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Integrating Quality and Breast Cancer Care: Role of the Clinical Nurse Leader

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Breast cancer remains a global public health problem that consistently challenges oncology nurses and interdisciplinary healthcare professionals to reduce mortality, increase length and meaningfulness of survivorship, or alleviate discomfort if longevity is not a possibility. Although significant progress has been achieved, a fragmented, complex healthcare system has stimulated the creation of new paradigms, roles, and leadership initiatives. One emerging and multifaceted nursing role, the clinical nurse leader (CNL), has been developed to use evidence-based practice and identify gaps in quality of care delivery, coordination, and management for a specific population of patients. CNLs improve organizational effectiveness and optimize client outcomes by working with frontline teams at the level of the clinical microsystem (Harris & Roussel, 2010). Because quality and continuous performance improvement are the catalysts for transforming care, oncology nursing must incorporate this new leadership role to inspire professional development and address the six quality aims defined by the Institute of Medicine (IOM) (Rose, Stovall, Ganz, Desch, & Hewitt, 2008) (see Table 1). This article will introduce the CNL role and describe a CNL-led project that enabled a breast center's national accreditation by integrating quality improvement interventions into comprehensive breast cancer care.

Quality Care

According to prominent leaders in the field of performance improvement, high-quality care must be intentional (Nelson, Batalden, & Godfrey, 2007), continuous (Berwick, 2011), creative (Bennis, 2007), and without compromise (Cronenwett

et al., 2007). Although several definitions of quality care exist, the IOM stated that "quality care means providing patients with appropriate services in a technically competent manner with good communication, shared decision making, and cultural sensitivity" (La Fargue & Coleman, 2008, p. 114), which captures the essence of multidimensional cancer care and forms the foundation of a proposed blueprint for better cancer care systems.

Role of the Clinical Nurse Leader

The CNL role was conceptualized from 1999–2003 and introduced by the American Association of Colleges of Nursing ([AACN], 2007) in response to the complex and error-prone U.S. healthcare system, shortage of bedside nurses, and the IOM's report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). CNLs are educated at the master's level as advanced generalists to lead client-centered interprofessional care teams in a clinical microsystem. CNLs act as lateral integrators of care for a specified cohort of patients (AACN, 2007). In that regard, oncology nurses are well suited to expand their wide-ranging scope of practice and certification options to build skills, knowledge, and transformational leadership capacity. As informal leaders and stewards of evidence-based practice, most oncology nurses already assume accountability for patient care outcomes. CNLs are synergistic with existing nursing roles and also fill the gaps in leadership training and systems thinking that have been absent in most nursing education and practice programs (Berwick, 2011). Curricular topics are guided by five distinct elements and 18 components of implementation detailed in a pivotal white paper (AACN, 2007).

Those role functions and end-of-program competencies are summarized in Table 2.

Internship Experience

More than 1,400 CNLs work in the United States (Norris, Webb, McKeon, Jacob, & Herrin-Griffith, 2012). All CNLs are required to complete an internship of 400 hours in a designated clinical setting prior to graduation. The current author's internship was completed in a medium-sized community hospital serving 144,000 patients per year and integrated delivery system in northern California from January–May 2010. The

Table 1. Institute of Medicine Aims for Improving the Healthcare System

| Aim | Purpose |
|-----------------------|--|
| Efficacy | Provide effective, evidence-based care. |
| Efficiency | Plan for reduction of waste (time, energy, money, supplies). |
| Equity | Offer equal access to health care and benefits regardless of race, ethnicity, gender, or income. |
| Patient-centered care | Consider unique patient culture and needs; advocate shared decision making. |
| Safety | Implement this system properly to reduce patient harm. |
| Timeliness | Reduce unintended waiting for patients, families, and providers. |

Note. Based on information from Institute of Medicine, 2001; Rose et al., 2008.

primary internship objective was to assess and improve frontline and system-wide breast cancer care and service delivery, which resulted in a nurse-led quality initiative that produced resources for organizational self-assessment, clinical program development, and stimulated interdisciplinary preparation for the National Accreditation Program for Breast Centers (Winchester, 2011).

Similar to most community hospitals, several geographically separated settings of care and multiple portals of entry into the system can contribute to fragmented care, disjointed communication, and dissatisfaction of patients and staff (Coleman, 2005). Administrative and clinical leaders (including employees who were breast cancer survivors) were interviewed and expressed that three areas of focus—clinical microsystems, lateral integration, and frontline staff—would

yield the most immediate opportunities for improvement. A literature review also was conducted to elicit relevant interdisciplinary measures, and revealed more than 100 quality indicators.

Clinical Microsystems and Organizational Self-Assessment

Microsystems are the local units of action where patients, families, and health-care teams meet and act as the basic building blocks of any healthcare system, regardless of size or setting (Nelson et al., 2007). Quality leader and former Administrator of the Centers for Medicare and Medicaid Services, Donald Berwick, stated that clinical microsystems are the “exclusive pathway to value” (Nelson et al., 2007, p. xxi). Therefore, assessing the quality of care delivery on the front lines reinforces the importance of listening

to staff working directly with patients. Applying the microsystems theory, a reasonable first step was to conduct an organizational SWOT analysis (i.e., examining for strengths, weaknesses, opportunities, and threats) to engage with staff in departments that deliver breast cancer care. Harris, Roussel, Walters, and Dearman (2011) highlighted the value of a SWOT analysis, which provides critical context for performance improvement, outcomes analysis, and the environment surrounding service delivery.

A conceptual framework developed by Coleman and Lebovic (1996) also was used with interviewees to explore needs within each clinical program area, from prevention through palliative care (see Figure 1). Although time consuming, the value of conducting a SWOT analysis for organizational assessment renders a realistic starting point for all involved stakeholders. In combination with a conceptual framework for reference, the SWOT analysis served as a practical process tool for identifying gaps in perceived quality of care management, observing team communication, and soliciting comments regarding clinical programs and patient satisfaction (Coleman, 2005). During 12 site visits, 33 people with different responsibilities in more than 12 departments were interviewed to probe problems and solutions related to interdisciplinary breast care services. Throughout the organizational self-assessment, one theme emerged from all interdepartmental staff interviews: the desire to obtain national accreditation for the hospital’s breast cancer program. Another benefit of conducting an organizational self-assessment is that the data collected can stimulate other initiatives to support accreditation, grant proposals, staff satisfaction surveys, or payer incentive programs.

Integrating Quality and Comprehensive Breast Cancer Care

CNLs may function primarily in the clinical microsystem; however, they also must advocate for the overall organizational strategic and management goals. In a community hospital, numerous national awards may be desirable to earn public trust and showcase institutional quality outcomes. For example, organizations may seek to earn Magnet recognition status by the American Nurses Credentialing Center, achieve

Table 2. Clinical Nurse Leader End-of-Program Competencies

| Function | Competency |
|--------------------------------|--|
| Advocate | Affects change through advocacy for the profession, interdisciplinary healthcare team, and the client Communicates effectively to achieve quality client outcomes and lateral integration of care for a cohort of clients |
| Clinician | Assumes accountability for healthcare outcomes for a specific group of clients in a unit or setting, recognizing the influence of the meso- and macrosystems on the microsystem Assimilates and applies research-based information to design, implement, and evaluate client plans of care |
| Educator | Uses appropriate teaching and learning principles and strategies, as well as current information, materials, and technologies to facilitate the learning of clients, groups, and other healthcare professionals |
| Information manager | Uses information systems and technology at the point of care to improve healthcare outcomes. |
| Interdisciplinary collaborator | Partners with other clinical and administrative leaders to improve patient care quality and redesign systems of care delivery |
| Member of a profession | Actively pursues new knowledge and skills as the clinical nurse leader role, needs of clients, and healthcare system evolve |
| Outcomes manager | Synthesizes data, information, and knowledge to evaluate and achieve optimal client and care environment outcomes |
| Systems analyst | Participates in systems and anticipates risks to client safety to improve healthcare outcomes |
| Team manager | Properly delegates and uses the nursing team resources (human and fiscal) and serves as a leader and partner on the interdisciplinary healthcare team Identifies clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client centered |

Note. Based on information from American Association of Colleges of Nursing, 2007; Bender et al., 2013.

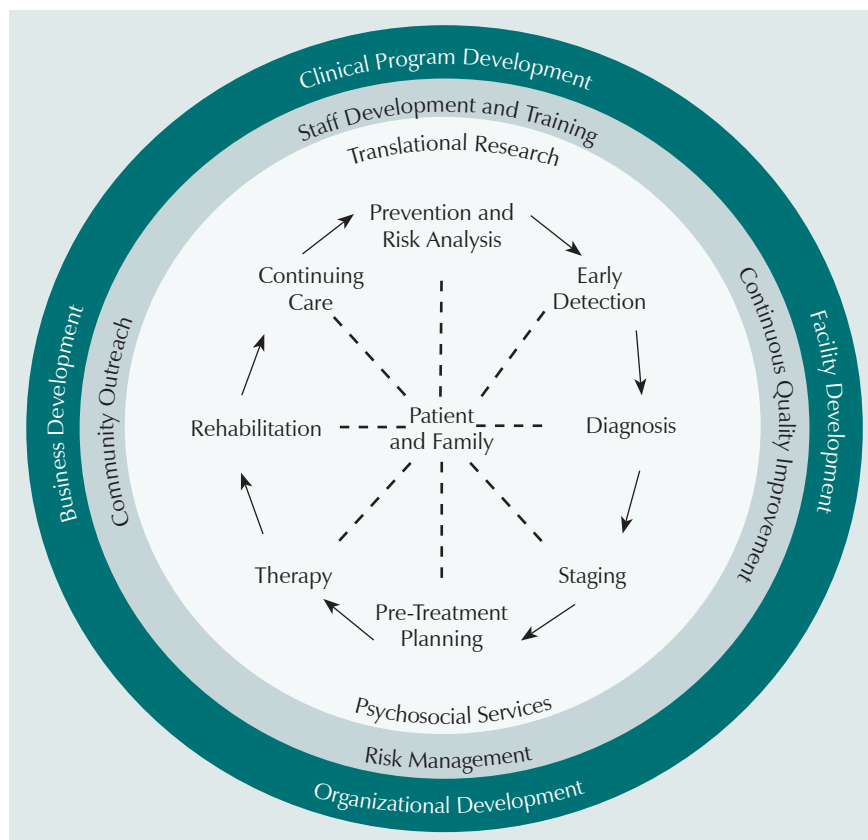


Figure 1. Conceptual Framework for Comprehensive Breast Care

Note. From "Organizing a Comprehensive Breast Center" (p. 964), by C. Coleman and G. Lebovic in J.R. Harris, M.E., Lippman, M. Morrow, and S. Hellman (Eds.), *Diseases of the Breast*, 1996, Philadelphia, PA: Lippincott Williams and Wilkins. Copyright 1996 by Lippincott Williams and Wilkins. Adapted with permission.

national patient safety goals of the Joint Commission, or obtain designation as a comprehensive cancer or breast center by the American College of Surgeons. As team leaders, expert clinicians, educators, and outcomes managers, CNLs are uniquely qualified to direct the development, implementation, and evaluation of such organizational initiatives.

Since the 1970s, comprehensive breast centers in the United States have developed. However, no uniform criteria existed for measuring and monitoring quality outcomes (Adcock, 2004; Coleman, 2005; Kaufman et al., 2010; Rose et al., 2008; Winchester, 2011; Winchester, Stewart, Phillips, & Ward, 2010). In Europe, where the organizational entities are called "breast units," national consensus-based quality criteria for education and practice were instituted as requirements during formative phases of breast cancer program development. European quality measures and educational requirements are continually updated through alliances of consum-

ers, clinicians, and public health and government representatives (European Society of Breast Cancer Specialists, 2000). Since the early 2000s in America, several national programs have been launched to respond to consumer and payer demands for better quality of care, outcomes analysis, research, and professional education. The American College of Surgeons and the National Consortium of Breast Centers have developed rigorous, voluntary accreditation programs (Kaufman et al., 2010; Winchester, 2011). During the current author's CNL internship, an interdisciplinary breast care quality committee was formed. The workgroup built on the initial SWOT analysis and created specific action plans for performance improvement to prepare for the National Accreditation Program for Breast Centers (Coleman, 2010; Winchester, 2011). This recognition was successfully achieved one year later after a site visit by a certified physician liaison from the cancer program division of the American College of Surgeons.

Implications for Oncology Nursing

Nurses have been integral partners at the forefront of the quality revolution in health care (AACN, 2007; Cronenwett et al., 2007; Ogrinc et al., 2012). One key recommendation from the IOM's (2010) report, *The Future of Nursing: Leading Change, Advancing Health*, is to expand opportunities for nurses to lead and diffuse collaborative improvement efforts that foster innovation, redesign of healthcare systems, and patient-centered models of care. New roles such as the CNL offer the opportunity to accomplish this goal. As trusted clinicians and patient advocates, oncology nurses and CNLs are in an exemplary position to facilitate learning environments that stimulate curiosity, creativity, and competence. Doing so will surely lead to improved patient and health system outcomes by challenging the status quo, raising the bar, and integrating quality across the cancer care continuum.

The author dedicates this article to the memory of Rose Mary Carroll-Johnson, RN, MN, for her unwavering commitment to oncology nursing as a teacher, mentor, and editor.

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