

———— Unit 2 ————

**Academic, Clinical,
and Community
Partnerships**

TWO

Creating and Maintaining Academic, Clinical, and Community Partnerships

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■ Learning Objectives

- Identify the significance of partnerships in the implementation of the CNL role.
- Identify core values for the CNL in developing and sustaining partnerships.
- Identify core competencies needed for the CNL to support partnerships.
- Define partnerships.
- Describe the steps requisite to creating academic, clinical, and community partnerships.
- Identify exemplars of partnerships in the implementation of the CNL role.
- Describe the process for sustaining academic, clinical, and community partnerships.

“There is no peace among equals because equality doesn’t exist in this universe. Either one prevails or the other follows, or both negotiate their differences and create a greater partnership.”

Harold J. Duarte-Bernhardt

Key Terms

Partnership
Accountability
Needs assessment

Altruism
Integrity

CNL Roles

Client and community advocate
Cultivator of partnerships with
patients, families, groups, and
communities

Coordinator of client care
Manager of care
Effective communicator
Interpreter and user of qualitative data

CNL Professional Values

Altruism
Accountability

Integrity

CNL Core Competencies

Communication
Critical thinking

Nursing technology and resource
management

Introduction

A shortage of nurses in the United States focused the attention of clinicians, academicians, and communities on its causes, impacts, and possible solutions. The results of multiple studies have included recommendations for the development of academic and clinical relationships as partnerships between organizations. As early as 1998, the Pew Health Professions Commission called for the development of partnerships for the education of health professionals that would integrate the commitments of the care delivery systems with those of health education professionals and the needs of the communities served. In similar manner, a study by the Institute of Medicine (2000) resulted in recommendations for increased collaboration between

institutions as a means to enhance patient safety, and the Robert Wood Johnson Foundation called for new practice models to enhance education-practice partnerships (Kimball & O'Neil, 2002). Additionally, the National League for Nursing (2003) called for nurse educators, students, consumers, and nursing service representatives to form partnerships that would dramatically reform learning and teaching, and would enhance the relationships between and among students, teachers, researchers, and clinicians.

Efforts to address the need to transform professional nursing care and nursing education led to the development of four separate task forces by American Association of Colleges of Nursing (AACN). With the establishment of an implementation task force to launch the clinical nurse leader role through education-practice partnerships, AACN ushered in an educational model that would be responsive to the changing needs of the healthcare environment (AACN, 2007a). The development of partnerships between educators, clinicians, and communities is an essential element to the successful implementation of the CNL role and forms the foundation for education and practice.

Partnership

The word *partnership* was derived in the 14th century from the Middle English use of the word *partner*. The original meaning was one that designated joint heirs or part holders and was itself derived from the Anglo-French word *parcener*, which referred to a division or share (*Merriam-Webster Online Dictionary*, 2008). Terms that appear closely related to the concept of partnership include *partner*, *partnering*, *part*, *partnered*, *partial*, and *partition*. These words have also evolved from the word *partner* and are generally used to describe a relationship in which there is a division or sharing of some larger whole with joint rights or responsibilities. The use of the term *partnership* appears in many forms, including those used to describe legal transactions as may be seen in a business, personal relationships that may express the state of committed bonding between two individuals, and even as a way of describing individuals who engage in a specific activity together, such as dancing.

A *partnership* can be defined as an alliance or union between individuals or groups that is characterized by mutual cooperation and responsibility to achieve a specified goal (*American Heritage College Dictionary*, 2007). Gallant, Beaulieu, and Carnevale (2002) and Hook (2006) focused on the context of the professional-patient relationship in partnerships. Their work established attributes for partnership

“Friendship is essentially a partnership.”

Aristotle

such as shared decision making, relationships, professional competence, shared knowledge, autonomy, communication, participation, and shared power. Steinhart and Alsup (2001) identified trust, effective communications, shared values, monitoring programs, and long-term relationships as necessary in

the formation of successful partnerships. In similar manner, the European Foundation for Quality Management (EFQM) model for health care includes partnership development as one of the eight elements of quality improvement (Vallejo et al., 2006). Their content analysis included the following elements of their model on partnership as:

- Requiring clearly identified mutual benefit;
- Consisting of shared goals;
- Being supported with expertise, resources, and knowledge;
- Delivering enhanced value to stakeholders by optimizing core competencies; and
- Building a sustainable relationship based on trust, respect, and openness.

Creating Academic, Clinical, and Community Partnerships

Antecedents for development of partnership within the CNL role must include recognition of unmet needs within the partner settings. In the education arena, unmet needs arise as the result of factors such as faculty vacancies, space constraints, limited equipment or supply resources, increased population diversity, and a lack of available practice models (Stanley, Hoiting, Burton, Harris, & Norman, 2007; Stark, 2003).

In the clinical arena unmet needs may result from increased complexity of the healthcare environment, the rapid advances in technology, an aging population, or licensure and certification requirements to maintain a well-educated, professional work force (Bartels, 2005; Bartels & Bednash, 2005; Zahner & Gredig, 2005). A review of hospital initiatives to support the education of nurses cited drivers for the formation of partnerships as including the need for: mechanisms whereby nurses could balance work and education, mechanisms for delivery of continuing education, the need for increased levels of nurses with BSN and MSN degrees, and pressures to decrease recruitment and retention costs (Cheung & Aiken, 2006).

Box 2-1 Gap Analysis

1. Determine the current state of the organization or microsystem in terms of available resources, performance, goals, values, knowledge, or internal and external constraints using performance data, stakeholder input, employee responses, or other sources.
2. Determine the desired or necessary state based on stakeholder input, benchmark data, community standards, or other comparison measures.
3. Analyze the gap between the current and desired states to identify problems, opportunities, strengths, weaknesses, or other concerns.
4. Prioritize needs and determine their importance to meeting organizational objectives, cost effectiveness, impact on stakeholders, or other goals.
5. Identify potential solutions and opportunities for improvements.

In communities, in addition to their roles as employers and procurers of goods and services, clinical and education partners may be needed to produce additional benefits, including being a source of volunteers, positively affecting productivity and safety, and acting as a source of health promotion. Concurrently, communities can contribute to health care through the provision of expertise as demonstrated by enterprises such as the auto industry, whose human factors engineering has been applied to health care (Kerfoot, Rapala, Ebright, & Rogers, 2006).

When unmet needs are recognized within the academic, clinical, and community institutions, the evaluation of the suitability of partnership may then progress. The role of the CNL in the formation of partnerships at any level should begin with a needs assessment or gap analysis. This systematic collection of information will be necessary for setting goals, developing an implementation plan, allocating resources, and establishing success indicators (See Box 2-1).

In order for a partnership relationship to be formed, the essential attributes of trust, respect, openness, and shared values must be present within the proposed relationship. If any of these is absent, the partnership will fail to progress and needs will continue to be unmet. If the essential attributes are present, however, the partnership will progress with the formulation of shared goals, establishment of communication strategies, designation of resources to be shared, and the designation of a monitoring program (Gallant et al., 2002).

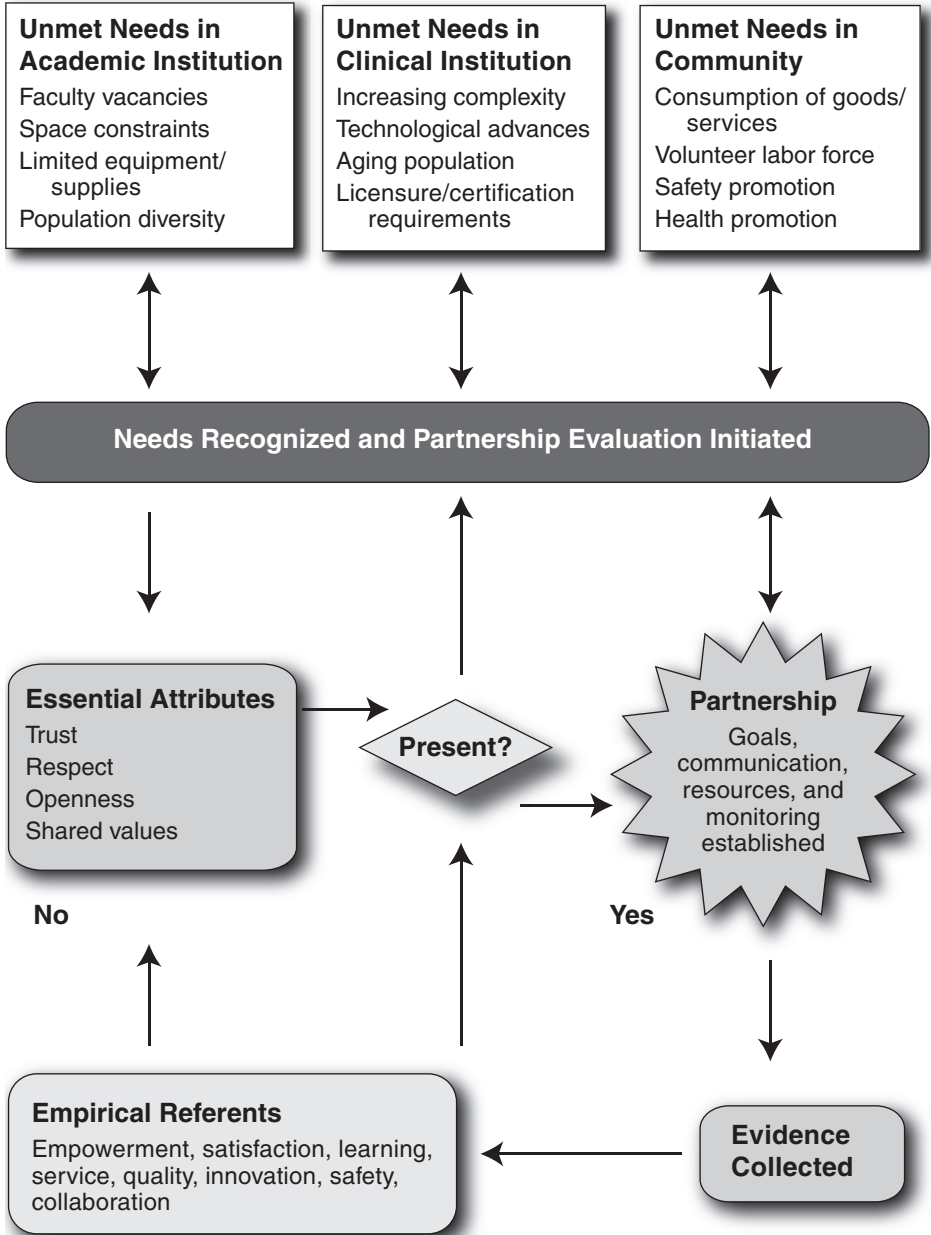
The role of the CNL as a facilitator in the establishment of partnerships provides the opportunity to implement strategies to ensure the success of the initiatives. From the beginning, sharing of information with stakeholders throughout all involved organizations is crucial to successful implementation of partner initiatives. The clinical, academic, and community partnership is believed to result in empowerment, integration, collaboration, effectiveness, increased satisfaction, quality enhancements, innovation, learning, improvements, and enhanced services within the partnering institutions. When these results are realized, the positive outcomes form the basis for a sustained partnership. In the event that expected results are not achieved, reevaluation of the partnership will result in the need to reassert the essential attributes of the partnership and may also lead to continued unmet needs. Figure 2-1 provides a model of the partnership formation process.

Exemplars of Partnership

The University of Maryland found itself in need of additional faculty, clinical sites for student experiences, additional resources, and employment opportunities for new graduates to ensure the success of its academic program. At the same time, the University of Maryland Medical Center (UMMC) faced the challenges of an increased inpatient census, sicker patients, increased staff vacancies, and a need to provide opportunities for the continuing education of their nurses (University of Maryland School of Nursing, 2007). The two institutions initiated an exploration of each other's needs, assets, and individual visions. When a shared vision emerged, they began to develop a plan with priorities and starting points. Planning evolved with a commitment of resources, sharing of a nurse researcher, and participation of both institutions in research and grant applications. Outcomes from the partnership have included increased clinical experiences for students, increased faculty, integration of the nursing education program and hospital to provide mobile healthcare services to rural areas, and increased enrollment by staff nurses in continuing education initiatives. Data collection on partnership outcomes has allowed formal evaluation of program results and has led to continued modifications and expansion of the program.

The exemplar of the University of Maryland incorporates the antecedent factors of identified needs at an educational and clinical institution and recognition of the need to initiate partnership evaluation. When the essential attributes of trust, respect, openness, and shared values were present, the partnership was formed.

Figure 2-1 Partnership formation process



The formation of the partnership progresses with the formation of shared goals, communications, shared resources, and monitoring programs.

In 2004, the Department of Veterans Affairs Medical Centers of the Tennessee Valley Healthcare System (VA TVHS) faced multiple challenges in the provision of patient care. Among these was a fragmented care delivery system that often resulted in frustration for patients, their families, providers, and nurses when patients transitioned from one level of care to another within the system. Nurse managers recognized the need for enhanced multidisciplinary collaboration in the care delivery process, but were often overwhelmed by the operating demands of the units and were unable to focus sufficient attention on clinical care issues. Staff nurses found themselves unable to meet the care needs of their patients because new equipment, advanced information technologies, increased patient acuity, and an aging patient population eroded the amount of time available for individual patients.

Concurrently, Vanderbilt University School of Nursing (VUSN) was facing the challenge presented by rapid technological advances, demands from employing institutions to produce highly skilled and educated nurse generalists who could direct the care of patient populations rather than diagnostic groups. An education focus group was formed including hospitals, educators, and members of the community to identify future nurse management needs. The result of the partnership between VA TVHS and VUSN was the initiation of the CNL role with the first CNLs graduating from VUSN in August 2005.

Community involvement and participation was evident in the implementation of the CNL role as VUSN customized their program to address special needs of the United States Air Force Academy. Additionally, VA TVHS, VUSN, the VA Office of Nursing Services, and AACN collaborated to produce a video for national distribution explaining the CNL role. In 2006, VA TVHS and VUSN began a pilot study for evaluation of empirical referents for successful implementation of the CNL role as developed in collaboration between AACN and the Department of Veterans Affairs. Although the results indicated significant improvement in financial and satisfaction indicators (Hix, McKeon, & Walters, 2009), success of the clinical, academic, and community partnership could be evidenced by joint participation of partners in scholarly publishing activities. Additional activities could include presentations at national conferences, mentorship activities for CNLs from throughout the country, and even the joint celebration of special events and holidays.

Sustaining Partnerships

The lack of progress in changing the delivery of health care to match the complexity of patient needs has been attributed to failure to recognize interdependencies (Wiggins, 2006). Partnerships offer organizations the opportunity to not only recognize interdependencies, but to embrace them as providing mechanisms for effecting positive changes. Examination of the elements of successful partnerships in the implementation of the CNL role has provided insights into strategies that offer the potential to sustain these relationships.

Contract negotiations for student placement in clinical settings present an opportunity to incorporate evidence-based practice outcomes such as review or development of practice guidelines. Nurse executives can influence course content through discussion of important clinical and administrative issues (Newhouse, 2007).

An example of the partnership experience of leaders at the Hunterdon Medical Center and the College of New Jersey at Ewing led to recommendations for sustaining the partnership through frequent open dialogue, openness to learning, and close collaboration. Specific recommendations included that meetings be held on a monthly or other regular schedule; include the chief nursing officer, faculty, and other academic administrators; and that students and other practice stakeholders meet and provide feedback regarding education or implementation matters (Rusch & Bakewell-Sachs, 2007).

The extent to which academic, clinical, and community partnerships are able to be maintained depends in part on the investment in efforts to understand the culture and values of the individual organizational participants. To this end, feedback between and among all stakeholders must be sought and given with the goal of continuously improving outcomes. Although activities such as curriculum development, orientation of students and faculty, and assessment and improvement of performance are critical to evaluation and implementation, it is equally important to maintain a focus on the relationships within the partnership. In this manner, celebrating success, recognizing achievements, and sharing the credit for what is accomplished are essential to the establishment of a common culture and keeping the spirit of the partnership alive.

“I have found no greater satisfaction than achieving success through honest dealing and strict adherence to the view that, for you to gain, those you deal with should gain as well.”

Alan Greenspan

Summary

- The formation of partnerships begins with recognition of unmet needs and challenges within and between the academic, clinical, and community entities.
- The collection of data and stakeholder input form the basis for a gap analysis that can be used to initiate dialogue for negotiation of the partnership.
- Only when trust, respect, shared values, and openness are present will the partnership be able to move forward.
- In the implementation phase, partnership goals, communication strategies, resources, and monitoring mechanisms are determined.
- As the work of the partnership progresses, evidence is collected for use in outcome evaluation.
- Empirical referents as indicators of the results of the partnership are then evaluated, analyzed, and shared among partners and stakeholders.
- If essential attributes of the partnership continue to be in place, the process of goal revision and review of needs is undertaken as the partnership is sustained.
- As the partnership continues, activities such as publishing results of the work, joining to provide recognition to staff, and celebrating success are important to maintaining the relationship between organizations.

Reflection Questions

1. Focus has been maintained on the establishing and maintaining partnerships between and among nursing organizations and the community. What, if any, changes would you expect in the partnership model if the partnerships were interprofessional, as might occur between a medical school and a hospital?
2. Formal relationships between institutions are not always possible or necessary. What types of collaborative initiatives could a CNL engage in with other healthcare institutions in the community? What types of indicators could be used as empirical referents?

Learning Activities

1. Conduct a needs assessment of a microsystem in a healthcare facility. Use the gap analysis outline to guide your work.
2. Working with your CNL preceptor, identify with your preceptor how each partner benefits from the academic-clinical relationship.

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