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# UNIT 2

## Academic, Clinical, and Community Partnerships



# THREE

## Building and Sustaining Academic, Clinical, and Community Partnerships

■ Sandra E. Walters



### Learning Objectives

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- Define partnership
- Identify key components of a partnership
- Identify the significance of academic, clinical, and community partnerships in building and sustaining the clinical nurse leader role
- Describe the process for building a sustainable clinical nurse leader academic, clinical, and community partnership
- Discuss microsystems analysis and its importance in relation to academic, clinical, and community partnerships

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

Harold J. Duarte-Bernhardt

## Key Terms

Partnership      Accountability      Stakeholder      Sustainment  
Microsystems and gap analysis

## CNL Roles

Advocate      Facilitator      Care coordinator      Care manager  
Communicator      Data interpreter

## CNL Professional Values

Altruism      Accountability      Integrity

## CNL Core Competencies

Communication      Critical thinking  
Technology and resource management  
Business acumen

## 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 partnerships between academic and clinical 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 (IOM, 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 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 the American Association of Colleges of Nursing (AACN). With the establishment of an implementation task force to launch the clinical nurse leader (CNL) role through education–practice partnerships, the AACN ushered in an educational model that could be responsive to the changing needs of the healthcare environment (AACN, 2007). 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.

In 2010, the IOM, in its report, *The Future of Nursing: Leading Change, Advancing Health*, made recommendations that require collaborative actions by nurses, the government, healthcare institutions, and other stakeholders in nursing education in order to improve the delivery of high-quality, seamless care. The education of CNLs in an environment where clinicians, educators, patients, and other community agencies form partnerships to maximize care outcomes is critical to the success of the CNL role.

## Definition of Partnership

The word *partnership* was derived in the 14th century from the Middle English use of the word *partner*. The original meaning 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, Incorporated, n.d.). 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 term *partnership* is used in many ways, including 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 to describe individuals who engage in a specific activity together, such as dancing.

**Friendship is essentially a partnership.**

Aristotle

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 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 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 to 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 eight elements of quality improvement (Vallejo et al., 2006). Their content analysis included the following elements as part of the model:

- 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. (Vallejo et al., 2006)

## Creating Academic, Clinical, and Community Partnerships

Antecedents for the 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

workforce (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 to help nurses balance work and education, mechanisms for delivery of continuing education, the need for increased levels of nurses with bachelor's (BSN) and master's (MSN) degrees, and pressures to decrease recruitment and retention costs (Cheung & Aiken, 2006).

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 for 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 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 (see **Box 3-1**). This systematic collection of information will be necessary for setting goals, developing an implementation plan, allocating resources, and establishing success indicators.

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

### **Box 3-1 Facets of 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.

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, and designation of shared resources and 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 these 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 higher quality 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 3-1** depicts a model of the partnership formation process.

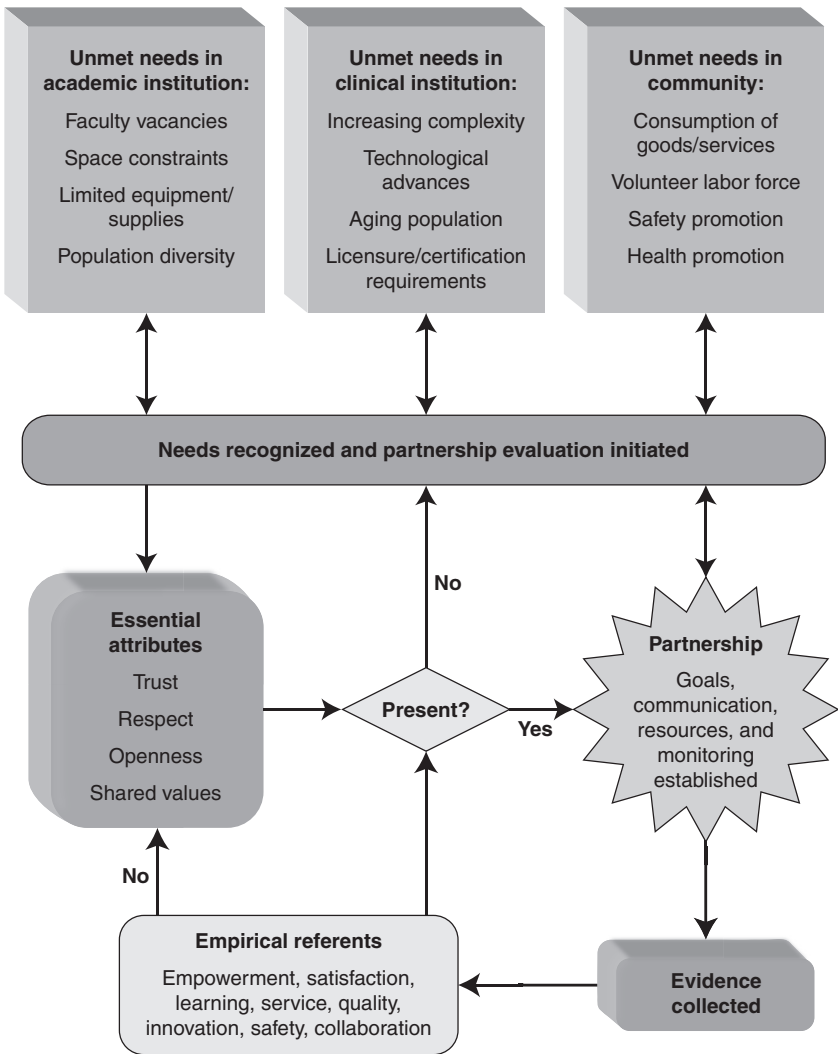
## Exemplars of Partnership

### *The University of Maryland*

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 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 Office of Communications, 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 to 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



Figure 3-1 Partnership formation process.



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

### ***The Tennessee Valley Healthcare System and Vanderbilt University School of Nursing***

In 2004, the Department of Veterans Affairs medical centers of the Tennessee Valley Healthcare System (TVHS) faced multiple challenges in the provision of patient care. Among these challenges 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 as 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 including hospitals, educators, and members of the community was formed to identify future nurse management needs. The result of the partnership between the 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 its program to address the special needs of the United States Air Force Academy. Additionally, the TVHS, VUSN, the Veterans Affairs Office of Nursing Services, and the AACN collaborated to produce a video for national distribution explaining the CNL role. In 2006, the TVHS and VUSN

began a pilot study for evaluation of empirical referents for successful implementation of the CNL role as developed in collaboration between the AACN and the Department of Veterans Affairs. The results indicated significant improvement in financial and satisfaction indicators (Hix, McKeon, & Walters, 2009); success of the clinical, academic, and community partnership was evidenced by joint participation of partners in scholarly publishing activities such as presentations at national conferences, mentorship activities for CNLs throughout the country, and even the joint celebration of special events and holidays. Effects of academic–clinical partnerships have been categorized as reaching multiple domains including economic, human capital, social capital, knowledge, and place (Davies & Bennett, 2008). While it may be difficult to make clear distinctions between domains, it may be beneficial to begin by examining how each institution impacts each domain and how a partnership may be used to bring about change.

## Sustaining Partnerships

The lack of progress in changing the delivery of health care to match the complexity of patient needs has been attributed to a 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. Evaluation of partnership outcomes is often measured in terms of the impact on the clinical setting, the academic setting, and the outcomes of care delivered. It is also important to consider the impact one partnership will have on other academic–clinical partnerships, as many hospitals serve as clinical sites for multiple academic institutions (Glazer, Erikson, Mylott, Mulready-Shick, & Banister, 2011).

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). Establishment of a joint academic service journal club may be used in a clinical setting to enhance staff awareness of evidence-based practice, promote leadership development, and enhance the learning environment of the organization (Duffy, Thompson, Hobbs, Niemeyer-Hackett, & Elpers, 2011).

**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

For example, 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 and include the chief nursing officer, faculty, and other academic administrators, and that students and other practice stakeholders should meet and provide feedback regarding education or implementation matters (Rusch & Bakewell-Sachs, 2007).

The extent to which academic, clinical, and community partnerships can 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.

## Summary

- The formation of partnerships begins with recognition of unmet needs and challenges within and between 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.
- A partnership can only move forward when trust, respect, shared values, and openness are present.
- 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 remain 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 become important to maintaining the relationship between organizations.



## Reflection Questions

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1. The focus of this chapter is on 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 informal 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

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1. Conduct a needs assessment of a microsystem in a healthcare facility. Use the gap analysis outline from Box 3-1 to guide your work.
2. Working with your CNL preceptor, identify how each partner benefits in an academic–clinical relationship.

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## WellStar Health System— CNL on All Acute Care Units

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Senior nursing leaders at WellStar Health System (WHS) are dreaming of the day that there is a clinical nurse leader (CNL) on every inpatient unit. WHS supports the 12-bed hospital model for the delivery of patient care lead by CNLs in acute care.

WellStar Douglas Hospital is a 102-bed hospital with four acute care units. Currently there is one CNL working on the 16-bed postoperative unit. This CNL is paving the way for four additional CNL students to join her during their clinical immersion experience. By the end of fiscal year 2013, WellStar Douglas will have five CNLs leading the way to improve patient outcomes in acute care. WellStar Paulding will have one CNL functioning on the acute care unit.

WellStar Cobb Hospital will start its implementation journey of CNLs with four CNLs in spring 2013. Two CNLs are being placed on the stroke/neurological unit, and two are being placed on the renal failure unit.

WellStar Kennestone Hospital will have eight CNLs working on four of the acute care units. Senior nursing leaders have chosen units where they believe the CNLs will make the biggest impact on improving clinical outcomes for patients. Two CNLs will be on the stroke/neurological unit, two on the cardiac dysrhythmia unit, two on the renal/hemodialysis unit, and two on the medical unit.

WHS will be adding 23 additional CNLs to Cobb and Kennestone Hospitals in spring 2014, when the second cohort graduates from the University of West Georgia.