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## EXPERIENCE EXCHANGE

# Clinical nurse leaders in the community: Building an academic faculty practice partnership

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## Abstract

The Affordable Care Act (ACA) emphasis on preventive care and primary health has given community organizations and outpatient care environments renewed attention. Nursing has been offered the opportunity to lead healthcare into a new era. One of the two new nursing programs to be given life in this movement is the Clinical Nurse Leader (CNL). The CNL is a graduate level educated nurse who specializes in healthcare systems leadership, a facilitator of care in the complex healthcare environments of today. They are equipped to see the wider and broader perspective of things, assess needs, research the best interventions for problems identified, implement these interventions, and evaluate the processes and outcomes of the interventions. This paper describes the experience of a school of nursing and health professions and a community non-profit organization in developing a community faculty practice partnership allowing for CNL, nurse practitioner, and Doctorate of Psychology students to be placed at a community clinic serving high-risk patients. The Synergy Model of community partnership formation by Lasker and Weiss is used as the complimentary model to show how the CNL approach to a microsystem can be effectively adopted into the community setting with beneficial outcomes to both parties of the partnership.

**Key Words:** Clinical nurse leader, Community setting, Community partnership, Faculty practice, Synergy

## 1 Introduction

The nation is facing a new chapter in healthcare brought about by the Affordable Care Act (ACA). Recognizing the unsustainability of the trajectory in healthcare cost from the past four decades, the ACA emphasis on preventive care and primary health has given community organizations and outpatient care environments renewed attention. As a profession, nursing has been offered the opportunity to lead healthcare into this new phase as eloquently advocated in the Institute of Medicine report, *The Future of Nursing*.<sup>[1]</sup> One of the two new nursing programs to be given life in this movement is the Clinical Nurse Leader (CNL). The CNL is a graduate level educated nurse who specializes in healthcare systems leadership, a facilitator of care in the complex

healthcare environments of today. They are equipped to see the wider and larger perspective of things, assess needs, research the best interventions for problems identified, implement these interventions, and evaluate the processes and outcomes of the interventions.<sup>[2]</sup>

Assumed by early adopters of the role to improve care within the inpatient environment of acute hospitals,<sup>[3]</sup> the CNL's can be adopted in outpatient settings in the era of the ACA. The challenge in providing preventive health care can be as complex as acute patient care management. With the attention shifting to the outpatient arena, schools of nursing have looked towards community organizations as clinical placement sites for nursing students. Using the CNL model of working in and strengthening a microsystem, a school of

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nursing and health professions and a community non-profit organization developed a community faculty practice partnership allowing for CNL, NP and Doctorate of Psychology students to be placed at a community clinic serving high-risk patients. The CNL model is also used to nurture and sustain the relationship.

The Synergy Model of community partnership formation by Lasker and Weiss<sup>[4,5]</sup> is applied as the complimentary model to illustrate how the CNL approach to working in the microsystem can be effectively adopted into the community setting. Community health emphasizes population needs by building bridges, a skill that requires a bigger view of understanding the influences that affect care, and the ability to facilitate many stakeholders to join in a mission; the CNL education is, inherently, to train nurses to build those bridges.

## 2 The clinical nurse leader

The IOM report in 1999, *To Err is Human: Building a Safer Health System*, spearheaded an awakening that the United States (U.S.) healthcare system is in need to repair.<sup>[6]</sup> With errors costing human lives and an estimated 17-29 billion dollars to healthcare cost, the report emphasized the increasing complex and fragmented nature of the system in which the patient is no longer the focus in the delivery care. The report initiated a movement towards quality of care and improving patient outcomes, bringing the focus of healthcare back to the patient, referred to as "patient-centered care".<sup>[6,7]</sup> Several reports by the IOM followed on the need to restructure the education of healthcare providers to focus patient-centered needs emphasizing evidence-based practice, the use of informatics, building interdisciplinary teamwork, and for nurses to take a leading role in the changing healthcare environment.<sup>[1,6]</sup> In this paradigm shift, the CNL was developed to meet the future healthcare needs of the country.

The foundation to the CNL educational model is prepare the nurse of the future to meet the needs of the healthcare system as a provider and as a leader, an instigator of change. It is a call to the profession to step up to the plate that nursing education must be reassessed, invigorated, and "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".<sup>[6]</sup>

The vision of the CNL is for the role to work in the mi-

croscystems of various healthcare settings with the main goal of improving patient outcomes. The CNL is given the skillset to assess, research for the best interventions, evaluate the interventions, implement the most appropriate intervention, and evaluate its effectiveness, all within the context of a team, with stakeholders to win and followers to lead, enabling successful implementations of best practices.<sup>[2,6]</sup> The analogy of the CNL as the conductor of an orchestra can be used to explain the role: the microsystem is made up of various instruments (professions or stakeholders) each with their lead (informal leaders among stakeholders), with each instrument requiring different playing techniques (cultural differences or differences in expectations) but following a score (the evidence-based intervention or shared vision) to produce a most harmonious sound (the best patient outcome). The CNL, like the conductor, must be educated to see the bigger picture, to understand all the nuances of a musical score and instruments in order to facilitate and produce the best outcome.

The other assumptions of the CNL are that the CNL is committed to the use of data, information; and technology to make informed decisions; understand the importance of social justice and prudent fiscal stewardship; appreciate that knowledge is the foundation to improvement for patients, providers, and most importantly, for the CNL who must be committed to life-long learning; and assume the responsibility as champion of the nursing profession, guarding and nurturing it to meet the highest standards of expectation and professionalism.<sup>[2,6]</sup>

### The microsystem

Championed by Dartmouth Institute, the microsystem in healthcare is defined as the environment where care happens for patients provided by interdisciplinary members of the healthcare team. Together with the patients, this team manages changing information effectively to maintain safety and promote the best outcomes in care. This microsystem became the focus of where healthcare improvement in quality and safety can start.<sup>[8]</sup>

The work of improving any microsystem starts with leadership of a healthcare setting supporting the CNL to perform a thorough microsystem assessment to identify the problem or problems that affect care and require change.<sup>[2,8-10]</sup> In CNL education, students are given the tools to assist in completing the microsystem assessment; these include the 5 P's (Purpose, Patients, Professionals, Processes, and Patterns) and process mapping.<sup>[8]</sup> CNLs are encouraged to communicate with all stakeholders to understand the microsystem better. Upon identification of the problem of priority, CNLs perform a literature review to find the most current, evidence-based intervention suited to bring about change. The next step requires the development of specific, measurable, attainable, realistic and timely (SMART) objectives.

The CNL also understands the challenges that come with introducing change in a microsystem, that it has to be championed and sold, that it requires team building with continuous effort to nurture stakeholders to accept and sustain the novel intervention. In bringing about change, a criterion essential to the success of the CNL's effort is shared vision and mission of the stakeholders in the microsystem. Through the whole process from assessment to implementation, CNLs understand the need to be continuously aware of changing strengths and limitations; emotional intelligence and process evaluation skills are quite applicable. Evaluations of outcomes end the cycle of implementing a change;<sup>[2,9,10]</sup> the end also serves the start in the next Plan, Do, Study and Act (PDSA) cycle, keeping to the continuous nature of quality improvement.

### 3 A community clinic as the microsystem

The microsystem as defined above describes the function of a community clinic with the goal of meeting the needs of a geographic area or population. The microsystem comprises the environment where an interdisciplinary team provides integrated healthcare to patients. The goals are to achieve best patient outcomes; the way to meet these goals is the constant management of data, information, and knowledge. Team members must interact efficiently and communicate effectively to coordinate care while leaders must provide the vision and lead the team to ensure the patients' needs are met to keep a population healthy and out of hospitals.

#### 3.1 Synergy in community partnership

The Synergy Model by Lasker and Weiss<sup>[4,5]</sup> in building community partnerships is a natural compliment to the CNL responsibilities as described. These authors emphasize the "who" and "how" of a partnership, and the sharing of common goals. These similarities with a well-established model in developing community health partnership provide a strong justification to how the CNL can be adopted into the community setting.

The foundation of the Synergy Model is such that community partnerships are necessary for the health maintenance and promotion of a population in a geographic area. Too many partnerships are started to address issues or problems of a community only to have them fail. The Synergy Model explains the essentials required for a successful community partnership:

- There must be leadership willing to collaborate with stakeholders of the partnership;
- Stakeholder composition must be inclusive;
- The partners share the same goals, vision or cause;
- Stakeholders are fully participatory members in the partnership development process;
- Communication is open and guided by leaders based on trust.

All these factors are fully considered in the CNL role within a microsystem. Table 1 provides a visual of the Synergy Model as it relates to the the CNL role.

**Table 1:** The complimentary relationship of the Synergy Model and CNL processes

The Synergy Model	The CNL Microsystem Quality Improvement Processes and Cycles
The "who" <ul style="list-style-type: none"> <li>• Leaders</li> <li>• Stakeholders</li> </ul>	Assessment (use the 5 P's): <ul style="list-style-type: none"> <li>• Identify leaders and key stakeholders</li> <li>• Identify other members of the microsystem</li> <li>• Assess willingness to collaborate</li> </ul>
	Assessment: <ul style="list-style-type: none"> <li>• Facilitate identification of a shared concern/goal</li> </ul> Implementation (team building): <ul style="list-style-type: none"> <li>• Encourage inclusive composition of members</li> <li>• Encourage participation of members</li> <li>• Assign roles <i>e.g.</i> research into best practices; administrative help; <i>etc.</i></li> </ul> Implementation (intervention): <ul style="list-style-type: none"> <li>• Research best practices and recommend intervention</li> <li>• Assign implementation roles with full member participation</li> </ul> Process evaluation: <ul style="list-style-type: none"> <li>• Open communication based on trust</li> <li>• Sustaining the partnership</li> </ul>
The "how" <ul style="list-style-type: none"> <li>• Inclusivity</li> <li>• Shared goal/vision</li> <li>• Participation</li> <li>• Communication</li> </ul>	

#### 3.2 The community partnership

The renewed importance of primary and preventive healthcare brought about by the ACA has encouraged the interest of nursing schools to place nursing students in the community setting. It is understood that nursing can contribute to the future of healthcare emphasizing health and not sick care. The champions of the CNL program at the school of nursing and health professions (SONHP), at which the author is a faculty member, understood the importance of bringing the CNL to the community setting. It is also recognized that the CNL students are particularly well suited to foster the school's commitment to social justice and service learning, in this case, access to healthcare for underserved patients. A congruence of events facilitated the beginning of the relationship between the school and a free clinic run by a non-profit in the middle of socio-economically depressed area in the city. The leadership of the organization saw a need to grow the clinic. They approached the nursing school for assistance. At the same time, a new faculty member in the CNL program with previous work experience in the area serving the homeless, streetwalkers, and transgender individuals started as a volunteer at the clinic, planting the seed

for the beginning of a faculty practice partnership. At this point, the faculty practice came in the form of healthcare systems leadership to work with the non-profit organization leaders on planning the next steps.

Early in the partnership, it was clear that the goals of the organization and the school were synergistic. The clinic has been functioning with an all-volunteer staff, in need of consistent leadership and staffing as it struggled to stay open for two half days per week. The administrators of the organization, of which the clinic is one spoke of its umbrella, realized that in order for the clinic to sustain and grow itself, it must be able to generate some income by initiating billing to government programs. However, it faced the typical chicken and egg dilemma: to generate the income, the clinic needs staff but before staff can be hired, the clinic must have a funding source. To complicate matters, a significant percentage of patients who use the clinic do not have health insurance coverage. As a commitment to developing the clinic, the organization leadership hired a fulltime clinic administrator to immediately address patient care follow-up issues and to build the capacity of the clinic. The school of nursing and health profession was seeking community partners to enable faculty practice sites to facilitate clinical placements of students. With a CNL program faculty volunteering, the school could begin placing CNL students to assist in the growth of the clinic.

### 3.3 Microsystem assessment

Using the 5 P's: Purpose, Patients, Professionals, Processes, and Patterns, the CNL conducts a microsystem assessment to fully understand a situation or a unit, in this case, the community clinic, and the partnership between the non-profit organization and the SONHP. The leaders of the non-profit organization of which the clinic belongs, as previously addressed, are committed to growing the clinic to serve the underserved population of the geographic area. They sought assistance from the school; the timing coincided with the SONHP's commitment to place students in outpatient settings and to build faculty practice partnerships in the community. The compatibility of goals and vision of the two institutions' leadership is key to the forward movement of the partnership, synergistic from the very beginning.

The first CNL student placed at the clinic, under the guidance of the faculty member and the clinic administrator, completed an assessment of the clinic patient population. It was apparent that about a third of the patients seen at the clinic had come for family planning services, many of which were also treated for sexually transmitted diseases.<sup>[11]</sup> Another third were noted to be transgender individuals seeking hormonal reassignment care. About 8,000 residents of the area served by the clinic were also found to be undocumented. The geographic area is also socio-economically depressed with a high concentration of the homeless, single-room occupancy hotels, massage parlors, and prostitution.

A Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis found several obstacles in the microsystem assessment including a lack of volunteer providers and nurses; insufficient physical capacity in the form of a lack of examination rooms and access to a functioning clean utility area; and a lack of standardization of processes and procedures. The volunteer nurses provided care based on individual wishes and preferences; clinic days were frequently cancelled on late notice when a provider had other professional priorities. The volunteer nurses and providers, however, were committed to the clinic and the cause of social justice, and when called upon, agreed to assist the CNL students to move the clinic forward. Critical support came from the administrators of the school of nursing and health professions and the non-profit organization.

In relation to the faculty practice partnership, other than the leaders of the non-profit organization and the SONHP, the clinic administrator, the faculty member, providers, nurses, and patients constitute the rest of the "who" per the Synergy Model.

### 3.4 Implementation: Team building and intervention

The team agreed on working to start a family planning clinic while working on the long-term goal of becoming a primary care clinic serving the high-risk and under-served populations of the area. With the new volunteer director of nursing and this author working on policies and procedures, three more CNL students interested in outpatient care were brought in to facilitate the move forward: individually and using tools from their CNL education—PDSA cycles, surveys, literature reviews, process mapping, *etc.*, they worked on the requirements of the family planning clinic; performed a cost benefit analysis; researched the policies and procedures on family planning; researched and gathered data on obtaining primary care medical home (PCMH) certification; and developed a standardized nursing orientation. A provider meeting of all volunteers was organized and held at the home of the volunteer medical director to gather everyone at one place to facilitate communication of the clinic goals and vision of the leaders.

Another faculty member of the SONHP, a nurse practitioner, was recruited for her experience in family planning and community health. Her expertise was critical in getting the right equipment for the clinic. At the same time, the administration of the non-profit organization agreed to move forward with renovating the clinic to allow for a better flow and physical capacity of a "real" clinic. Flowcharts were developed for processes; a timeline agreed upon; and a pamphlet developed and printed to advertise the services. Training of new volunteers began as with the constant work to improve use of the electronic health record (EHR) tied to the city's department of public health. The work of improving the EHR fell largely on the shoulder of the non-profit or-

ganization's informational technology team of two personnel. The technician assigned to the clinic had no healthcare experience but she undertook her role with exemplary commitment.

Every member of the team had full participation in the process, and each fulfilled a responsibility with collaborative support from all team members. Communication among members was frequent, at least once a week as a team. The experience completely met the "how" of the Synergy Model mirroring the inclusive and full participatory nature of team building.

After eight months of planning and capacity building, going through many PDSA cycles, the family planning clinic opened for services. Policies and procedures are in place and are being developed as the clinic grows. The first formalized orientation process with standardized procedures to care was initialized for old and new volunteers. Application to become a certified level one PCMH was submitted after six months of bringing the clinic practices to acceptable industry levels. The opening of the family planning clinic allowed for the SONHP to place nurse practitioner students at the clinic; they are to be exposed to caring for high-risk patients, many with double and triple diagnoses, challenging the application of theory learned. Within two weeks, the family planning clinic, running one day a week, were fully booked. Patients were being referred by word of mouth of the kind and compassionate care they are receiving. The first CNL student placed at the clinic was hired as a part-time nurse to facilitate the presence of licensed personnel everyday. With ongoing assessments and evaluation, the need for mental health services called for the inclusion of the SONHP's doctoral in psychology program to fill the gap. A faculty member of the program will join in the efforts to develop a much needed mental program with the administration of the non-profit organization; the presence of a faculty practitioner in clinical psychology will allow for students in the program to be placed at the clinic to learn and to serve the patients of complex needs. The beginning of a medical home of integrated care is taking shape.

#### 4 Sustaining the partnership

While the partnership is still young, the joint and full participatory efforts of both the SONHP and the non-profit organization bode well for long-term success of the clinic—the crucial "who" and "how" of Lasker and Weiss' Synergy Model. In CNL language, this partnership has the congruence of elements required for sustainability: shared vision and cause; patient needs; stakeholder buy-in; leadership; champions and informal leaders; and critical support from administration.

Beyond the essentials of building a successful partnership identified above, in comparing the parallel development of other faculty practice sites in the community, it has been ob-

served the ones that have moved forward with some momentum are the ones where at least one faculty member became the champion of the site. In other words, the faculty members adopted the sites and served as the CNL, coordinating, building teams, and facilitating the growth of the clinics. It is understood that as long as the faculty member continues to be wholly committed to the practice site and fully participate in the process of continuous quality improvement, and as long as goals and vision remain shared, as with the importance of leadership support, the chances of long-term success are high.

#### 5 Conclusion

The experience of developing the community faculty practice partnership tells of three considerations: the opportunities afforded by the ACA; the use of the CNL in the outpatient arena; and the complimentary nature of the Synergy Model with the CNL processes in the context of community partnership building.

Healthcare educational institutions must seize the opportunities provided by the ACA. In nursing, where inpatient clinical sites are becoming harder to find, the emphasis on preventive and primary care by the ACA gives schools the occasion to promote the placement of students in community settings for their clinical experience. This experience can impart a new appreciation that the future of healthcare lies not in the unsustainable cost of caring for sick people but in disease prevention, and that nurses, as realized by the IOM, must take on the role of advocating this change. The ACA also advances a new possibility that calls for the development of nursing faculty practice in the community to bridge the gap between educational institutions and communities with healthcare needs. Nursing has the expertise, and has, historically, the right intentions of, and commitment to, caring and healing patients. With faculty practicing at clinical sites, students, too, will get a better transition to clinical practice where faculty, committed to student education, will foster a healthy learning environment.

With the ACA, the CNL, too, has the promise of being the instigator of change in outpatient healthcare settings. The CNL skillset is particular suited for community health emphasizing primary and preventive health. With its broader and wider views, the CNL is groomed to be the bridge and team builder, the facilitator bringing about collaboration and cooperation, and the coordinator of care to generate better patient outcomes. The CNL experience at the clinic clearly discerns the CNL as the identifier of needs and the provider of solutions in the early stages of developing a faculty practice partnership. As the practice grows, the CNL will continue to provide solutions to new needs: integration of care by adding other healthcare disciplines; patient referrals and follow-up; coordination of care; data gathering and analysis; cost analyses; and process and outcomes evaluations.

The suitability of the CNL to community partnership building is seen in its commonality with the established Synergy Model. The CNL is equipped to assess the appropriateness of a partnership for the potentiality of long-term success. The skillset of the CNL and the processes the CNL have all share the proceedings of Lasker and Weiss' "who" and "how" in community partnership development and maintenance. This commonality provides the CNL credibility that the role can be effectively utilized in the community, in this

case, building a community faculty practice partnership.

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### Conflicts of Interest Disclosure

The author declares that there is no conflict of interest statement.

## References

- [1] Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health. Washington, DC: The National Academies Press. 2010. Available from: <http://futureofnursing.org>.
- [2] Harris JL, Roussel L, Thomas P. Initiating and sustaining the clinical role leader role. 2nd Ed. Burlington: Jones and Barrett; c2014. 531.
- [3] Bender M. Clinical nurse leader: a narrative review of the literature. *J Prof Nurs*. 2014 March/April; 30(2): 110-123. PMID:24720939 <http://dx.doi.org/10.1016/j.profnurs.2013.08.006>
- [4] Lasker RD, Weiss ES. Creating partnership synergy: the critical role of community stakeholders. *J Health Hum Serv Adm*. 2003 Summer; 26(1/2): 119-139. PMID:15330382
- [5] Lasker RD, Weiss ES. Broadening participation in community problem solving: a multidisciplinary model to support collaborative practice and research. *J Urban Health*. 2003 March; 80(1): 14-47. PMID:12612096 <http://dx.doi.org/10.1093/jurban/jtg014>
- [6] American Association of Colleges of Nursing. White Paper on the Education and Role of the Clinical Nurse Leader. Available from: <http://www.aacn.nche.edu/publications/white-papers/ClinicalNurseLeader.pdf>
- [7] Institute of Medicine. Crossing The Quality Chasm: A New Health System For The 21st Century. Washington, DC: The National Academies Press. 2001. Available from: <https://www.iom.edu>.
- [8] The Dartmouth Institute. The Microsystem Academy. Available from: <http://tdi.dartmouth.edu/research/intervention/microsystem-academy>
- [9] Nelson EC, Batalden PB, Godfrey MM. Quality by design: A clinical microsystems approach. San Francisco: Jossey-Bass; c2007. 459.
- [10] King C. Clinical Nurse Leader certification review. New York: Springer Publishing; c2012. 352.
- [11] Kim HJ. Decreasing disparities in family planning and reproductive care for women in the Tenderloin District of San Francisco. Paper presented at: Clinical Nurse Leader Association Fall Regional Conference. 2014 Oct 22-24; Dallas, Texas.