged in joint problem solving to accomplish a common goal” (Rogers, 2003). The idea of sharing a common goal or objective is important to understand because it implies that social processes have an impact on diffusion (Shirey, 2006). Specific individuals have more impact within an organization to affect the rate of diffusion. These individuals are known as opinion leaders. Opinion leaders are individuals whose position and/or persona have an effect on others within the social system (Shirey, 2006).

**Intervention, Implementation and Evaluation**

**Intervention to reduce the problem**

One of the opinion leaders within PPH is Joy Gorzeman, RN, MSN who transitioned from the role of Director for Transformation to the role of Chief Nursing Officer for Palomar Medical Center in the spring of 2010. Gorzeman’s work on evaluating the clinical practice and the needs of improving the coordination of patient care, coupled with the fact that two experienced PPH employees were pursuing the degree of CNL, proved to be the perfect timing to commence the discussions of introducing the CNL role into the organization. Understanding the culture climate of PPH and the potential threat of a new clinical role to existing structure, Gorzeman pursued the
idea of creating a Patient Care Coordinator role that encompasses many of the salient attributes and functions of the CNL as outlined in AACN’s White Paper (PPH, 2011).

According to the drafted job description, the Patient Care Coordinator works through lateral integration of patient care services by serving as the communication hub for the patient with the goal of improving the patient’s care experience and ultimately patient outcomes. The patient care coordinator will accomplish this by: 1) providing interdisciplinary coordination, 2) facilitating care planning, 3) serving as a physician liaison with regards to patient care, 4) encouraging quality improvement and adherence to evidence-based practices in partnership with the interdisciplinary healthcare team actively involved in the patient’s care, and 5) serving as an advocate for the patient, family, and interdisciplinary team. The Patient Care Coordinator will work to enhance patient outcomes and improve the patient’s quality of life through clinical and educational expertise. The role of the Patient Care Coordinator is committed to improvement of care processes and systems and will be responsible for evaluating the effectiveness of patient care provided based on measureable outcomes (PPH, 2011).

The Patient Care Coordinator was designed to act as a catalyst for change by serving as a change agent by translating and integrating new evidence into practice. The Patient Care Coordinator will deliver care at the point of care to patients across the lifespan with a focus on health promotion and risk reduction services, utilizing the best available evidence and integrative approach. The Patient Care Coordinator role will primarily be unit or setting based and will be responsible for the coordination of care for a specific cohort of patients. The Patient Care Coordinator will develop an overall or
holistic view of patients, families and caregivers and establish strong partnerships with them to deliver optimal care. In addition to all the previously stated functions, the Patient Care Coordinator will also actively serve to mentor and coach other healthcare providers from novice to expert while supporting PPH initiatives to improve patient/customer loyalty (PPH, 2011).

**Implementation**

The introduction of a new role into any organization is a lengthy process with many steps. The idea of implementing a Clinical Nurse Leader role within the PPH system has many political implications due to the climate and the perception of overlapping roles. It became very apparent that Roger’s diffusion of innovation model was completely appropriate with regards to strategizing and planning the infusion of the CNL role within PPH. The understanding that a new innovative idea needs time to be accepted and valued in order to be effective was important.

The White Paper for the CNL role was extensively reviewed by Gorzeman and the two PPH CNL students. Current CNL models throughout the country were evaluated utilizing different methods such as literature reviews, personal interviews and national education forums such as the Clinical Nurse Leader Association’s (CNLA) webinars. The role of the CNL is a new innovative idea to PPH. In order for the role to be accepted within the organization, it became apparent that fully understanding the role, function, impact and need would be vitally important. It was noted that only one facility within the San Diego region utilized the CNL model which was in its pilot stage process. Joy Gorzeman’s previous experience with implementing the CNL role at another facility
proved to beneficial as she served as the opinion leader to help plan and strategize the diffusion of the CNL role into PPH’s culture.

Multiple communication channels were utilized to help educate and increase awareness of the CNL role and its potential impact within the organization. One of the meetings was with the “care delivery process redesign group.” With the construction of the new Palomar Medical Center underway with a target opening for the summer of 2012, the care delivery process redesign group was tasked with evaluating current workflow process and current practice models. This group was also provided the forum to look and evaluate new innovation with the goal of improving patient care coordination and the patient care experience. The patient care experience was defined as the patient’s personal perspective as they journey and interact with the staff in the varying departments throughout the health system. This group was truly multidisciplinary and included groups from: front line nursing staff, Clinical Nurse Specialists, administration, quality, dietary, case management, social work, pharmacy, laboratory, radiology, system engineers and consultants.

Another group that was identified as crucial to obtain “buy in” of the benefits of the CNL role was the professional practice council (PPC). The PPC consists of the staff member chairs from the varying unit practice councils (UPC). The unit practice councils are part of PPH’s established shared governance model. This model allows staff to have direct input on varying practice issues that occur within their corresponding departments and the district as a whole. The members of the PPH include: front line clinicians, CNS’s, nursing educators and nursing administrators. This group was identified as vital because
it encompasses many of the organization’s key opinion leaders. Other presentations on the CNL role were delivered to nursing leadership meetings and with key members of the advanced practice nurse (APN) groups. Some skepticism was identified in the differing meetings with the concern of role confusion and overlap. These issues were addressed with multiple small question and answer groups.

Multiple microsystems were evaluated for appropriateness and readiness to pilot the new role. One such microsystem was the orthopedic spine surgery service line. The two PPH employed CNL students were invited to be part of the Spine Service Line Planning Committee. This committee included: project managers, orthopedic surgeons, neurovascular surgeons, interventional radiologists, physiatrists and administration. Working with the project manager, the CNL students helped to develop a job description. Utilizing the AACN’s White Paper as a guide, a job description for a patient care coordinator was developed and contained the main functional qualities of the CNL. Outcome measures and clinical quality measures were also developed. All of the information was shared with the Spine Service Line Planning Committee and obtained approval. The CNL students also worked with the project manager to review applications for the position and assisted in the interview and selection process.

**Budget Considerations**

During the literature search and conduction of multiple interviews with organizations that have committed to the CNL role, it was noted that there were differing opportunities to financially support a CNL role. Because the role is so new and its long term benefits are promising but unknown, many organizations are making adjustments in
their current staffing model to ensure that the staffing budget remains cost or FTE neutral. At Flagler Hospital in St. Augustine, Florida, a six month pilot of the CNL role was conducted by covering thirty patients during the day shift with the use of three full time CNLs (Smith et al., 2006). St. Lucie Medical Center (SLMC) piloted the CNL role on a thirty six bed progressive care unit in 2006 with the use of two CNLs at a ratio of one CNL to eighteen patients (Gabuat et al., 2008). SLMC was also able to ensure that the pilot of the CNL role remained budget neutral by converting existing unit secretary positions to CNLs (Gabuat et al., 2008). The University of California San Diego Thornton Hospital piloted the CNL role in 2008 by replacing the existing break nurse with a CNL (Ryan, 2011). The plan at PPH would be to have one CNL cover one nursing unit that contains roughly thirty beds. PPH is still in the planning stages with regards on how to budget for the role. One option is to replace the break nurse with a CNL. Another option would be to restructure the allocation of CNS positions to include a CNL.

The cost benefit of a CNL role has had tremendous potential according to the literature. The CNL has been proven to be effective at both cost savings and assisting with direct revenue. Flagler hospital, with the implementation of the CNL role over a six month pilot, was able to demonstrate a 9% or 0.41 days decrease in patient’s length of stay which resulted in a cost savings of $416,150 not to mention the ability to generate revenue by admitting more patients. This same facility was also able to show a decrease in agency usage by 50% which represented a savings of $120,165 over that same six month period (Smith et al., 2006). Maine Medical Center was able to demonstrate a
decreased length of stay of intensive care unit patients by an average of six days per
patient which equated to a cost savings of $800,000 over fourteen months. This was
achieved by establishing a multidisciplinary team to round on patients who required
mechanical ventilation for greater than five days (Poulin-Tabor et al., 2008). The
Veterans Health Administration (VHA) was able to demonstrate a $461,774 cost
avoidance price tag by decreasing patient cancelations in the perioperative and
gastrointestinal settings with the advent of the CNL role who made consistent contact
with patients after initiation of a surgical request (Ott et al., 2009). The VHA was also
able to demonstrate a decrease in ventilator associated pneumonia (VAP) rates from
21.7% to 8.7% (Ott et al., 2009). VAP rates have been estimated to add an additional
$40,000 to the cost of care per incident (Tablan et al., 2004). All of these noted examples
demonstrate the cost benefit of implementing a CNL role and the potential areas of
impact fiscally.

**Evaluation**

While PPH is still within the planning stages of implementing this new role, there
are numerous metrics that can be evaluated to determine its effectiveness. Most of the
metrics identified in the literature fell into three categories: 1) Satisfaction, 2) Quality and
3) Fiscal.

In the category of satisfaction, multiple facilities looked at the areas of patient,
staff, and MD satisfaction with the implementation of a new role. Staff satisfaction were
assessed by the level of staff engagement and the effect on staff turnover by the impact of
the CNL to reduce staff interruptions and the improvement of communication with the
multiple members of the interdisciplinary team (Gabuat et al., 2008; Ott et al., 2009; Smith et al., 2006; Harris, Tornabeni & Walters, 2006). Patient satisfaction was measured by using patients’ responses to private surveys with regards to their perspective on the quality of nursing care provided and the ability of staff to keep them informed regarding their medical care (Smith et al., 2006; Ott et al., 2009). Physician satisfaction was another important factor to consider with the implantation of a new role. One study demonstrated that 95% of physicians in a survey group were “very satisfied with the nursing care and how well nurses kept them informed regarding their patients’ condition” (Smith et al., 2006).

Multiple examples in the area of quality can be utilized to determine the effectiveness of communication by the CNL. At Flagler Hospital, the CNL was able to decrease the use of restraints and decrease the number of patient falls (Smith et al., 2006). Another pilot study at St. Lucie Medical Center demonstrated an improvement on core measure data for congestive heart failure, acute myocardial infarction and pneumonia by ensuring complete and accurate charting by the nursing staff (Gabuat et al., 2008). The VHA was able to demonstrate that effective communication from the CNL resulted in a decrease in pressure ulcer prevalence rates from 12.5% to 4.2% (Ott et al., 2009). This was achieved by communication of the CNL to the staff with regards to stressing the importance of a thorough skin assessment and utilization of skin care protocols (Ott et al., 2009).

As previously stated, there are numerous metrics with regards to fiscal impact that can be measured to determine the benefit of implementing a CNL role. Some of these
include: decreased incremental overtime, decrease in the length of stay, decrease in VAP rates, decrease in agency use, and a decrease in canceled procedures (Smith et al., 2006; Harris, Tornabeni & Walters, 2006; Ott et al., 2009).

Some of the metrics considered to evaluate the new patient care coordinator role includes decreasing the usage of contract nursing labor (travelers or registry) by creating an active learning environment and engaging staff which leads to increased staff satisfaction which will decrease staff turnover rates. Increased communication by the CNL and the front line staff will help with improving care coordination which will result in increased patient satisfaction as well as physician satisfaction. The ability of the CNL to assist with improving the quality and timing of crucial patient care hand offs by revamping the hand off tool can also have an impact on incremental OT. Engagement by the CNL with performing concurrent chart reviews and continuous education of frontline staff can have a positive impact on core measure outcomes. Development and involvement in consistent patient care rounding may have an impact on a patients length of stay, fall rates, hospital acquired infections (such as ventilator associated pneumonia, catheter associated urinary tract infections, central line infections), and supply utilization costs.

**Conclusion**

Fragmentation of care and communication gaps are growing issues in today’s health care arena. With the future of accountable care organizations looming and the realization of decreased reimbursements and payments linked to outcomes only further challenges organizations like PPH to look for innovative ways to care for its patient
population. Part of the answer may lie with the addition of the skillset of a CNL. The Clinical Nurse Leader (CNL) role is a new and innovative role that was developed by the AACN in response to the increase of client care needs as well as the changing health care delivery environment (AACN, 2007). The CNL role is seen as bridge for communication from the world of academia to the microsystem level at the patient’s bedside. The CNL is designed to identify and correct gaps in communication, produce systems that bridge silos and eliminate fragmented care, all the while viewing the patient as a whole (Harris, Tornabeni & Walters, 2006). As Tim Porter-O’Grady states (2010), CNLs are changing the face of nursing to become true care partners with other members across the health system by “acting as an integrator of the threads of care provided by many to weave a new fabric of comprehensive, coordinated care.” This is exactly what PPH is trying to accomplish with the advent of a new role that is designed to help close the communication gaps in patient care.
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