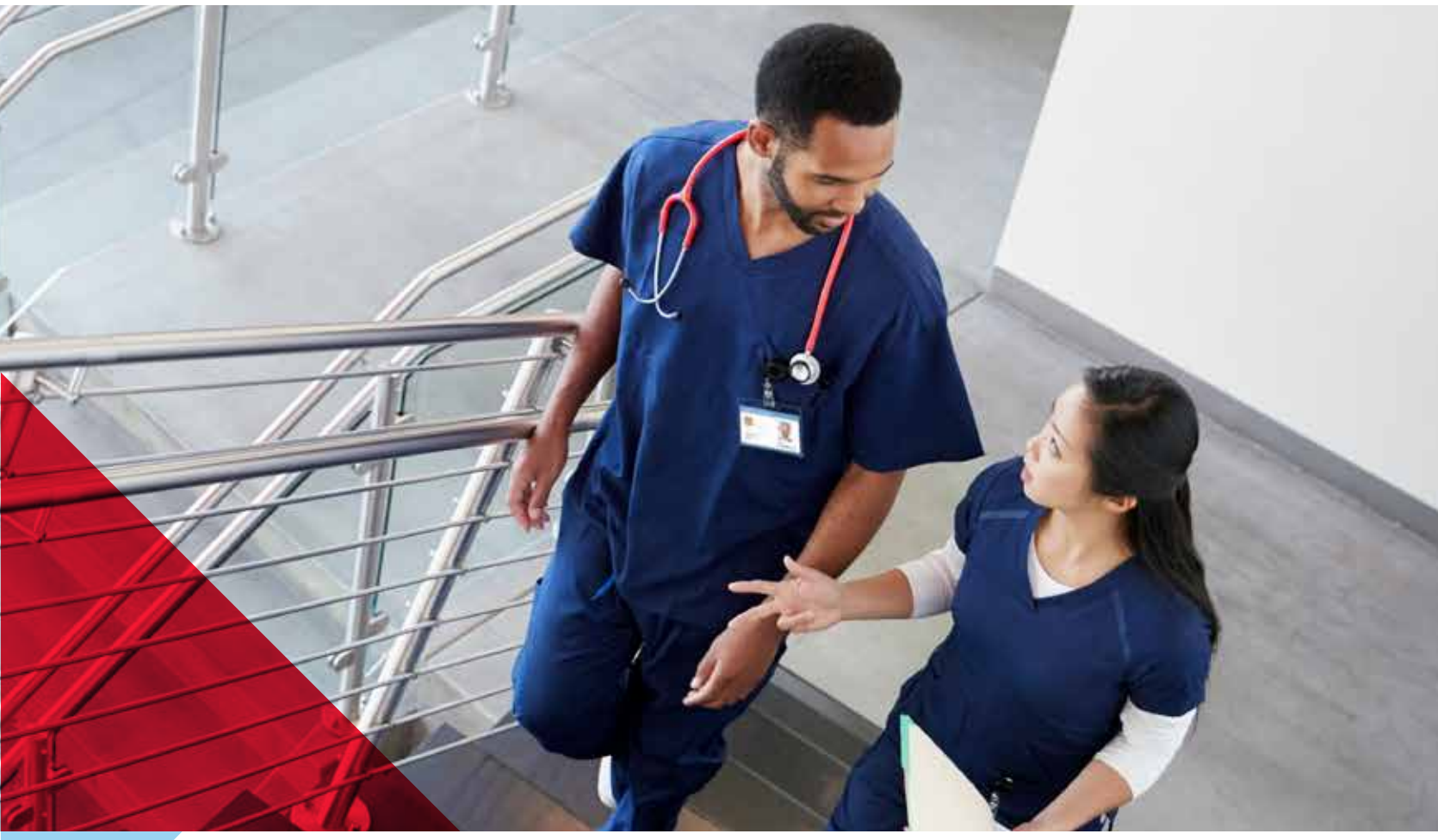
AONL | American Organization for Nursing Leadership



Innovations in Clinical Ladder Programs: Trends and Strategies

FALL 2026

laudio INSIGHTS

Contents

Welcome

Dear Colleague:

Now in the initiative's third year, the American Organization for Nursing Leadership (AONL) is leading a national effort to better understand and respond to the key workforce challenges facing nurse leaders. The central aim of this work is to highlight these challenges while also identifying practical strategies to strengthen and support nurse leaders in addressing them.

As part of this effort, AONL has partnered with Laudio, a purpose-built software and analytics company whose mission is to inspire and amplify the people who deliver great healthcare. Frontline leaders and executives use Laudio to streamline work for leaders and help drive large-scale change through everyday human actions.

AONL and Laudio Insights, Laudio's dedicated analytics group, have partnered on bi-annual reports, published each spring and fall, highlighting data and best practices to inform decision-making for frontline leaders and their executives. The prior report, *Engaging and Retaining Gen Z: Trends and Strategies* (AONL, Spring 2026), shared actionable data on the new norms and expectations of Gen Z nurses as well as how nurse executives and managers are innovating to support them.

This Fall 2026 report, *Innovations in Clinical Ladder Programs: Trends and Strategies,* offers new insights into how clinical ladder programs (CLPs) can be modernized to strengthen engagement, retention and career growth across the nursing workforce, grounded in a national data set of more than 41,500 RNs and 70,500 clinical ladder applications. These data-backed insights are coupled with strategies shared by nurse executives and nurse professional development experts who have redesigned their programs to better reflect the needs and expectations of today's nurses. The findings are intended to promote constructive conversations about how nurse leaders can best support nurses at every stage of their careers while building CLPs that are financially sustainable and aligned with organizational strategy.

The evolving and increasingly complex roles of nurse leaders are essential to delivering effective and sustainable care. Our aim is to provide a data-driven foundation to support the continued evolution of healthcare, with a particular focus on strengthening its frontline leaders.

Sincerely,

Claire M. Zangerle
Chief Executive Officer,
American Organization for
Nursing Leadership
Chief Nurse Executive and SVP,
American Hospital Association

Tim Darling
Co-Founder, Laudio
President, Laudio Insights

Background

An introduction to clinical ladder programs (CLPs)
CLPs have been a feature of the nursing workforce within healthcare organizations for more than fifty years. Introduced in the 1970s and given a strong theoretical foundation in the 1980s through Patricia Benner's "From Novice to Expert" framework (Benner, 1984), CLPs were built around a straightforward premise: nurses who remain at the point of care deserve a structured pathway to grow clinically and professionally, to receive recognition for their contributions and to advance their careers without leaving clinical practice. Despite decades of evolution in how these programs are designed and administered, that foundational purpose has remained consistent.

At their core, CLPs recognize nurses' contributions to their organization's strategic priorities, their commitment to clinical development and professional advancement and their role in driving quality patient outcomes. When implemented well, they give nurses a transparent and achievable pathway for career growth and give health systems one of their most direct tools for retaining experienced nurses in direct patient care. A substantial body of evidence supports their effectiveness as a retention strategy (Ahn, 2023; Celano, 2025). Yet participation rates across health systems remain lower than many leaders would expect; this report directly examines that gap.

Effective CLPs start with a clearly defined purpose. While discussions around CLPs now include topics such as evolving workforce expectations, organizational culture, recognition, compensation and financial reports, it can be valuable to align all stakeholders around the primary focus: a commitment to professional development, especially in nursing. When leaders clearly establish that purpose, it serves as a foundation and compass for the decisions, investments and outcomes the organization seeks to achieve. The popularity of CLPs among RNs has also sparked increasing conversation about extending similar ladder pathways to LPNs, nursing assistive personnel and other interprofessional support and diagnostic service roles.

Relevant terminology
CLPs sit inside the overall nurse professional development (NPD) journey. Some literature and organizations leverage terms more common outside of healthcare; for this report, we maintain the following terms which are most used both in practice and academic literature.

- **Clinical ladder program (CLP):** A formalized, evidence-based strategic initiative that supports workforce development by providing a transparent pathway for advancement based on demonstrated achievements, professional contributions, leadership and outcomes.
- **Levels (or rungs):** Progressive tiers that reflect growth and expanding level of expertise, responsibility, leadership and impact consistent with frameworks such as Benner's "From Novice to Expert" model and the American Nurses Credentialing Center (ANCC)'s Magnet® model.
- **Clinical ladder activities:** Documented contributions that demonstrate professional practice excellence and impact on outcomes, such as quality improvement projects, evidence-based practice initiatives, precepting, certification, committee work, research and community involvement.

- **Application (and application cycle):** The process by which a nurse applies for a specific ladder level and completes and submits the activities needed to meet the requirements of that level. Most organizations require this process to be completed every year to maintain ladder status. Some organizations allow nurses to maintain their levels automatically once the initial level is reached and incorporated into their job description, although this is not common.
- **Level awarded:** The level granted to the individual applicant based on the review and approval of supporting evidence demonstrating that requirements of the level for which the applicant has applied have been met.

Career growth vs. professional development

For most of their history, CLPs have emphasized professional development: building clinical competency, recognizing nurses for their contributions and serving as a vehicle for advancement and compensation. A CLP's primary function was to deepen mastery of practice and reward sustained commitment to ongoing clinical excellence.

Newer generations bring different expectations. They look to CLPs not only for recognition in their current role, but to broaden their skill sets in ways that position them for advancement, whether within their own organization or beyond it. Healthcare leaders have started using the term 'lattice'; indicating a response to a need for more horizontal opportunities (e.g., expanded skillsets and job growth) as opposed to purely vertical advancement. Creating opportunities for broadening exposure is highly valued by Gen Z, as detailed in the prior report (AONL, Spring 2026). This report does not use the term lattice (other than in the interview and discussion section), but the term "ladder" as used here is inclusive of horizontal growth.

Career growth and professional development are related but distinct purposes, and how an organization prioritizes one over the other shapes how their CLP is designed, funded and experienced by nurses.

The budgeting and participation process

Whatever form a CLP takes, it must be underwritten by an organization's financial commitment to it. Financial considerations often define how many nurses can participate in a CLP at any given time, and which tiers are available to them. The decision to implement a CLP is an organizational one, and a CLP must be structured in a way the organization can financially sustain it over time. Reported participation across organizations ranges from roughly 15 to 60 percent of eligible nurses. However, finances are one of several factors shaping that range; program design and organizational culture also influence how many nurses ultimately engage in a CLP.

The components of a clinical ladder program

As the name implies, a CLP provides nurses with a structured pathway for advancing their careers within an organization. Advancement typically requires nurses to demonstrate depth of clinical expertise through a combination of years of experience, professional certification, precepting, mentoring and participation in evidence-based practice, quality improvement or process improvement initiatives.

CLP structures vary across organizations, though the underlying intent is consistent. Most organizations offer between three and five levels; Slagle et al. (2023) found that while most CLPs are grounded in Benner's "From Novice to Expert" framework, which would align with five levels, the

number of levels in practice ranges from three to eight, with four being the most common. Some organizations have intentionally simplified their structure to reduce friction and improve access, operating a two-level CLP designed for ease of use. Others use more differentiated models that assign point values not only for advancing to the next level but also for maintaining active participation at a nurse's current level, rewarding sustained engagement rather than advancement alone.

The process for applying to a CLP generally follows a standard process (see Figure 1). The nurse determines the ladder level for which they wish to apply, gathers evidence of qualifying activities completed within a defined period and compiles that evidence into a folder, binder or electronic portfolio for review (Slagle et al., 2023). A committee evaluates whether the submitted evidence meets the required criteria and either awards the level or provides feedback for resubmission (Slagle et al., 2023; Stricklin et al., 2023).

An increasingly common model is the digital CLP; with this model, nurses apply through a technology platform, upload evidence of qualifying activities within a defined application cycle and receive committee decisions within the system. This streamlined, technology-enabled variation of the traditional portfolio approach reduces administrative burden while preserving the review structure.

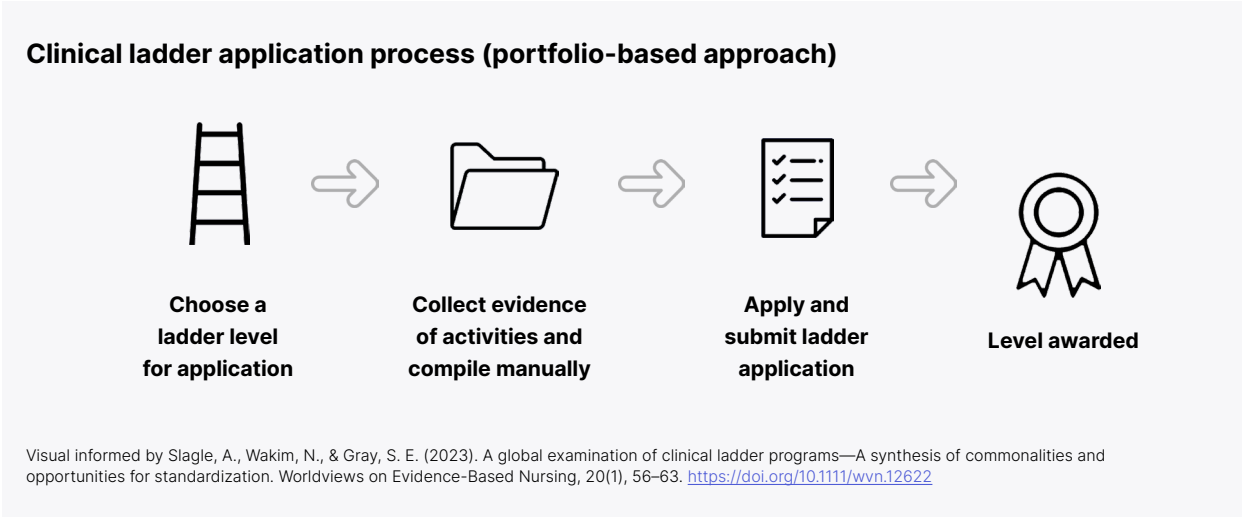


Figure 1

Differences exist in: the types of activities required for completion; the approval process, including whether applications are first reviewed by a unit manager before being sent to the committee; eligibility criteria for participation; frequency with which applications can be submitted; intervals before re-submission; compensation for achieving the ladder level (as either an hourly rate change or a one-time bonus); and whether ladder levels align with job descriptions. In addition, some organizations use a technology-enabled alternative to the traditional manual approach which can reduce administrative burden while preserving the application and review structure.

In a second, far less common model, the initial CLP level(s) is embedded into the nurse's job description. The nurse then remains at that level without the need to compile an additional portfolio until they are ready to move to the next level.

CLP activity engagement
Nurses are more likely to engage with a CLP when three conditions are present:

a. they have time available to complete required activities (e.g., paid non-productive time to work on their clinical ladder projects is available because the work supports organizational strategy and outcomes)
b. they perceive the recognition or reward as proportionate to the time and effort the application requires
c. they feel supported and encouraged by their direct leader (Li et al., 2022; Kallio et al., 2022)

When any of these conditions are absent, even partially, participation declines.

Within those constraints, nurses tend to be pragmatic about which activities they pursue. In practice, nurses select activities that align with their individual strengths, support their personal career trajectory and most efficiently satisfy the program's criteria or point requirements. Existing literature offers limited insight into the specific factors that shape these individual decisions; the interview component of this report, resulting from conversations with NPD leaders who observe these patterns directly, yields important findings on this question.

About this report
This report examines how nurse leaders and healthcare organizations use CLPs to strengthen engagement, support retention and contribute to sustainable, meaningful nursing careers. Through analysis of workforce data and in-depth interviews with nurse executives and NPD leaders, the report explores what is working, where gaps exist and how programs may need to evolve to meet the expectations of today's workforce — a workforce that is younger, more diverse in its career expectations and increasingly clear about what professional advancement should look and feel like.

The presence of a formal ladder is not the only measure of an organization's commitment to nurse growth and recognition; what matters is that nurses have a transparent, supported and equitable pathway to develop professionally, receive recognition and advance in clinical practice. The evidence suggests that when CLPs are well-designed, adequately resourced and actively supported by leaders at every level, they contribute to environments where nurses at all stages of their careers can grow, contribute to quality and safety and build lasting professional identities within their organizations (Li, 2022; Moore, 2019). The question this report explores is whether today's CLPs are delivering on that promise, and what it would take for more of them to do so.

Executive Summary

This report combines a national CLP database[1] with interviews from nurse executives and NPD leaders to examine how CLPs are evolving in response to workforce change, financial pressures and growing expectations for personalized career development. The nurse executives and NPD leaders interviewed have worked over the last few years on innovating CLPs.

While CLPs are associated with stronger retention, leadership development and professional engagement, the analysis reveals significant variation in program design, participation and outcomes. Many programs continue to reflect traditional assumptions about career advancement, even as a growing Gen Z workforce seeks more flexible, skills-based and personalized development experiences. At the same time, leading organizations are demonstrating that modernized CLPs can become powerful tools for workforce sustainability, organizational strategy and nursing excellence when supported by strong executive sponsorship and thoughtful program design.

Inconsistent design reinforces tenure-based progression

Nationally, CLPs vary substantially in both ladder structures and required activities. Most programs continue to emphasize formal education, certifications, credentials and tenure-associated accomplishments as the primary pathways to advancement. While leadership, mentorship and quality improvement activities are commonly recognized, the overall design of many programs still reflects a traditional view of professional growth centered on time served and accumulated qualifications. This variation creates inconsistent advancement expectations across organizations and may limit the ability of CLPs to recognize diverse forms of contribution and expertise.

Misalignment with Gen Z and early-career participation gaps

As Gen Z nurses become the fastest-growing segment of the RN workforce, many CLPs are struggling to align with their expectations for flexibility, skills-based progression, personalized development,

1 StaffGarden, inclusive of 41,500 RNs and 70,500 clinical ladder applications

and more frequent recognition. Participation rates are lowest during the first 12 to 18 months of employment, often due to eligibility restrictions or competing onboarding requirements. Because a disproportionate number of Gen Z nurses are in their first year of practice, these barriers affect younger nurses most directly. Interview participants consistently highlighted the need for earlier engagement, stronger peer communities, flexible participation models and clearer development pathways that begin during onboarding rather than years into a nurse's career.

Strong, but time-bound, retention impact

The analysis finds a significant positive relationship between CLP achievement and nurse retention. Earning a ladder level in year one is associated with up to a 10-point increase in second-year retention; a finding that is statistically significant and, to the best of our knowledge, published here for the first time.

The impact appears strongest in the year following ladder achievement, suggesting that ongoing participation and annual renewal are important for sustaining value over time. Given the high cost of RN turnover, the findings indicate that well-designed CLPs can generate meaningful financial returns while also supporting engagement, recognition and career development.

What leaders can do: six priorities

The report identifies six priorities that distinguish high-performing CLPs and provide a roadmap for future program design.

Three strategic executive priorities:

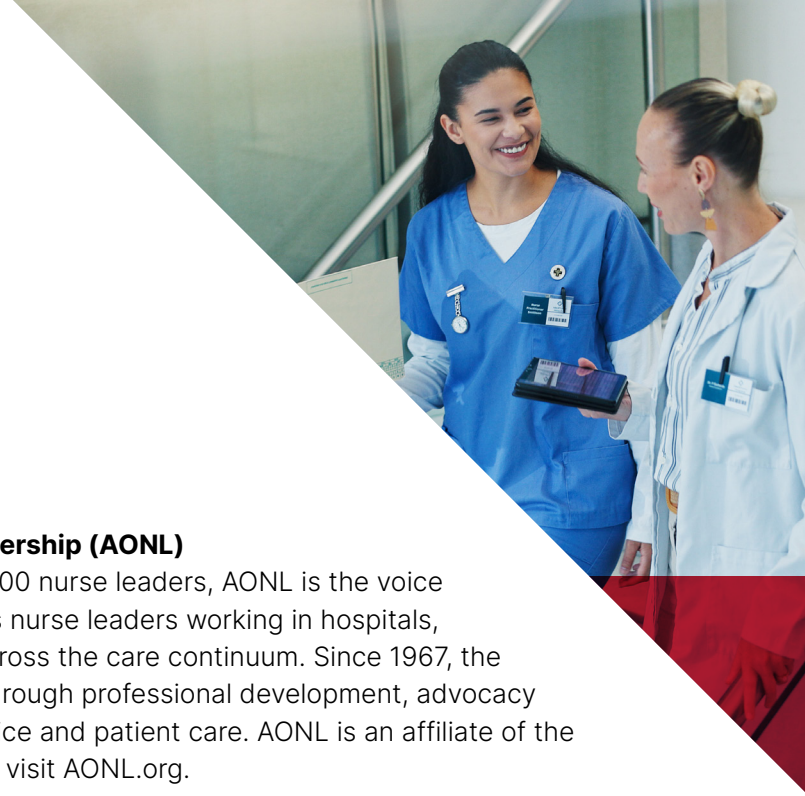
1. Align CLPs with organizational strategy by connecting ladder activities to workforce, quality, patient care, leadership and business objectives.
2. Champion programs visibly and structurally through sustained executive sponsorship, dedicated resources, governance support and meaningful recognition.
3. Build and communicate the financial case by measuring retention, leadership pathways development, quality outcomes and return on investment.

Three operational priorities:

1. Leverage technology to reduce administrative burden, streamline applications, automate processes and improve scalability.
2. Design for today's workforce through community and flexibility by incorporating peer support, cohort models, earlier engagement and more personalized pathways.
3. Create accessible "on-ramps" to evidence-based practice and research through mentorship, structured project opportunities, fellowships and incremental development experiences.

While acknowledging the current environment's complex and unrelenting demands on nurse leaders' time, this report's findings suggest that the next generation of CLPs will succeed by making professional growth more accessible, strategically aligned and meaningful to the nurses they are designed to serve.

By quantifying some of the measurable impact associated with ladders nationally, the report aims to justify the changes and investments that leaders are evaluating and prioritizing today.



About AONL and Laudio

About the American Organization for Nursing Leadership (AONL)
As the national professional organization of over 12,500 nurse leaders, AONL is the voice of nursing leadership. Our membership encompasses nurse leaders working in hospitals, health systems, academia and other care settings across the care continuum. Since 1967, the organization has led the field of nursing leadership through professional development, advocacy and research that advances nursing leadership practice and patient care. AONL is an affiliate of the American Hospital Association. For more information, visit AONL.org.

About Laudio
Laudio empowers healthcare leaders to drive large-scale change through everyday human actions. Laudio's AI-enhanced platform streamlines workflows for frontline leaders, strengthens interpersonal connections and aligns C-suite objectives with frontline efforts, boosting operational efficiency, employee engagement and patient experience. Laudio makes it possible for patients, frontline workers and health system leaders to thrive together. Discover how at www.laudio.com.

About StaffGarden
StaffGarden is a digital clinical ecosystem dedicated to empowering healthcare systems, uplifting clinical professionals and improving patient care with clinical data management tools to track, manage and enhance clinical excellence at scale. Learn more at www.staffgarden.com.

About Laudio Insights
Laudio Insights is Laudio and StaffGarden's analytics, research and publications division. Managers' and nurses' use of Laudio and StaffGarden enables us to collect unique detailed work environment data for leaders who manage over 150,000 RNs, in 200+ hospital and health system sites in the United States. From the data, Laudio Insights creates actionable and independent analytics. Laudio Insights publishes content that provides decision-making support to frontline leaders and their executives.

Overview of the Laudio/StaffGarden data set

The Laudio platform serves as a centralized hub for frontline leaders' core daily work across employee experience, quality and safety and patient experience. It integrates data from underlying systems, including human resource information systems (HRIS), electronic health record (EHR) / admission, discharge, transfer (ADT) data and time and attendance solutions, into actionable workflows. The Laudio platform uses AI to prompt leader actions (e.g., employee recognition and appreciation) that elevate organizational culture and performance. Laudio's data set includes over 150 acute care hospitals and hundreds of ambulatory and clinic facilities nationally. The data set used in this analysis covers 15,000 distinct managers, inclusive of all roles and over 300,000 front-line employees, inclusive of all sites of care. Some of the statistical analyses use a subset of the data set where the analysis requires exclusion criteria.

StaffGarden is a platform that manages and optimizes competencies and clinical ladder programs (CLPs). 330 facilities use StaffGarden to define, manage and complete CLPs for their nurses. The StaffGarden data set includes 41,500 unique RNs and 70,500 ladder applications, of which 36,800 have been completed and successfully awarded the level they applied for. Some of the statistical analyses use a subset of the data set; additional exclusion criteria are documented in the charts' footnotes.

Together, 49% of the facilities in the data set are currently ANCC Magnet® facilities.

StaffGarden's data set, as a sample, has a higher representation of the Southeast regions in the US than the full population (details in Appendix 1).

Analysis 1

CLPs have variation in activity types and ladder levels

There is wide variation in the types of ladder activities allowed

As discussed in the background section of this report, CLPs are organized by ladder levels to which RNs may apply. RNs are awarded a level if they successfully submit demonstrable evidence that meets the required activities for that level.

Figure 2 shows the most common activity types used in ladder levels 1, 2 and 3. (Even though there is no consistent use of number of rungs in the ladder across organizations, levels 1, 2 and 3 are by far the most common.) A full list of all the activity types and details is available in Appendix 2.

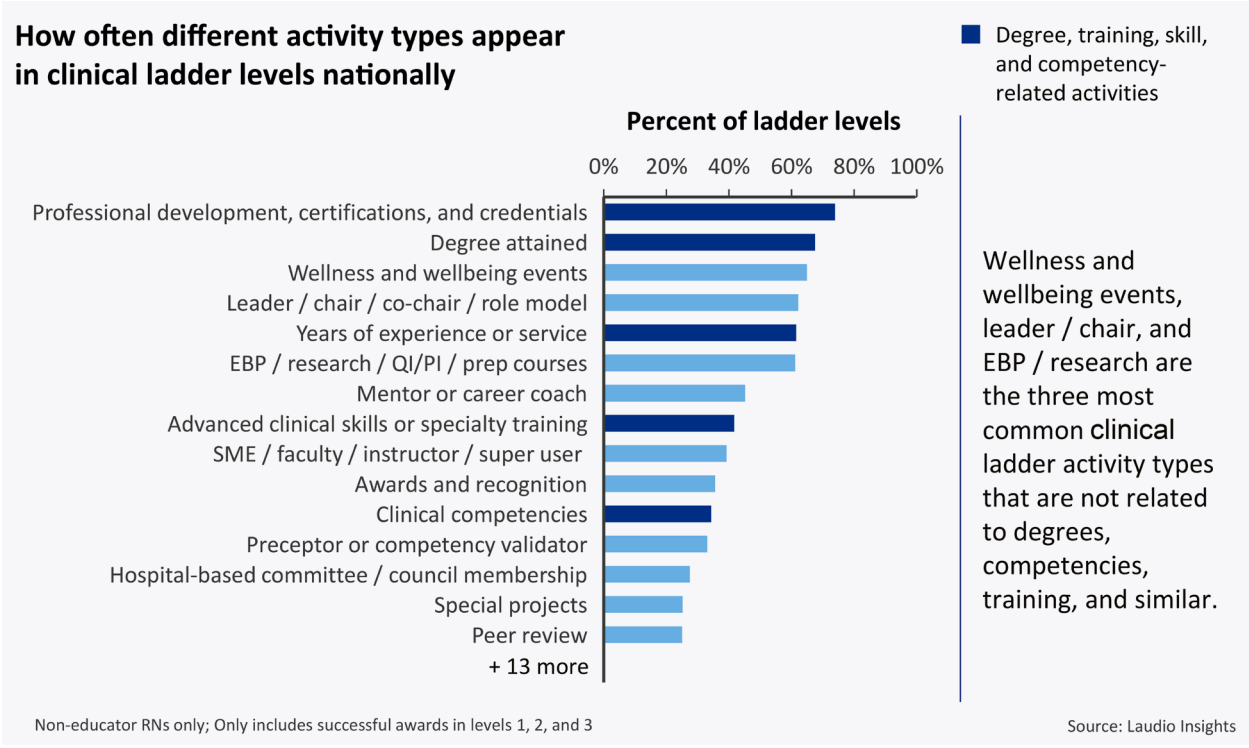


Figure 2

For example, "Professional development, certifications and credentials" is the most common activity type occurring in 74% (n=23,600) of ladder levels.[2] This group includes continuing education, certifications and structured development to build expertise. Highlighted in dark blue are activities that are related to attaining degrees, training, skills and competencies, i.e., formal learnings that are often associated with time and tenure to achieve. "Wellness and well-being events" (e.g., activities that focus on meaningful peer connections, personal growth and resilience such as fitness challenges or reflective practices) are the third most popular activity type and the most popular activity type not related to formal education.

"Evidence-Based Practice (EBP), research, Quality Improvement / Performance Improvement projects (QI/PI) and prep courses" are the sixth most common activity type; note however, that this category includes many items. Most of the activities counted in this category are the completion of research ethics and compliance courses (e.g., as offered by CITI, the Collaborative Institutional Training Initiative) for those who are serving as primary investigators and members of the research team. Completion of targeted PI projects, such as creating and reviewing the results of a clinical quality audit, are the next most popular activity within the EBP type. Full EBP projects are included in this category, though they are rare. This finding is consistent with the NPD interviews detailed in the next section.

The distribution of activity types points to the implicit assumptions that healthcare leaders are making about the type of development and progression they are looking for as well as their understanding of what nurses value. For example, this view shows health systems prefer to reward tenure and advanced qualifications alongside a range of local leadership roles including mentorship, serving as committee chairs and quality research.

As detailed in the analyses and interviews from the prior AONL-Laudio Insights report, 2026 is the "tipping point" for Gen Z RNs, as their growth in the workforce shifts the workplace towards their needs and norms (AONL, Spring 2026). Born 1997–2012 (AECF, 2024), Gen Z RNs are accelerating a move from tenure-based career paths to skills- and competency-based ones. Nurse leaders report that these nurses challenge "time served" expectations. Leaders of CLPs are responding to this challenge by beginning to change "time served" expectations in ladder level requirements.

KEY TAKEAWAY

The mix of activities in completed ladder applications show that many CLPs today anchor on tenure-based qualifications while Gen Z RNs are pushing for more skills- and competency-based opportunities.

2 These only include ladder levels that have been successfully awarded; that are at level 1, 2 or 3; and that do not follow a ladder awarded in the prior calendar year (to avoid mixing level renewals which in some organizations may require fewer activities).

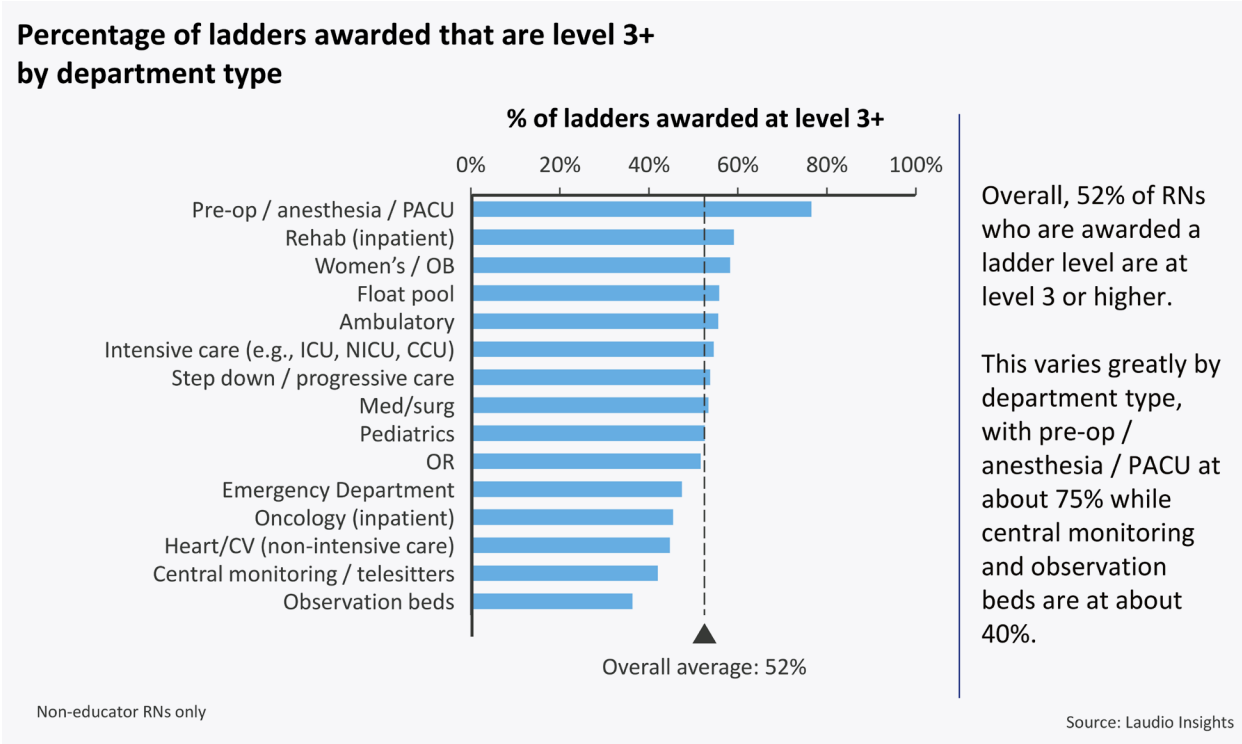


Figure 3

Mix of ladder levels varies by specialty

There is not a consistent national standard for what constitutes ladder levels 1, 2, 3 or higher; however, most organizations use ladder levels 3 and higher for those who have achieved substantial progress and contribution to their own careers and the organization.

52% (n=36,800) of RNs who are awarded a ladder level in any given year are awarded a level 3 or higher, as shown in Figure 3. These are nurses who have invested time in ladder level achievement in prior years and are maintaining a continued investment in their organization leadership and their own development.

The rates vary by specialty with about 75% (n=1,130) of RNs who achieve a ladder level in pre-op/ anesthesia/PACU in any given year being at level 3+. This may represent a strong culture of growth within specialty areas as well as having more tenured nurses on staff. On the other end, observation bed and central monitoring RNs have the lowest percentage of level 3+ ladders awarded at about 40% (n=460).

Analysis 2

CLP participation rates vary by tenure and specialty

CLP participation rates vary by tenure

While CLP participation rates are consistent from 18-36 months' tenure, as shown in Figure 4, participation rates are lower in the first 18 months. CLPs may have eligibility requirements limiting participation to those beyond their first year to 18 months; first-year RNs may also be consumed with residency and other onboarding programs, limiting their ability to join a CLP.

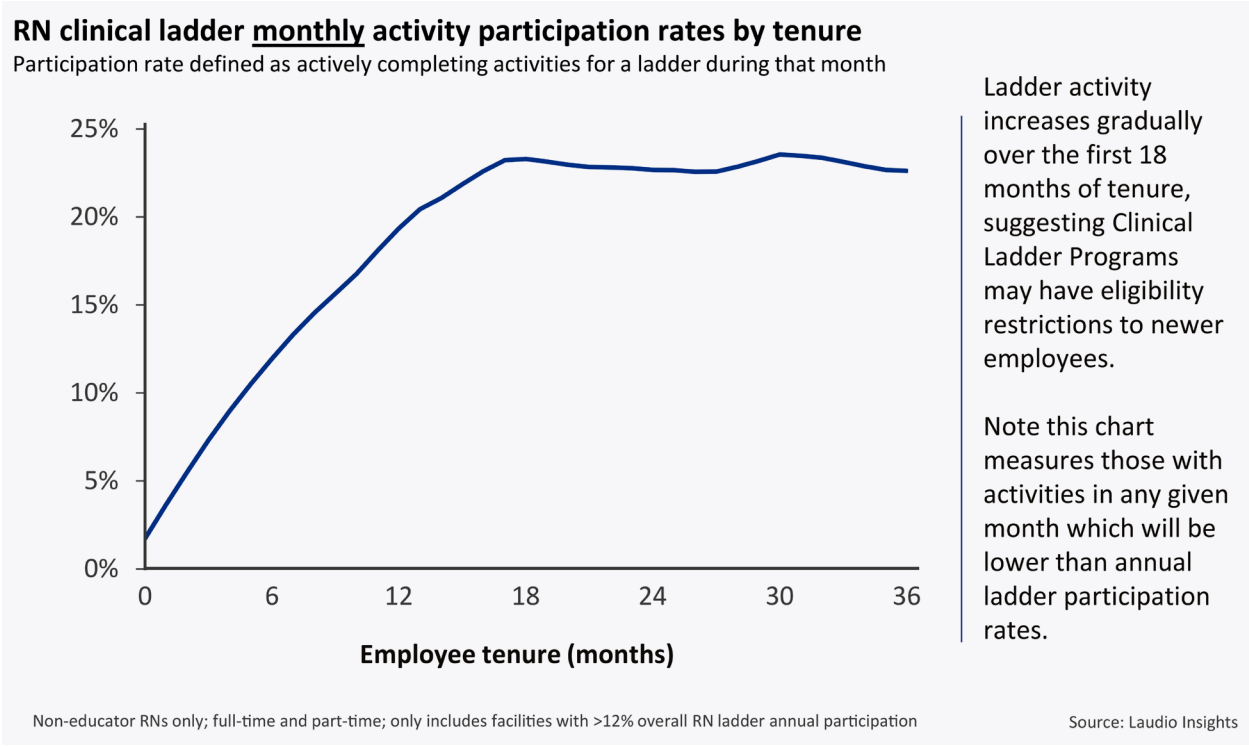


Figure 4

However, as shown in Figure 5, about 26% (n=30,000) of Gen Z RNs are in their first 12 months of tenure in 2026, relative to much lower percentages for older generations. For med/surg units, the rate is even higher at 31% (analysis not shown). The implication is that any eligibility requirement that limits or disincentivizes first-year RNs from participating in CLPs disproportionately affects Gen Z RNs. Increasing early eligibility and participation may be challenging for new-to-practices RNs especially, as they prioritize readiness, direct patient care delivery/tasks, learning the role and responsibilities and developing to perspective that takes them from tasks to leadership.

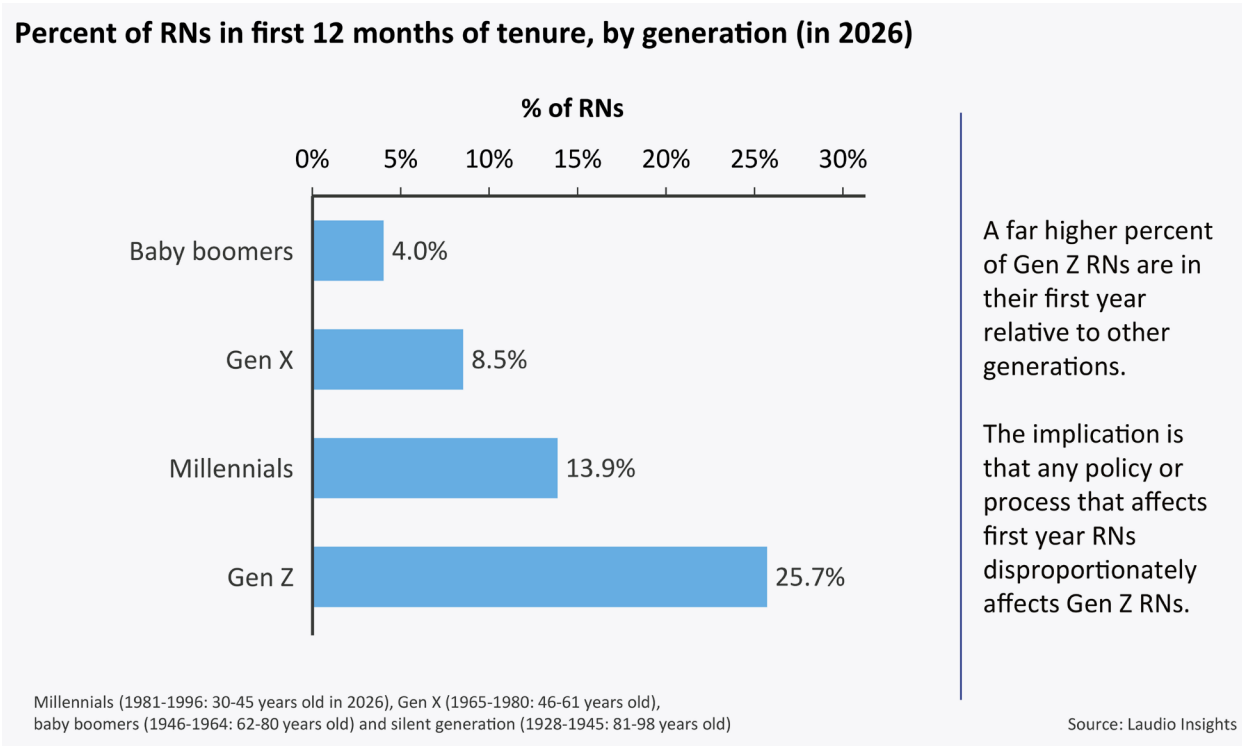


Figure 5

As detailed in the prior AONL-Laudio Insights report (AONL, Spring 2026), nurse leaders highlighted personalizing professional development as the primary priority in responding to the needs and norms of Gen Z RNs; innovating CLPs and encouraging earlier participation especially for Gen Z RNs can be a major component of those initiatives. Also, Gen Z RNs are entering high-acuity specialties, such as transplant, step-down and critical care units, at a higher proportion than their overall representation in the workforce (AONL, Spring 2026).

CLP participation rates vary by specialty

When reviewing CLP participation rates nationally, the analysis identified three distinct facility types: those with no active CLP program, those that were in the early stages of piloting, testing, refining and deploying a CLP (these all had participation rates of under 12%) and those with a robust and well-funded program.

For those with robust CLP programs, participation rates average 43%, as shown in Figure 6. There is some variation in participation rates by specialty, with pre-op/anesthesia/PACU and transplant at almost 50% (n=950 and 4,700 completed ladder levels, respectively). Med/surg and step down/ progressive care units have among the lowest participation rates.

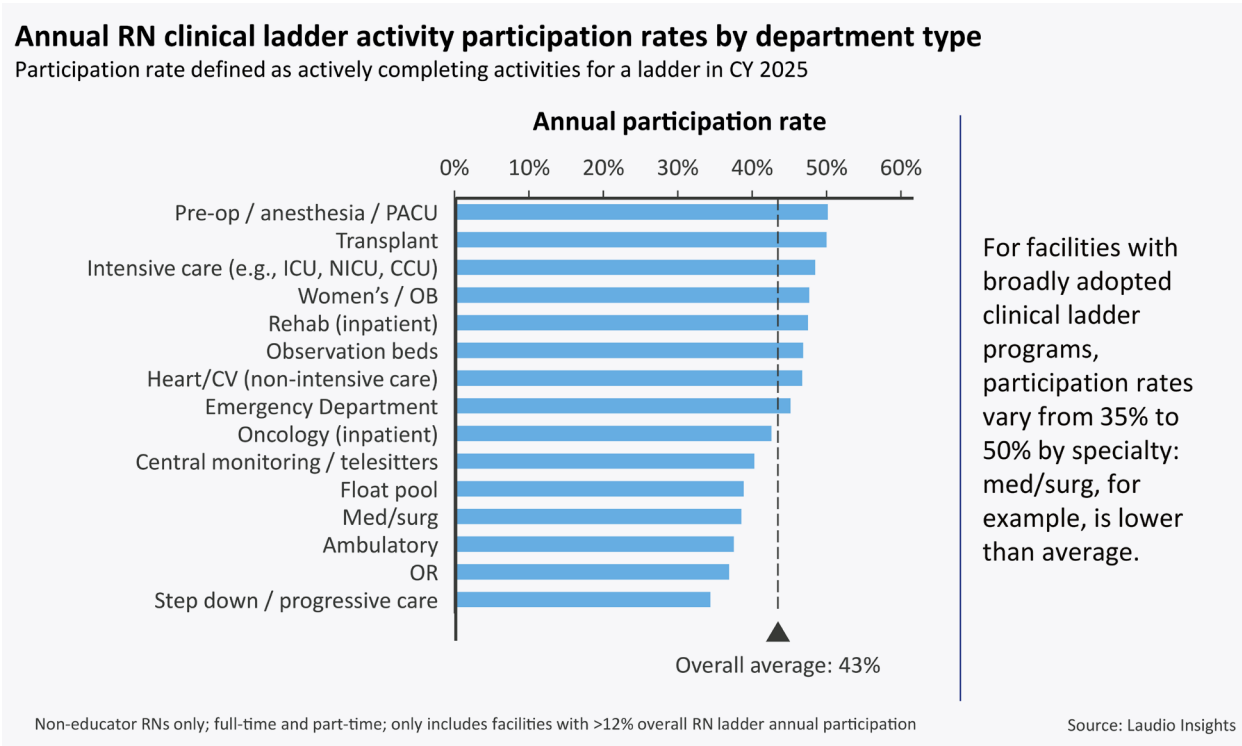
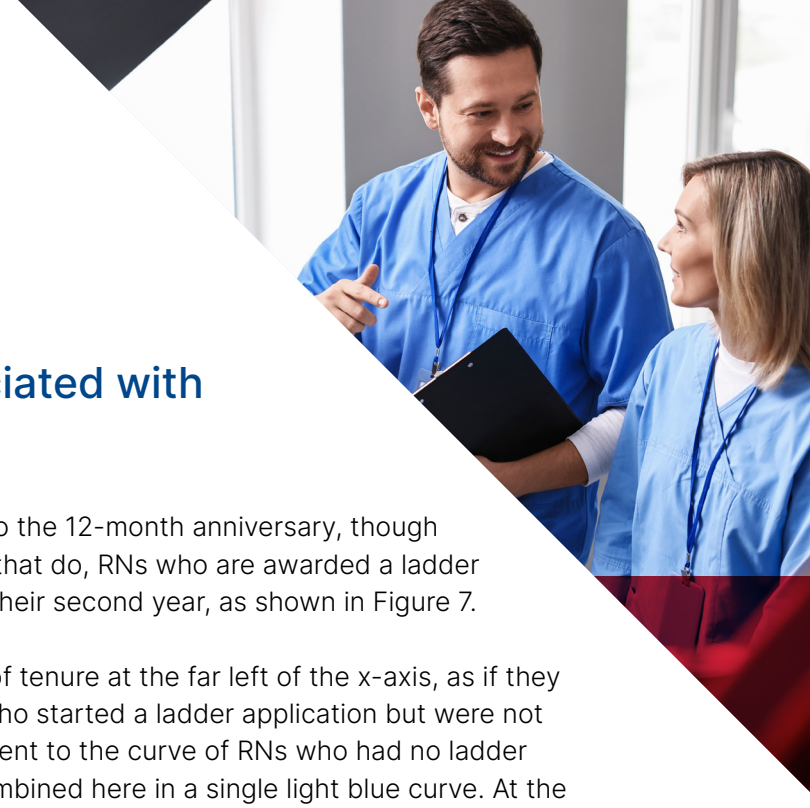


Figure 6

Note that not all organizations make CLPs available to ambulatory departments. A global examination of CLPs shows that they are geared primarily around acute care settings and very minimally around ambulatory (Slagle et al., 2027). However, the limited literature on CLPs in ambulatory does suggest that CLPs have a positive impact on nurse engagement and leadership development in ambulatory care (Gatton, n.d.).



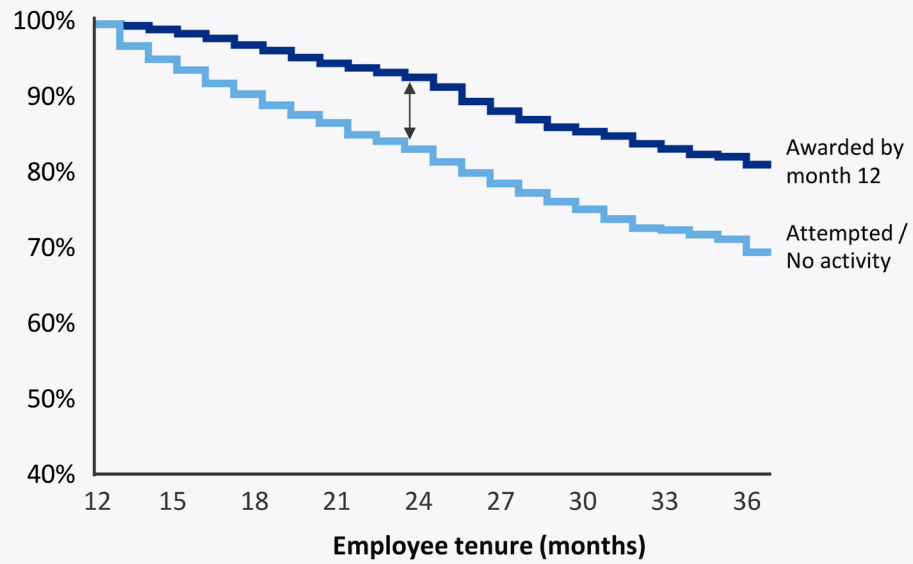
Analysis 3

Clinical ladder awards are associated with higher retention

Some organizations allow ladder participation prior to the 12-month anniversary, though it is not common (as detailed in Figure 4). For those that do, RNs who are awarded a ladder level by 12 months have higher rates of retention in their second year, as shown in Figure 7.

Figure 7 aligns all RNs as they start the 12th month of tenure at the far left of the x-axis, as if they had all started on the same day. The curve of RNs who started a ladder application but were not awarded a level by the 12th month is roughly equivalent to the curve of RNs who had no ladder activity by their 12th month of tenure so they are combined here in a single light blue curve. At the 24-month point, 93% of RNs who were awarded a ladder level remain (the dark blue curve) while only 83% of RNs who had not (the light blue curve).

RN retention curve starting at 12 months' tenure by first year ladder award status



RNs awarded a ladder level within their first year of tenure (in dark blue) have a second-year retention rate that is significantly higher (93% vs 83%, as measured by the arrow) than RNs with no first-year ladder activity (in light blue).

Analysis using the log-rank test indicated a significant difference in retention ($p<0.0001$). Roughly equivalent retention rate patterns were observed for RN with either attempted or no activities (without being awarded a level) during their first year.

Source: Laudio Insights

Figure 7

This is a statistically significant finding using the log-rank test; to the best of our knowledge, it is published here for the first time. For Figure 7, n=2,855 ladders awarded and n=19,568 attempted or no activity. The 10-percentage point gap that emerges in the 12- to 24-month window stays mostly constant after 24 months, implying that the lasting retention value of being awarded a ladder level lasts about a year; beyond that, an annual renewal is needed to regenerate the value.

KEY TAKEAWAY

Early ladder advancement boosts second-year nurse retention by 10 percentage points (91% vs. 81%), creating a measurable, statistically significant financial ROI through turnover cost avoidance.

Figure 8 shows the difference in retention rates for RNs who have been awarded a ladder level in the prior year relative to those who have not.[3] The shaded area shows the 95% confidence interval; for almost all of the months, the confidence interval is above zero. These findings of statistically significant positive retention benefits of achieving a ladder level are published here for the first time.

For the first 36 months, the organizational retention benefit was about 5 to 10 percentage points; in later years, the benefit was about 3 points. With the average cost for RN turnover at about $60,000 (NSI, 2026), a 3-point retention benefit is equivalent to about $2,000 in annual cost avoidance. Compared to the average bonus or salary increase associated with ladder levels,[4] as confirmed in the report interviews, this demonstrates that a CLP at lower ladder levels can provide a positive financial ROI.

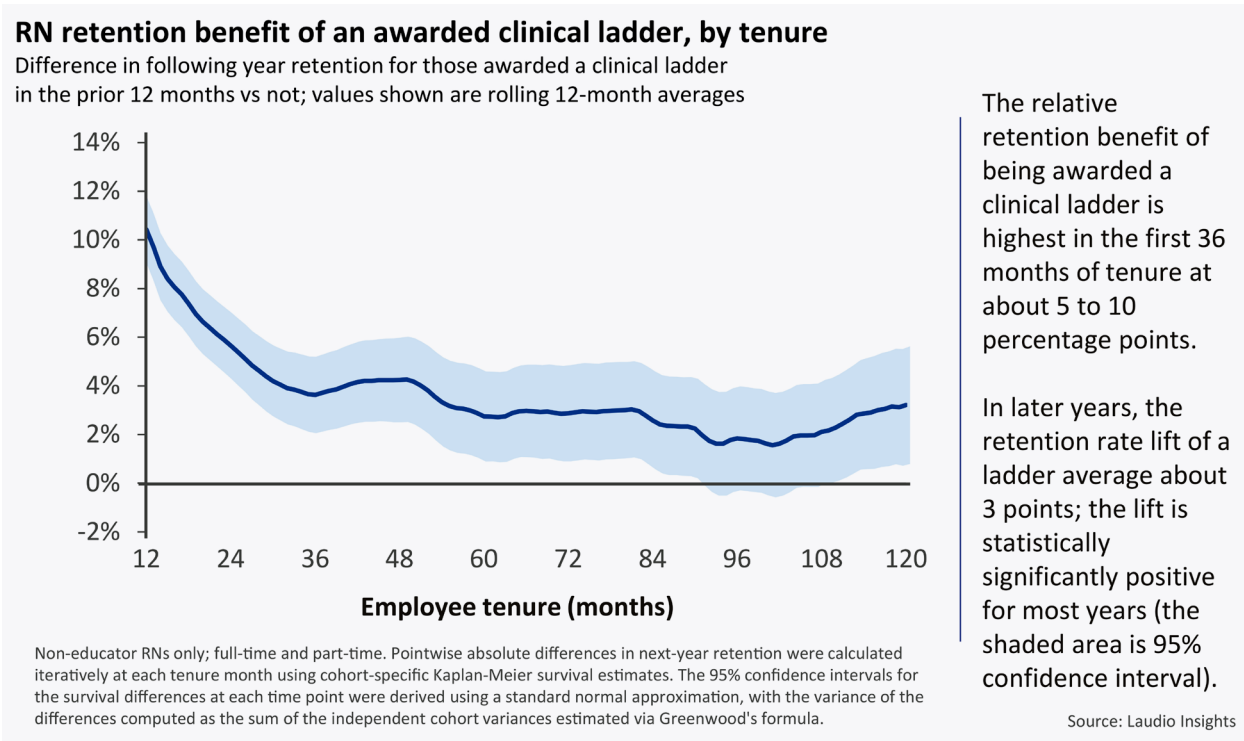


Figure 8

3 The plotted differences in estimated probabilities of next-year retention between strata based on clinical ladder activity in the preceding year are estimated as 1-year survival times using the Kaplan-Meier method, accompanied by pointwise 95% confidence intervals calculated using the Greenwood formula.
4 An approximate range for ladder level bonuses or salary increases start at about $1,500 per year for lower levels and go up to about $7,000 for higher ladder levels.

Overview of the nurse executive and nurse professional development (NPD) interviews

CLPs have long served as a cornerstone of a nursing professional development strategy. Yet as the nursing workforce evolves, these programs are being tested in new ways: by a growing Gen Z workforce that expects individualized pathways and frequent recognition, by financial pressures that put new scrutiny on all program investments and by the rapid expansion of ambulatory care that outpaces many programs' design. For the executives and NPD leaders who own these programs, the deeper work lies in holding several tensions in balance.

One is the tension between strategy and passion. On the one hand, leaders are expected to point the CLP toward organizational priorities, quality and process improvement and team member retention. CLPs can also support the Magnet® journey if that is an organizational goal. However, on the other hand, if they direct that energy too prescriptively, they risk turning professional development into assigned work and losing individual nurses' autonomy. The leaders of many successful CLPs have made strategic work visible and available through point weighting and example projects while leaving nurses free to follow their own passion within that structure.

Another tension is one of accountability. Leaders must decide where responsibility for CLP participation should sit, weighing the formal roles and responsibilities of the nurse manager against their natural influence at a moment when the role is already among the most overwhelmed in nursing (AONL, Fall 2024). Several leaders point to the director level, organized by service line, as the place to carry that accountability without adding further burden on the unit. However, the nurse manager has a critical role in communicating the CLP, encouraging nurses to participate and using nurses' ladder activities as a platform for recognition and meaningful interactions in one-on-one check-ins.

A financial tension underwrites many CLPs. Nursing comprises most of the health system workforce. As compensation for ladder activities proves to be one of the most tangible forms of recognition an organization can offer, leaders must continually balance what the organization can sustainably fund against the recognition nurses have earned, pairing the financial investment with professional governance, visibility and public recognition when the budget alone cannot stretch to meet it.

Finally, running beneath all of these is the practical tension of administration. Sustaining a CLP at scale requires deliberate investment in both the people who run the program and the technology that supports it, and much of the nurse executive's role lies in eliminating the complexity of participation across the entire experience. That work spans how the program is communicated, how activities are structured and the administrative requirements of the application process itself, from uploading documentation to the review and approval steps and the linkage to whatever form of associated compensation the program carries. By continually removing friction at each of these points, leaders keep administration manageable and ensure the CLP feels like an accessible opportunity for nurses — rather than one more burden to navigate.

From June through July of 2026, researchers conducted in-depth interviews with seven nurse executives and six nursing professional development leaders from 11 health systems across the United States that have demonstrated strong CLPs and strong levels of nursing engagement. Participants represented a cross-section of geographic regions, system sizes, care settings and organizational models. Participants were asked to describe how their programs are structured, what is working and why, what barriers persist and what they would change. Leaders also shared the strategies, innovations and investments that make the greatest difference.

Two underlying themes emerged from the interviews. The first is that CLP success requires nursing executive-level strategic decisions about investment, accountability, alignment and culture. The second is that program-level operational excellence determines whether that strategy reaches nurses where they work. As a result, we developed the following priorities for successful CLPs.

Three strategic executive priorities for sustainable CLPs:

1. Align the program to organizational strategy
2. Champion the program visibly and structurally
3. Make the financial case

Three operational priorities for maximizing CLP engagement and impact:

1. Simplify participation and leverage technology
2. Design for today's workforce through community
3. Create accessible "on ramps" to EBP and research

In the sections below, the brick icon  indicates foundational actions and the light bulb icon  indicates innovative ideas. All the actions proposed in the sections below are from guidance provided by managers and executives in the interviews. Quotes from the nurse leader interviews support themes.

Executive Priority 1

Align the program to organizational strategy

Connect professional development investment to clinical outcomes and system priorities

When nurses see the line between their development and their unit's and organization's priorities and can connect that work to their own professional passions, the program becomes meaningful rather than perfunctory, and the organization gains a strategic tool for directing clinical energy in real time. One nurse executive described deliberately aligning CLP paths with the organization's strategic pillars, opening routes into leadership, quality, education and clinical specialization, and found the financial dimension drew surprising interest.

> *"We don't view clinical ladders as an isolated recognition program. We see them as part of the entire ecosystem that attracts, develops, retains and prepares our nurses throughout their careers."*

The strongest programs are positioned as one component of a system-wide workforce strategy rather than a standalone recognition program, connecting recruitment, residency and clinical practice into a single ecosystem that grows the organization's own talent.

> *"Is the goal to get more people invested in the current ladder, or to develop a ladder our nurses want to be their best in? Those sound like the same thing, but they weren't."*

Map all activities to strategic KPIs
Map every program activity to at least one nursing strategic plan Key Performance Indicator (KPI) or organizational goal. Make that alignment visible to nurses in the platform, in communications and in the conversations nurse managers have with CLP participants.

Require outcome articulation in portfolio submissions
Ask nurses to articulate, as part of their portfolio or application, how their activities connect to a patient outcome, unit goal or organizational priority, not simply that they completed the activity.

Include CLP participation in nursing executive dashboards
Use program participation data as part of the nursing dashboard, alongside engagement scores, retention data and quality metrics, so that the CLP's contribution to organizational performance is visible at the executive level.

Align program calendar to strategic planning cycle
Align the program's launch calendar and communication rhythm with the organization's annual strategic planning cycle so that program adjustments reflect current priorities, not last year's goals.

Offer example projects but do not mandate them
Signal organizational priorities by making high-priority project examples visible and easy to find, rather than directing nurses toward specific work. Completing ladder levels should feel like a professional opportunity, not another assignment; when strategic direction crowds out nurse-chosen passion, engagement drops even as compliance holds steady.

Frame the program as one lever in a system-wide workforce strategy
Position the CLP explicitly as one component of an integrated workforce ecosystem, spanning recruitment, residency, clinical practice and career-long development, rather than as a standalone recognition or pay program. Nurses engage more fully when the CLP is presented as part of how the organization grows its own talent than when it stands alone as an activity to complete.

Implement dynamic annual activity weighting tied to strategic priorities
Annually recalibrate activity point values based on current organizational strategic priorities. If pressure injury rates are a system priority, activities in that area earn more points. If new academic partnerships require more preceptors, consider increasing the points given to preceptorship activities. This approach transforms the program into a living strategic tool that directs nurse energy toward what matters most each year.

Link clinical ladder activities to accreditation and hospital designation programs
QI initiatives provide opportunities for nurses to engage in the development of evidence-based practice. At the same time, they also provide compelling stories and process improvement evidence for accreditation and hospital designation programs.

Route strategic initiatives directly to nurses who have advanced ladder levels
When the organization launches a system priority, a technology pilot, a quality initiative or a new service line, build CLP participation into the call for contributors so the program becomes the mechanism for identifying and deploying advanced clinical talent. One organization asked RNs to include their ladder level as they completed applications for a system initiative; this allowed the organization to propose connecting CLP projects with projects needed to support the initiative's goal.

Design a dual top-tier track for leadership vs. direct patient care expertise
Rather than treating the highest ladder level as a single destination, create parallel top-tier designations, one advancing toward formal leadership roles and one recognizing sustained direct patient care expertise, so nurses aren't forced into a formal leadership track as the only way to reach the top of the ladder. This protects the organization's most experienced clinicians from an implicit "advance or plateau" choice, while still giving the program a visible leadership pathway.

Executive Priority 2

Champion the program visibly and structurally

As nurse executives, be a primary voice, architect and investor in professional development culture

Across the seven nurse executives interviewed, the single most consistent differentiator between high-performing and low-performing CLPs was the visible, active championship of the nurse executive, through vocal messaging, governance integration, structural investment and recognition architecture. CLPs rise or fall with the executive who owns them.

> *"I can get you any award you want on the wall, but if I'm building the house on quicksand, it won't stand."*

The CLPs with highest participation rates treated championing as an ongoing responsibility rather than a periodic budget pitch, surfacing work of nurses advancing within CLPs publicly and tying it to the strategic plan. This established the value case well before resourcing conversations arrived.

Lead the message personally
The nurse executive serves as the primary and first communicator of the program's purpose, value and mission alignment. The message must come from the top before it can cascade down.

Connect to mission and values
Frame the program explicitly in the language of mission, values and organizational purpose, not as a retention incentive or an HR initiative, but as an expression of what the organization believes about nursing excellence.

Model champion presence at program milestones: Nurse executives should attend CLP recognition events, such as final project presentations. Engage directly with each presenter's work and take notes, then reference specific nurses and projects by name later, when rounding at their site. The follow-up is what makes the presence credible: it signals that contributions are visible and remembered at the highest level of the organization.

Build a recognition architecture: Establish a low-cost, high-visibility recognition infrastructure: nurse executive newsletters that share the names of all nurses completing levels, recognition at leadership meetings and acknowledgment in system communications create social proof and peer motivation at scale.

Protect dedicated program capacity
Ensure the NPD leader responsible for CLP administration has dedicated role capacity, not a side-of-desk responsibility, and the organizational authority to convene cross-functional stakeholders including HR, finance and IT.

Match the pace of change to what the organization can absorb: When a program already works, targeted fixes to the top few complaints can serve better than a wholesale redesign during periods of heavy organizational change.

Establish a Nursing Institute or equivalent structural home
Create dedicated organizational infrastructure for nursing professional development: a formal institute, legal entity or center of excellence, which signals the strategic importance of professional development to the entire system and protects it from budget cycles.

Activate market- and campus-level nurse executive ownership
In health systems with multiple markets or campuses, nurse executives at each market or campus should be the primary activators of program communication and culture, with system-level NPD leaders providing the framework and tools but market nurse executives owning the championship role.

Embed program in executive leadership language
Integrate the clinical ladder program into the nurse executive's own leadership language through presentations to boards, conversations with CFOs and other C-suite colleagues and community engagement, as evidence of how the organization invests in nursing excellence and workforce sustainability.

Standardize ladder-level definitions across multi-entity systems
Where facilities have designed their own CLPs, prioritize an enterprise-wide definition for ladder levels. One system found a single level carrying five different definitions across multiple facilities; this inconsistency across facilities creates a sense of unfairness. Advancement should be equitably achievable regardless of location.

Executive Priority 3

Make the financial case

Build the ROI infrastructure to sustain investment under financial scrutiny

CLPs are increasingly asked to justify their cost in an environment of tightening margins. The financial impact of CLPs is typically based on improved retention and associated reductions in premium pay; many organizations may not be measuring this impact, and if they are, the impact may be treated as a "soft number" rather than a hard one. Therefore, the case for a CLP also needs to account for the program's overall value in supporting professional growth and engagement and the compounding value that it brings to patient quality, safety and experience.

Nurse executives who proactively build the ROI measurement and business case are best positioned to defend their programs. The data exists in every organization, and the discipline to leverage it is what separates protected programs from those at risk.

> *"It's the long-game strategy. When you treat nursing as a line item and just start cutting it, you know what happens — it creates more expense, not less."*

The most durable version of the business case is built not in a single budget meeting but through ongoing visibility, as described in Executive Priority 2. One system nurse executive described reaching exactly that position: if she proposed cutting the CLP to save money, the first objection would come from her CFOs and presidents, because the program had become part of the heart of the organization. Another executive framed the business case as cost avoidance, weighing the program cost against the external search fees and longer vacancies that follow when the system must replace nurse leaders.

Engage HR and Finance as design partners from the start
Involve HR and Finance in shaping the program's design, not only its approval or later administration. HR understands recruiting and employee-relations touchpoints; finance understands the budget realities within which the program must live. Building the ladder with them, rather than presenting it to them, produces a program both can defend downstream.

Translate retention differences into turnover cost avoidance
Calculate the cost of nurse turnover at your organization and use it to translate even modest retention differences into dollar figures that resonate with CFOs and other finance leaders. An example analysis is in Analysis 3, using national average values.

Track participant vs. non-participant retention
Track retention rates of CLP participants versus non-participants as a baseline metric. This is the foundation of the business case and can be built from data most organizations already have. National data is available in Section 1 of this report, showing about ten percentage points' higher retention for early-tenure RNs (a major priority for organizations) and about three percentage points for later tenure RNs.

Report financial ROI annually
Present the program's financial return on investment annually to finance leadership, using the same language and framing as other organizational investments such as cost, return and margin impact.

Track secondary outcomes alongside retention
Track secondary outcomes that strengthen the case: certification rate changes, education rate progression, nurse engagement score changes and quality metric trends in high-participation units.

Track advancement into formal leadership as a pathway metric
Count how many CLP participants move into charge nurse, supervisor, manager or other formal leadership roles; one executive observed that most of her leadership hires had first achieved advanced ladder levels, emphasizing the program as a leadership pathway as well as a retention tool. Note that such a pattern, without a corresponding level of advanced achievement among those who stay in direct patient care, may also indicate additional ladder paths are needed for bedside roles.

Model ROI across multiple scenarios
Build a multi-scenario ROI model that evaluates the program's financial return under different participation and retention assumptions. Averaging across scenarios provides a defensible and conservative figure that withstands scrutiny. One organization demonstrated an average three-year ROI of $1.2 million across four modeling scenarios, exclusive of clinical quality benefits; most organizations had a range of potential impact that all showed positive outcomes.

Use tenure cohort modeling to optimize investment
Model participation levels by tenure cohort, zero to two years, three to five years and beyond, to identify where the financial incentive produces the greatest retention impact. Use this analysis to make value-informed decisions about where to concentrate investment when budget pressure requires reprioritization. The rationale for tenure-cohort modeling is due to different retention baseline values and impact of CLP participation rates across tenures, as detailed in Section 1.

Direct CLP projects toward current quality priorities
Prioritize a share of project topics toward the organization's quality challenges, such as falls prevention, so participation maps directly to the outcomes finance and quality leaders already track, strengthening the ROI narrative.

Build a parallel quality/safety-linked ROI analysis
Conduct a parallel ROI analysis that links CLP participation to quality and safety measure improvements, giving the program two heterogeneous yet interdependent financial justifications (workforce and clinical).

Operational Priority 1

Simplify participation and leverage technology

Use digital platforms to enable participation at scale and remove administrative friction

CLP process complexity is the most consistently cited barrier to participation across every organization interviewed, and technology is the lever that either compounds that friction or removes it. Nurses who feel overwhelmed disengage before they begin, so the foundational work focuses on removing barriers: mapping the nurse's experience from first login to final submission, defining every activity in plain language, setting realistic deadlines and configuring the platform around the nurse with single sign-on, one place to submit and support for those less comfortable with digital tools.

Innovative strategies extend the same logic through AI: confirming a portfolio is complete before review, matching nurses to activities, mapping personalized career roadmaps and carrying the downstream work of bonus payments and HR updates so that hitting submit is the last step a nurse has to take in their annual CLP journey.

> *"If I had a magic wand, I'd sprinkle fairy dust on every tedious piece we could remove without losing the integrity of the program."*

Conduct a nurse-lens process review
Review the nurse application experience step by step, from first login to final submission, and ask at each step: does this serve the program's integrity, or does it exist because no one has questioned it? Remove or streamline everything that serves administrative convenience rather than program quality.

Lead with "what you actually need" to succeed, not "here's everything available"
Orient nurses to the program with only the essential information: how many activities are required, which ones are most used and what the process looks like from start to finish. Nurses who understand the scope are far more likely to begin.

Create technology support resources for less "digitally comfortable" nurses
Build tip sheets, short videos and one-on-one consult options specifically for nurses who are less comfortable with digital platforms, particularly tenured nurses who have the most to contribute but face the highest technology friction.

Eliminate activity ambiguity with definitions and resources
Create clear, plain-language definitions for every activity: what qualifies, what does not, what evidence is needed and where to find templates or resources. One organization made sure to include their most- and least-tenured nurses in this work to ensure it reflects a shared understanding of all generations. Ambiguity at the activity level is a primary source of abandonment and incomplete submissions.

Meet nurses where they are with digital promotion
Digitize and promote the program through channels nurses use, such as mobile-accessible platforms, secure messaging and digital newsletters, rather than relying on email or printed materials as primary communication tools.

Use technology to assist with portfolio pre-verification
The largest amount of time in administering a CLP is ensuring portfolios submitted by nurses have all the required components. Envision and advocate for technology to assist in pre-verification of portfolio completeness; for example, a platform capability that scans submitted evidence before the formal review phase, confirms all required documentation is present and flags gaps for the nurse to address before reviewers invest time in an incomplete application. CLP administration technologies do this natively; alternatively, uploading ladder level requirements and each application into a Large Language Model/AI tool can be an effective way to get an instant first pass.

Use existing technology to turn everyday charting into ladder evidence
Envision AI and EHR technologies working in concert so the nursing documentation already in the system is a source of evidence for required CLP activities. Patient education documented in the system can inform the implementation of education workflows. Co-signing or documentation of preceptee competency validation can serve as evidence of precepting activity. Mapping clinical ladder activities with records from existing technology that are part of the current workflow can reduce documentation burden.

Provide example CLP paths with different activities based on interests and goals
NPDs can consider creating a few example ladder level templates that show different collections of activities that would meet the requirements, demonstrating to nurses that they can support their own interests and goals through CLP participation. NPDs can also propose using Large Language Models to support nurses by presenting activities based on their interests as well as organizational priorities; for example, a nurse enters a prompt about their passion or development goal, pastes in a pre-written standard script outlining the ladder level's requirements and example activities and receives a curated set of activities aligned to both their interests and the outcomes the organization needs.

Automate downstream bonus and HR processing
Automate downstream administrative processes, such as bonus payments, pay plan adjustments and HR record updates, through platform integration with payroll and HR systems. When nurses see their incentive on the next paycheck without further intervention, it reinforces the program's value and the organization's investment in them.

Operational Priority 2

Design for today's workforce through community

Build flexibility, frequent recognition and peer community into the program's foundation

CLPs built for a prior generation of nurses are misaligned with today's workforce; the way nurses engage now is as social as it is structural. Gen Z nurses, now the fastest-growing segment of the RN workforce, want flexibility to ebb and flow in their participation, recognition that does not require waiting a full year, individualized pathways and a visible roadmap from the moment they join an organization. The NPDs interviewed share that Gen Z RNs, in their experience, also engage far more readily when working alongside peers: nurses who move through the ladder levels together, in buddy systems, unit cohorts or champion networks, complete at dramatically higher rates than those going it alone.

Foundationally, recognition and community do much of the work: opt-in structures, visible completion bonuses, levels defined by scope rather than activity count, group-based promotion and in-person support. The innovative ideas reach further: twice-yearly recognition cycles, eligibility for final-year student nurses, intergenerational mentoring, compensated cross-unit pathways and a trained corps of peer champions.

> *"Nursing loves a cohort. When they're doing it together, in a buddy system, it just goes really, really well."*

> *"We made it flexible so people could ebb and flow — put in real effort and hit the top level, or step away for a year and come back."*

Create opt-in, no-penalty structures
Offer opt-in program structures where nurses choose their level of engagement in each cycle of the CLP without a penalty for stepping back or stepping down. The ability to "ebb and flow" is not a concession to lower standards; it is the design feature that sustains multi-year participation.

Differentiate levels by scope of contribution, not quantity
Differentiate levels by the scope and focus of professional contribution, not simply by the quantity of activities. Higher levels should reflect a wider lens of impact, beyond the unit, toward the profession, rather than just more of the same work.

Consider use of completion bonuses rather than salary adjustments
Consider financial recognition as a bonus tied to cycle completion rather than a salary adjustment as bonuses are more visible, near-term and motivating. Several organizations reported that increases delivered through salary adjustments in the employees' paychecks tend to go unnoticed, whereas a lump-sum payment creates a more immediate and visible sense of accomplishment.

Introduce the program during residency and onboarding
Introduce the program to nurses during residency and onboarding, not two years later when they become eligible. Nurses who understand from day one that a professional development pathway exists are more likely to engage in the program when their eligibility time comes.

Include activities that recognize what nurses are already doing
Ensure the activity menu includes options that nurses at all career stages and care settings can complete, including activities that recognize things nurses are already doing above their job requirements, so the first steps feel accessible and momentum-building rather than daunting.

Promote the program in group settings, not just broad communications
Promote the program at unit- and team-level in group settings as well as through system-wide emails. NPDs observe that nurses are more likely to engage and participate when they learn about the program and work through activity completion alongside their peers.

Offer in-person application support sessions
Conduct in-person support sessions where nurses can bring their applications-in-progress and get help from educators, council members or champions. Even in a digital-first environment, face-to-face support meaningfully reduces anxiety and abandonment.

Consider twice-yearly application cycles
When nurses were directly asked, early-career nurses were unambiguous in their preference: they do not want to wait twelve months to see the fruits of their professional development efforts. The opportunity for twice-yearly application cycles may enhance participation.

Extend eligibility to student nurses
Extend program eligibility to employed student nurses in their final year, giving them visibility into professional development culture, the organization's values and the full range of nursing practice before they graduate. A health system who has extended eligibility to student nurses converts 90% of these students into nursing positions.

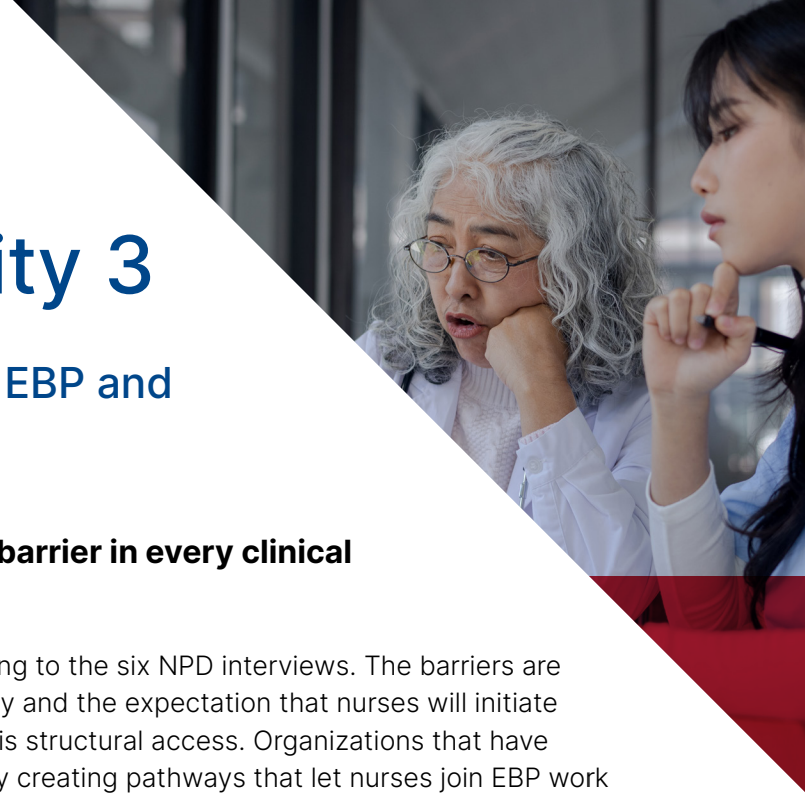
Create intergenerational mentoring structures within the program
Design deliberate intergenerational pairing structures where tenured nurses (who bring experience, motivation and clinical depth) collaborate with newer nurses (who contribute technological fluency and platform comfort). Neither group alone holds the ideal CLP participants; together, they improve both completion rates and professional relationships.

Add a cross-unit group-work pathway
Offer a group-based ladder level completion option, with rigor built in so every member contributes, that deliberately pairs nurses from different units rather than defaulting to same-unit teams. Treat the collaboration time as paid time, not personal time.

Build a peer champion network at scale
Build a system-wide network of peer champions: clinical nurses who volunteer, are vetted by their leaders and are trained to provide at-the-elbow coaching and application support across every specialty and setting. One health system sustains approximately two hundred champions connected through a dedicated communication platform.

Establish a care site champion advisory committee
Create a formal care site or unit champion advisory committee, including clinical educators, NPDs, nurse managers and staff nurses, which provides ongoing feedback, serves as on-site support for nurses, ensures alignment across service lines and shapes annual program updates.

Create a digital champion community for peer-to-peer support
Connect the champion community through a dedicated digital channel, a platform discussion board or equivalent, where champions share questions, resources and solutions in real time. When the community is self-sustaining and peer-led, the NPD team's coordination burden decreases while program energy increases.



Operational Priority 3

Create accessible “on ramps” to EBP and research

Remove the most persistent participation barrier in every clinical ladder program

EBP and research projects are rare activities, according to the six NPD interviews. The barriers are consistent: fear of the unknown, perceived complexity and the expectation that nurses will initiate independent projects. The barrier is not capability; it is structural access. Organizations that have removed it did so not by lowering expectations but by creating pathways that let nurses join EBP work before they are ready to lead it: enabling them to join existing unit projects rather than launching their own, embedding researcher and faculty mentorship in the project, framing the work in familiar terms like “quality improvement,” and coaching nurses through it directly.

The innovative leaders introduce EBPs early in RN tenure and break the projects into steps, such as introducing an EBP experience during residency. Other approaches include building an incremental pathway from submitting an idea to disseminating it system-wide and supporting fellowships that turn a ladder level requirement into lasting interest.

> *“Right out of the gate, our residency program has them completing an evidence-based practice project, so by the time they’re eligible for the ladder program, they already have the tools.”*

> *“We started our CLP and Magnet® journey with not one nurse research protocol. Now we have over one hundred nurse-driven protocols.”*

Create “ready to join” EBP projects at the unit level
Create structured opportunities for nurses to join existing unit-level EBP and quality improvement projects rather than requiring them to initiate projects independently. A nurse who can “jump on the bandwagon” of an in-progress project is far more likely to engage with an EBP than one who must conceive and launch something from scratch.

Establish nurse researcher and faculty EBP partnerships
Build faculty and nurse researcher partnerships that give bedside nurses access to EBP expertise, project infrastructure and mentorship. When a nurse researcher or EBP specialist is embedded in the unit or available through a dedicated fellowship program, the barrier to initiation drops significantly.

Frame EBPs in familiar, accessible language
Frame EBP activities in accessible language and organize them under familiar frameworks, like quality improvement, patient safety initiatives and unit-based councils, so that nurses recognize the work they are already doing as EBP-adjacent and can build from there.

Build EBP experience into the residency program before CLP eligibility
Integrate an EBP project requirement into the nurse residency program, so that nurses complete their first EBP experience before they reach CLP eligibility. When nurses then encounter EBP requirements for a ladder level, they are not starting from zero. They arrive with a completed project and a foundation of EBP literacy.

Create incremental EBP activity pathways from idea to dissemination
Design an incremental EBP activity pathway within the program itself: submitting an idea to a leader (one point), having the idea implemented (two points), having it implemented and disseminated system-wide (three points). Each step is achievable, and the progression normalizes innovation as something every nurse can participate in.

Offer EBP fellowships as a ladder activity “on ramp”
Offer EBP fellowships that give nurses a structured, supported pathway into research and EBP work, with faculty partners, protected time and a cohort of peers. Nurses who begin in a fellowship as a ladder activity often discover a sustained interest in EBPs.

Conclusion

The findings in this report highlight a pivotal moment for CLPs. As health systems face ongoing workforce shortages, financial pressures and rapid generational change, CLPs are increasingly being asked to do more than recognize professional achievement. To meet the needs of an evolving workforce and remain impactful, they must serve as strategic tools for retaining talent, developing future leaders, advancing clinical excellence and strengthening organizational performance.

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Appendix 1

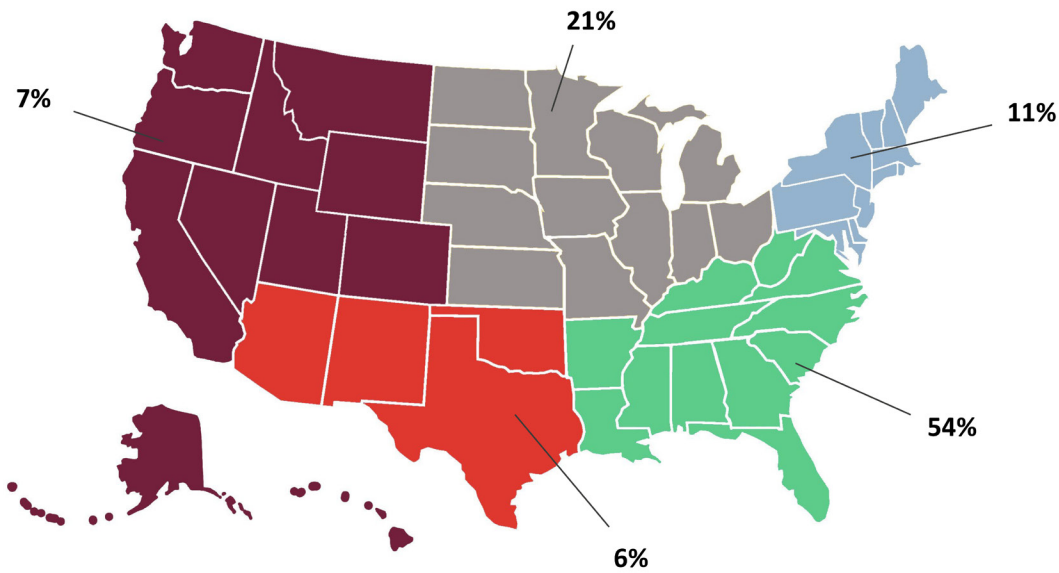
Distribution of clinical ladder applications in the data set by geography

49% of the facilities in the data set are currently ANCC Magnet® facilities.

77% of ladder applications are from current ANCC Magnet® facilities.

This higher percentage is not because Magnet® facilities have more ladder applications per nurses; rather, because, in this data set, smaller facilities are less likely to be Magnet® facilities. For example, 18 of the largest 20 facilities in the data set are Magnet® designated.

Distribution of clinical ladder applications by geography (2025)
n = 70,500 ladder applications



Source: Laudio Insights

Figure 9

Appendix 2

Ladder activity types

Building on Figure 2, these are ladder activity types, the percentage of ladder levels that include them and a brief description of the specific activities seen in each type.

The percentages given are from 23,600 successfully awarded clinical ladder levels.

Professional development, certifications and credentials (74%)
These requirements emphasize continuous learning, clinical skill development and formal credentialing. Activities include continuing education (either through conference attendance or online), specialty certifications, leadership programs and structured professional development such as preceptor training and residencies to build expertise.

Degree attained (67%)
These requirements define attainment of formal education, including degrees such as ADN/ASN, BSN, MSN or doctoral qualifications. They also include ongoing advancement through further study or coursework to reflect growing expertise.

Wellness and well-being events (65%)
These requirements focus on well-being, resilience and engagement in health-promoting activities such as fitness challenges, wellness programs, reflective practices and journal clubs that support personal and team well-being.

Leader/chair/co-chair/role model (62%)
These requirements emphasize leadership and influence through formal and informal roles including committee leadership, program champion roles, and leading initiatives that improve care, quality, workforce or operations.

Years of experience or service (61%)
These requirements define levels of clinical experience or tenure, using bands such as early-career (1–5 years), mid-career (5–10 years) and experienced (10–20+ years) to differentiate expertise and contribution.

EBP / research / QI/PI / prep courses (61%)
These requirements focus on using evidence, data and improvement methods to enhance practice. Activities include EBP research development, literature review, participation in PI/QI projects and progressing to leading or disseminating research and improvement initiatives.

Mentor or career coach (45%)
These requirements focus on developing others through mentoring and coaching, including mentor training, serving as mentor or mentee and progressing to formal roles or programs. Advanced levels emphasize leadership development and improving team performance.

Advanced clinical skills or specialty training (42%)
These requirements emphasize advanced clinical capability and adaptability, including certifications (e.g., ACLS), specialized procedures and cross-training or floating across units to support high-quality care.

SME/faculty/instructor/super user (39%)
These requirements focus on teaching and knowledge transfer, including delivering education, serving as a super user, developing materials and contributing to policy or competency development to build organizational capability.

Awards and recognition (36%)
These requirements recognize professional impact through patient, peer or organizational acknowledgement, including nominating a colleague for awards, formally acknowledging a colleague's performance or receiving praise, awards and nominations that reflect excellence and reputation.

Clinical competencies (34%)
These requirements focus on maintaining core and specialized clinical skills within one's area of specialty practice. Advanced levels include contributing to competency development and supporting complex care.

Preceptor or competency validator (33%)
These requirements focus on onboarding and developing others, including precepting (often measured in hours) and validating competencies to ensure safe and effective practice.

Hospital-based committee/council membership (27%)
These requirements focus on participation in governance and collaborative structures, including committees, councils and task forces that influence practice, quality and operations.

Special projects (25%)
These requirements emphasize contributions beyond core duties, including participation in initiatives, additional responsibilities and activities that support team culture and patient care.

Peer review (25%)
These requirements focus on structured peer evaluation, including chart review, peer interviews and performance reviews, progressing to formal reviewer roles and using feedback to improve practice and team performance.

Professional organization leadership/board membership (25%)
These requirements focus on engagement in professional organizations, from membership and conference participation to committee involvement and leadership roles (e.g., officer, board member), influencing practice and standards.

Volunteer or community involvement (24%)
These requirements involve community engagement, ranging from participation in volunteer activities to leading outreach, education or initiatives with greater impact and sustained commitment.

Resource/champion/ambassador/advocacy (12%)
These requirements focus on supporting workforce engagement, including recruitment activities, serving as a unit resource or champion and promoting initiatives that improve culture, retention and performance.

Pursuing advanced degree (10%)
These requirements focus on pursuit of academic progression, including enrollment in degree programs (e.g., BSN, MSN, DNP/PhD) and continued coursework, reflecting commitment to advanced knowledge and career development.

Charge nurse/shift coordinator/house supervisor (6%)
These requirements focus on frontline leadership roles, including charge nurse and supervisory responsibilities, progressing from relief coverage to consistent leadership, overseeing operations, staffing and team performance.

Audit/chart review/rounding (5%)
These requirements focus on quality monitoring through audits, chart reviews and rounds. They include data collection, compliance checks and progressing to coordinating audits, analyzing results and driving improvements.

Scholarly presentations/speaker at non-hospital conferences (5%)
These requirements focus on sharing knowledge through presentations and posters at internal and external forums, progressing from local contributions to regional/national presentations and broader thought leadership.

Publications including abstract submissions (4%)
These requirements focus on written dissemination, including newsletters, articles and manuscripts. Expectations progress from contributions to peer-reviewed publication and leading scholarly output.

Professional organization membership/ conference attendance (4%)
These requirements focus on learning and engagement through conferences, webinars, courses and professional memberships, progressing to more active participation and application of learning.

Innovative ideas and projects (1%)
These requirements focus on generating and implementing innovations, including submitting ideas, participating in technology or practice changes and progressing to leading initiatives that improve outcomes.

Job expectations (1%)
These requirements emphasize alignment with organizational values and standards, including communication, teamwork, safety, ethical practice, accurate documentation and delivering high-quality, person-centered care.

Patient-centered initiatives (1%)
These requirements focus on engaging patients and families through education, shared decision-making and experience improvement, progressing to leading initiatives that enhance safety, outcomes and person-centered care.

Financial stewardship (1%)
These requirements focus on resource management and cost efficiency, including identifying savings, developing and implementing strategies, supporting budgeting and progressing to leading system-level improvements in cost and outcomes.

Appendix 3

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