The clinical nurse leader (CNL) role has evolved since the American Association of Colleges of Nursing published a white paper on the role in 2007. Since then, various publications have evaluated the role of CNLs in enhancing quality outcomes for patients. The introduction of the CNL role in the oncology setting, although occurring with variability across the United States, provides a unique opportunity to explore the benefits of this role in cancer care outcomes.

**AT A GLANCE**
- This article presents a brief history of the CNL role and highlights the integration of CNLs in a comprehensive cancer center.
- Exemplars of their quality work in this setting are highlighted, along with recommendations for implementing the CNL role in diverse cancer care settings.
- As the CNL role continues to be refined across diverse healthcare contexts, the oncology community may benefit from the generalist approach to quality care in enhancing outcomes related to infection, falls, and patient satisfaction for individuals with cancer.

**A**

Clinical Nurse Leader

Evolution of the role in oncology care

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A clinical nurse leader (CNL) is a master’s-prepared advanced generalist who is responsible for coordinating care and improving patient outcomes at the microsystem level (American Association of Colleges of Nursing [AACN], 2007). Since its inception in 2006, more than 6,000 nurses have successfully earned CNL certification (Commission on Nurse Certification [CNC], 2017). The majority of certified CNLs work in acute care inpatient settings (n = 2,708); they also are employed in ambulatory care (n = 322), home health (n = 52), and hospice (n = 36) settings (CNC, 2017), each of which is a context in which patients with cancer may be treated.

CNLs are change agents and innovators who must be able to function in multiple roles: clinician (at the point of care); outcomes manager; client advocate; educator; information manager; systems analyst or risk anticipator; team manager; lifelong learner; and member of a profession (AACN, 2007). CNLs collaborate with interprofessional colleagues to promote evidence-based, quality-improvement initiatives, with an emphasis on healthcare financing, quality, safety, and measurable outcomes (Baernholdt & Cottingham, 2010). CNL practice may increase patient and nurse satisfaction and improve quality outcomes, including reducing falls, pressure injuries, and nosocomial infections, while also improving interprofessional communication and collaboration (Baernholdt & Cottingham, 2010). Identifying approaches to thoughtfully integrate the CNL role in a diversity of practice settings can support the successful implementation of this role into practice (Kaack et al., 2018).

Although CNLs are described as nurse generalists who are broadly responsible for quality-driven care coordination, several aspects of this focus may be particularly beneficial in the oncology care setting. Reviews of the CNL role have highlighted potential improvements in patient quality and safety outcomes, which include patient satisfaction, infection rates, and falls (Bender, 2014). Patients with cancer, who become immune-compromised during treatment, are at increased risk for potentially life-threatening outcomes, including infection (Strojnik, Mahkovic-Hergouth, Novakovic, & Seruga, 2016) and bleeding (Russell, Holst, Kjeldsen, Stensballe, & Perner, 2017) secondary to disease or treatment-related cytopenias. Because of this increased risk, the CNL emphasis on quality outcomes is particularly imperative. In addition to attention to quality, the complexities of care coordination for individuals with cancer as they transition within and between healthcare systems may benefit from the implementation of the CNL role. Previous publications have highlighted the potential role of CNLs in integrating quality and breast cancer care (Coleman, 2013). Rigorous studies of the relationship between role implementation...
and outcomes are needed across specialty areas; therefore, current outcomes are reflected in institutional experiences (Bender, 2014).

Implementation

The CNL role was implemented at the University of Texas MD Anderson Cancer Center in Houston, Texas, in September 2012 as part of a newly designed patient care delivery model. In this context, CNLs are responsible for improving patient outcomes, fostering continuity of care and care coordination, collaborating with interprofessional colleagues, and practicing patient- and family-centered care, all at the microsystem level (Bowman, Curtin, & Adornetto-Garcia, 2014). CNLs have focused on improving communication with patients and caregivers and enhancing patient safety in care at the bedside (Bowman et al., 2014). Quality-improvement initiatives include hardwiring bedside shift report and purposeful rounding, and more focused attention to nurse-sensitive indicators such as catheter-associated urinary tract infections and falls with injury (Bowman et al., 2014). The success of such activities is demonstrated in a sustained improvement in patient experience scores related to nurse communication, as well as improvement in several nurse-sensitive indicators (Bowman et al., 2014).

Quality Metrics

Although the CNL role cannot be directly correlated to any single improvement outcome, individuals in this role have been instrumental in the implementation of many unit-specific or system-wide quality-improvement initiatives. Examples of such initiatives include a quality-improvement initiative focused on reducing discharge delays on a hematology unit (Rock, 2017); development of new institutionally standardized guidelines for the management of incarcerated patients during hospitalization for stem cell transplantation (Sullivan, Cao, Davis, Jewell, & Nassar, 2016); implementation of an evidence-based pain assessment instrument for nonverbal patients in the intensive care setting (Jawe & Curtin, 2016); and observed improvement in patient satisfaction scores related to a CNL-led hourly rounding initiative (Delanoix, 2015). In addition to numerous quality initiatives, CNLs also are engaged in research to explore potential contributors to quality outcomes. These include a study of perceived missed nursing care in the oncology setting, for which a CNL served as principal investigator (Villamin, Anderson, Fellman, Urbauer, & Brassil, 2018). In addition, CNLs were instrumental collaborators on a study by Johnston (2017) of a video-based fall prevention education program involving more than 2,000 patients. CNLs routinely engage with microsystem-, unit-, and institution-based initiatives to improve infection, fall, and pressure injury rates among diverse medical, surgical, and hematologic oncology populations at MD Anderson Cancer Center.

Considerations

The CNL role, which is flexible and highly adaptable, can be integrated and optimized across oncology settings. Similar to roles like that of nurse navigator, which focuses on population expertise to assist patients in care coordination but can be woven throughout various settings and stages of the cancer care continuum (Lubejko et al., 2017), CNLs can be operationalized to apply expertise in care quality to support the microsystem in which cancer care is delivered. Integrating the CNL role in the cancer care setting requires a commitment to education, strategic implementation, and outcomes measurement. Just as is recommended for other newer roles, like that of nurse navigator (Lubejko et al., 2017), a significant component of the CNL role is educating colleagues and institutions about the role and its value to patient care. In the case of the CNL role, this also requires a commitment either by CNLs directly, or by researchers with whom they work, to apply science to more clearly define the outcomes aligned to the implementation of the role, which is a continued opportunity for the CNL community (Bender, 2014). From a strategic perspective, once introduced into the organization, the CNL role should be incorporated in organizational charts, new employee orientation, and nurse residency or similar programs. Clearly defined position descriptions can promote consistency in practice and role adoption. At MD Anderson Cancer Center, an educational program to support the mentorship, return to degree programs, and transition to role was fundamental in supporting the introduction and sustainment of the CNL role (Bowman et al., 2014). Developing mentorship programs, classes, and resources that promote CNL professional growth also can empower CNL autonomy.

Conclusion

Ultimately, CNLs, who are integral healthcare team members immersed at the front line, are essential in coordinating patient care throughout the cancer trajectory, from diagnosis to survivorship, and across treatment settings. CNLs serve as liaisons at the microsystem level, collaborating with interdisciplinary colleagues to...
advocate for patient care needs. CNLs can promote best practices, facilitate process improvement initiatives to affect quality metrics and patient experience, and facilitate the incorporation of evidence-based guidelines and standards into policies and procedures. Trained in multifaceted roles that emphasize quality care and outcomes, CNLs are ultimately integral in promoting safe and effective cancer care from the generalist perspective.

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