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Commentary

In this commentary, a clinical nurse leader (CNL) reflects on the role of the CNL in promoting continuity of care.

Clinical Nurse Leader–Integrated Care Delivery

An Approach to Organizing Nursing Knowledge Into Practice Models That Promote Interprofessional, Team-Based Care

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THE STORY told by Segal[1] in "Looking for Continuity of Care" is unfortunately typical for many patients and families working their way through today's health care system. The problem expressed so articulately by Segal is a distinct lack of the critical health care communication and collaboration practices that drive continuity of care. This state of affairs continues despite the fact that we have an extensive literature defining what care quality should look like in terms of patient-centeredness, timeliness, safety, efficiency, effectiveness, and equity.[2] One issue is current care delivery infrastructures, which actively hinder interprofessional collaborative care processes.[3,4] As Segal's experience exemplified so acutely, the majority of today's care environments are structured so that nurses, physicians, other care providers, and administrative managers and leaders deliver or ensure quality care via mutually exclusive processes, with unique expected outcomes that are informed by distinct disciplinary curricula and training.

Researchers and health care leaders are actively seeking ways to redesign care systems in ways that overcome these critical challenges. The purposes of this article are to (*a*) describe current conceptualizations of interprofessional communication and collaboration; (*b*) summarize the literature on clinical leadership, a mode of clinical behavior to promote engagement in specific practices; and (*c*) delineate current theory and evidence about clinical nurse leader (CNL)–integrated care delivery, an approach to structuring

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nursing knowledge and practice into a care model that promotes interprofessional, team-based care.

INTERPROFESSIONAL COMMUNICATION AND COLLABORATION

Collaborative practice is growing as a national priority for health care improvement, with interprofessional communication and collaboration increasingly acknowledged as a powerful "tool" to improve the quality, outcomes, and cost of care.[5] The Interprofessional Education Collaborative, an organization with representation from nursing, pharmacy, medicine, dentistry, and public health, among other health professions, just released an updated report that defines the competencies necessary to enact interprofessional collaboration. These include (1) values/ethics for interprofessional practice, (2) roles and responsibilities, (3) interprofessional communication, and (4) teams and teamwork.[6] The first competency explicates the need to reconceptualize traditional professional values to include a perspective that collaboration is ethically necessary for patient-centered care. Second, clinicians need to use knowledge of their own and each other's professional roles and responsibilities in the course of providing care delivery services to patients, families, and communities. Third, clinicians should communicate with each other and patients using diverse tools and strategies. And, fourth, clinicians must work to create team dynamics and perform in teams within their care settings. The goal is to move from an active intent to collaborate to actual collaborative practices, which then evolve over time into collaborative teamwork and ultimately to intentional interprofessional team-based care.

The work remains, however, to get from the current state of disjointed and siloed disciplinary practices to the goal of interprofessional team-based care. San Martín-Rodríguez and colleagues[7] worked to conceptualize the systemic, organizational, and interactional determinants that interact to facilitate or hinder the manifestation of interprofessional communication and collaboration. Systemic elements involve the social and cultural norms of health care practitioners and patients, competing practice philosophies of each health care discipline, and wide-ranging educational background of all participants in health care. Organizational determinants include a health care setting's mission, values, and management structures, including resource allocation and formal coordination mechanisms dedicated to interdisciplinary collaboration. Interactional determinants include a willingness of clinicians to collaborate, mutual trust and respect for all members of any collaborative team, and personal communicative skills, which mirror the competencies for interprofessional collaboration set forth by the Interprofessional Education Collaborative. A recent concept analysis of interprofessional collaboration within the context of chronic disease management also confirmed the need for antecedent awareness, education, and belief that interprofessional collaboration improves care for attributes of interprofessional collaboration to emerge.[8]

These multilevel and interdependent determinants, attributes, and competencies must all be addressed to develop routines of collaborative care at the front lines of care, which presents considerable challenges to health care organizations. For example, a care delivery system may have a group of professionals who meet all the conditions for collaboration to occur, but if organizational structures are not in place to sustain collaboration, interactions may not take place as desired. Or the case may be reversed, where an organization has a structural commitment to interdisciplinary collaboration, but frontline clinicians may not be familiar or comfortable with the process of collaboration and need clinical role modeling and education at the point of care for it to occur.[9]

CLINICAL LEADERSHIP

Clinical role modeling can be considered a form of clinical leadership, an evolving concept with a growing body of theory and

evidence within the nursing literature.[10,11] A clinical leader is a clinician positioned at the front lines of care who ensures other clinicians engage in specific practices or goals through their own clinical practice, as opposed to administrative oversight or management functions. The literature on clinical leadership aligns closely with what has been described earlier in terms of interprofessional collaboration structures (determinants) and processes (competencies). A recent review of the literature identified clinical competence, effective communication and team-building skills, and an engaging and positive attitude as general attributes of clinical leaders.[12] Another meta-analysis concluded clinical leadership is a "complex process" that drives service improvement and the effective management of teams.[13] Others have defined clinical leadership as a "transformational process" where the judicious use of task functions (ie, goal setting), relational functions (ie, collaboration), and environmental functions (ie, negotiating support) should result in superior team performance.[13]

Numerous reports have identified the need for supportive infrastructure and alignment with organizational strategy to sustain clinical leadership, suggesting clinical leadership can only be as strong as the environment that supports it.[14-19] As one report summarized, clinical leadership can be considered a complex process of managing relationships at the microsystem level to facilitate the restructuring of multirelational care delivery processes—improving care quality requires sustained effort and appropriate, supportive infrastructures to become embedded, or acculturated, into everyday practice.[20] Touati and colleagues[21] found, for example, that clinical leadership alone was insufficient to produce major changes in interprofessional relations within an oncology service network; it needed to be accompanied by a "constellation" of administrative and political leadership to provide the authority and resources needed to evoke change. Patrick and colleagues[22] also found that structural empowerment (access to organization structures, resources, and support) directly influenced staff nurse clinical leadership practices, providing evidence of the reinforcing link between clinical leadership and organizational support.

The clinical leadership literature highlights the fact that professional nursing competencies, for example, advocacy and teamwork, can be conceived as clinical leadership practices that promote care delivery transformation at the front lines of care, but only if attention is paid to the organization of nursing competencies into care delivery models that appropriately and adequately structure clinical leadership practices. These practices include managing relationships and restructuring multirelational care delivery, which aligns well with the literature on the competencies and determinants of interprofessional collaboration. The fact that RNs comprise the largest sector of the health care workforce, with more than 3 million RNs currently employed, more than 4 times the number of physicians,[23] provides a powerful incentive to fully leverage nursing roles, responsibilities, and functions that they are educated, competent, and licensed to perform into care delivery models that promote interprofessional collaborative dynamics at the front lines of care.

CNL-INTEGRATED CARE DELIVERY

CNL-integrated care delivery was developed specifically to leverage Master's level nursing expertise in transforming frontline care dynamics. The American Association of Colleges of Nursing launched the CNL initiative in 2003.[24] Original CNL initiative stakeholders included health system and policy organization leaders, along with the education faculty, who worked together to develop a Master's level CNL nursing curriculum advancing competencies in (*a*) clinical leadership, (*b*) care environment management, and (*c*) clinical outcomes management.[25] A subsequent task force facilitated the development of practice-education partnerships across the country to launch the education of CNLs and pilot their integration into health system's care delivery models.[26]

Since then, CNL-integrated care delivery has been identified by the Agency for Healthcare Research and Quality, the Institute of Medicine (now the National Academies of Science, Engineering, and Medicine), and the Robert Wood Johnson Foundation as an innovative strategy to improve care delivery[27-29]. It has a growing track record of implementation in health systems across the nation.[30] A recent literature review documented over 15 case reports describing the development and implementation of CNL practice in federal, community nonprofit, and for-profit settings, with subsequent improvements in (*a*) staff, physician, and patient satisfaction with care practices; (*b*) interdisciplinary communication and collaboration; (*c*) patient care processes; (*d*) lengths of stay; and (*e*) nursing-sensitive quality indicators such as falls and staff RN certification rates.[31] The evidence also includes 2 correlation studies associating CNL practice with improved nurse satisfaction, turnover, and leadership practices[32,33] and 2 short interrupted time-series studies quantifying a moderate-to-strong correlation between CNL implementation and improved care environment and quality outcomes.[34,35]

More recent studies have contributed to a better conceptual understanding of what CNL practice "is" and the mechanisms by which CNL integration into care delivery leads to reported outcomes.[36-39] The research involved developing, refining, and empirically validating a conceptual model of CNL practice that articulates an explanatory pathway of CNL-integrated care delivery, including CNL structuring and practices that result in improved care dynamics and patient outcomes (Figure). In these studies, CNL practice was validated as an ongoing process of continuous clinical leadership, whereby CNLs continuously enact 4 core practices: (1) facilitate effective ongoing communication, including the creation of multimodal communication tools and rounding structures; (2) strengthen intra- and interprofessional relationships by establishing a network of multiprofessional microsystem partners; (3) create and sustain teams by bringing people from all disciplines and departments affected by care processes to work together and improve them; and (4) support staff engagement via an ongoing, consistent supportive presence, through the provision of resources based on in-the-moment needs, and by empowering staff to

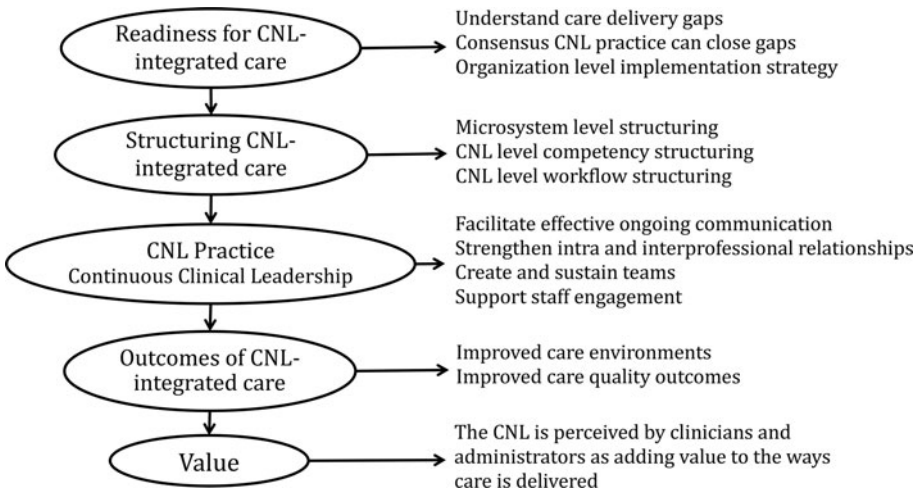

Figure. The empirically validated CNL practice model. CNL indicates clinical nurse leader. Adapted from Bender et al.[39]

perform to their full scope of practice and identify and create solutions for patient care needs.[36,39]

By consistently gathering and communicating information across professions, building intra- and interprofessional relationships, facilitating effective teamwork, and harnessing frontline staff knowledge of care deficits and their ideas for improvement, CNLs put the pieces in place to change the microsystem focus away from individual tasks and toward a broader understanding of how everyone plays a part in complex care processes to provide quality patient care. This interprofessional component of CNL practice expands the boundary of nursing practice to influence all professionals who are making contributions to patient care, promoting interprofessional team-based care.[37]

These studies[37-39] also identified the readiness and structuring elements that are necessary to enable the enactment of continuous clinical leadership practices by CNLs at the microsystem level. Readiness includes acknowledgment of care delivery gaps by health system clinicians and leaders and managers, as well as subsequent consensus that CNL education and competencies have the potential to close these gaps. Readiness also includes development of an implementation strategy, based on this acknowledgment, that is capable of preparing the environment for change. Structuring includes an appropriate administrative reporting structure and the clinical redesign of microsystem-level care delivery to incorporate a consistent, competency-based CNL workflow. Appropriate structuring and implementation of CNL practice result in outcomes that include both improved care environments and care quality. Validated elements of improved care environments included effective communication processes across professions, staff perceptions of owning their own practice, a perception that multiprofessional clinicians regularly work together to solve clinical problems, a perception that CNL practice changes the dynamics of clinical interactions between multiprofessional clinicians for the better, and overall satisfaction with the care environment. Validated elements of improved care quality included improvements in nursing-sensitive care quality indicators, better care coordination, less gaps or omissions in care, prevention of errors before reaching the patient, and staff spending more time with patients.

THE FUTURE OF NURSING IS LEADING INTERPROFESSIONAL CARE

CNL practice is a nursing-led innovation that directly responds to the call set forth by the Institute of Medicine's *Future of Nursing* report[28] for the nursing profession to lead and diffuse collaborative improvement efforts to redesign and improve practice environments and health. CNL-integrated care delivery provides one example of a nursing-led care model with a growing body of theory and evidence articulating how nursing knowledge and practice can promote interprofessional communication and collaborative dynamics with the goal of improving the patient's health care experience, as well as quality and safety outcomes.[40] There is, however, a need for more research and innovation in general on approaches that can leverage expert clinical knowledge as a mechanism for transforming clinical practices to generate the desired goal of intentional interprofessional team-based care. Berwick and colleagues have recently called for innovation that moves us beyond "institutionally based ... procedures and habits," but lament that innovation has not materialized "at anything near the scale needed."[41(p675)]

The barriers are significant, resulting in the continuation of fragmented practice lamented by Berwick and colleagues[41] and experienced by Segal.[1] The nursing profession, however, is both well situated and well qualified to address these challenges and lead the charge to advance the future of health care. Nurses are broadly distributed across the acute and ambulatory care environments. Furthermore, the nursing profession has an educational foundation that emphasizes ethics, communication, and caring relationships in the delivery of

health care, from the bachelor's to doctoral levels. But as the just published report *Assessing Progress on the Institute of Medicine Report The Future of Nursing*[42] highlights, there is still much work that needs to be done, increasing awareness of the nursing profession's capacity to significantly influence health care transformation. It is therefore important for the nursing profession to (*a*) redouble its efforts to educate nurses about, and instill competencies in, interprofessional communication and collaboration; and (*b*) increase the pace of efforts to work with payers, health care organizations, providers, employers, and regulators to redesign care delivery and payment systems with the goal of making them more dynamic, interprofessional, and patient-centered.

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