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**THE ESSENTIAL**

CLINICAL RESOURCES

FOR NURSING'S ACADEMIC MISSION



**American Association**  
*of Colleges of Nursing*

## *Essential Clinical Resources for Nursing's Academic Mission*

### **I. Background**

In 1997, the AACN Board of Directors established a Task Force on Essential Clinical Resources for Nursing's Academic Mission. The charge to the task force was to:

Develop a comprehensive statement on the essential elements of clinical support for the nursing academic mission. This should include a discussion of the clinical access necessary for preparation of a skilled group of professional nurses for basic and advanced nursing practice. In addition, the statement should articulate an understanding of the clinical elements necessary for the entire academic mission, including faculty practice and nursing research activities. The statement should also include a description of the facilitators and barriers to clinical access, particularly focusing on the dynamic nature of the health care delivery system.

The need to address this issue rose out of growing concerns expressed by nursing educators over changes not only in the health care delivery system but in nursing and higher education as well. Changes have necessitated significant alteration in the number and type of clinical resources needed to meet nursing's academic mission, including education, practice, and research. Concern also has been raised over the barriers to establishing meaningful relationships between the clinical enterprise and schools of nursing.

### *Issues and Context*

Learning to perform as a "nurse" is predicated on engaging in experiential learning with actual patients/clients. This type of learning opportunity usually is referred to as a "clinical practicum" and represents a field experience. Experiential learning can occur through a number of modalities, including computer and virtual reality simulations, case studies, interactive videos, and hands-on direct patient interactions or experiences. Each of these modalities is an appropriate and useful means of teaching; however, the primary focus of this document is the hands-on direct patient care—referred to as clinical site-based learning—experiences necessary for preparing qualified nursing practitioners and researchers.

Experiential learning necessary for baccalaureate educational preparation includes the supervised practice of skilled nursing care in a variety of direct practice sites such as hospitals, extended care institutions, clinics, schools, churches, homes, or other community venues. Students receive a variety of experiences across a health/illness continuum, graduating as novice practitioners for general nursing practice.

Graduate education, both at the master's and doctoral level, requires significant clinical resources for quality preparation of practitioners. Experiential learning opportunities for master's nursing education encompass a similar breadth of venues

as that for baccalaureate education. However, master's students preparing for direct patient care roles receive more focused education and clinical experiences on a particular health/illness point (acute/critical care or primary care) or specific population (family or elders), graduating as advanced practice clinicians. Other master's nursing students preparing for non-direct patient care roles (e.g., administration or community health) receive focused education and clinical experiences that reflect their areas of specialization. Doctoral students must have opportunities not only to practice in their specialty but also must have ample and appropriate research opportunities within their chosen field.

Baccalaureate and graduate nursing programs are situated in a variety of educational institutions with a diversity of connections to health care delivery sites. Regardless of affiliation within academia, however, the challenges of providing relevant clinical practica for students seeking a baccalaureate or higher degree in nursing are similar. Traditionally, hospitals have been a major source of clinical learning opportunities for most programs, concentrated geographically and constituting a convenient laboratory-type experience. Access by academic institutions to hospital practice sites has been through direct alignment with hospitals affiliated with an educational institution or by contractual agreements with unaligned hospitals. Reflecting current changes in the health care delivery system, contemporary nursing education at the baccalaureate and graduate levels also incorporates substantial clinical practice at community-based sites. Clinical arrangements at these community-based sites have been largely through contractual agreements; however, as integrated health systems evolve to provide a spectrum of services, these experiences also can be by direct alignment. The development of faculty practice sites owned and managed by academic nursing is producing another form of site directly aligned with academic nursing.

The most common model of clinical teaching, particularly in hospitals, has been to utilize faculty from the educational institution who are not employed or fiscally aligned to the practice site, and who do not provide direct clinical services for the clinical agency. Under this model, agency or on-site clinicians are used in a consulting capacity. Clinical guidance or instruction at community-located sites more often has used a preceptor model whereby practice site clinicians act as preceptors or clinical instructors. In general, community-located learning accentuates the logistical challenges of placing numbers of students across multiple geographical sites that accommodate small numbers of students while allowing for appropriate faculty oversight and guidance.

The dynamics of this country's rapidly evolving health care delivery system are intensifying the challenges of access to clinical learning opportunities in either hospital or community sites, using either an academically-based instructor or a preceptor model. These changes are necessitating a shift in how nursing education envisions, creates, and implements clinical teaching opportunities.

AACN's *Issue Bulletin* (March 1997) revealed that, while deans reported that applications remained strong, some schools had deliberately cut admissions to nurse practitioner programs because of a tightening pool of training locations. In a 1998

AACN survey (AACN, 1998a) regarding clinical practice settings, out of 219 responding academic institutions, only 36 (16%) reported not having any problems related to a decline in the number of clinical education and training sites available to students, or difficulties in placing students at clinical training sites. Ninety-eight (45%) schools reported problems with declining sites for undergraduate students. Ninety-six (44%) schools reported difficulties in placing undergraduate students.

Nursing faculty, as members of a practice discipline within academic institutions, are expected to maintain a high level of expertise in their practice specialty. In addition, nursing faculty are expected to expand and contribute to the scholarship of nursing through research, teaching, practice and integration (Boyer, 1990). To meet these goals faculty must have opportunities to engage in meaningful practice and must have access to sufficient and appropriate clinical resources for practice and research.

### *Dynamics of Healthcare Delivery*

The dynamics of the health care delivery system, especially its financing, are threatening the conventional means of access to clinical practice sites and are requiring a re-thinking of how nursing educators facilitate clinical learning and experiences. The health care system, in its recent evolution, has shifted its focus in a number of areas:

- from predominantly individual practice to group or institutional practice,
- from specialty to primary care emphasis,
- from fee-for-service to capitated services,
- from personal to population-focused care,
- from episodic to continuity of care,
- from illness to wellness care,
- from hospital-based to ambulatory-based care, and
- from institutionally-located to community-located health care delivery.

Overall, the health care system is moving from an array of disconnected agencies to integrated systems run increasingly by the private sector with an increasing emphasis on cost and the bottom line. In addition, the system is moving from a focus on services organized to serve the healthcare provider's needs to a focus on customer/consumer needs.

The shift to managed care has been a sweeping change for both private and public insurers. Enrollment in health maintenance organizations (HMOs) has risen, going from 6 million people in 1976 to over 76 million people in 1997 (American Association of Health Plans, 1998 & Interstudy, 1997). It is estimated that Medicaid expenditures will double; from 1995 to the year 2000, they will jump from \$202.2 billion to \$359.8 billion. Forty-five states operate Freedom-of-Choice waiver programs to enroll Medicaid beneficiaries in cost-effective managed care programs (HCFA, 1998).

The pressure to shift care delivery away from the most costly sites (i.e., hospital or tertiary care sites) has reduced the size of the acute care domain as a clinical resource. Hospital use is on the decline. Hospital beds per 1,000 persons fell from 51.5 in 1975 to 28.4 in 1996 (HCFA, 1996). The tremendous cost-cutting and re-

engineering of acute care delivery sites have diminished educational support from these agencies for the development of health care professionals. The expansion of ambulatory care within the tertiary care domain provides opportunities for clinical education sites but capacity varies and is more dispersed. Medicare statistics show that home care has been on an upsurge with the number of agencies increasing from 2,254 in 1975 to 8,437 in 1996 (HCFA, 1996). However, ambulatory/home/community practice sites are presented with the same economic pressures for cost-effective practice and subject to the same dynamics that may preclude their attention to education of future health care professionals.

The shift from a tertiary care-based delivery system to a more primary care-based system has provided expanded practice opportunities on an advanced practice level. Graduate education institutions have met market demands through the development and expansion of nurse practitioner programs. In 1991, there were 83 institutions that had one or more graduate nurse practitioner programs (Stanley, 1993). In fall 1997, of 657 institutions with nursing baccalaureate and/or graduate programs, 339 schools (51.6%) granted master's degrees and of these, 295 schools (87.0%) offered one or more nurse practitioner master's or post-master's programs. Between mid-1996 and mid-1997, nurse practitioner majors accounted for 57.4 % (N=19,786) of all nursing master's enrollees (AACN, 1998a). The move to nurse practitioner education and the increased number of programs has placed greater demands on accessing primary care and other clinical sites for education and dramatically has increased the clinical practicum hours in graduate education programs. These changes have promoted a strengthening of the preceptor model and fostered more and stronger connections with the direct practice community on the part of nursing educational institutions.

### ***Exploring New Models***

Health care delivery changes are providing nursing faculty with extraordinary opportunities to create new models for clinical learning. These new models will afford academic nursing the opportunity to reconnect nursing education with clinical practice. In many cases, this means forming partnerships in newly merged organizations and in new and different ways than in the past. Practice sites within integrated health systems abound but the challenge is to persuade agencies of the mutual benefits and added value in forming partnerships with educational institutions.

Nursing practice increasingly is focused on health promotion/disease prevention. Opportunities for clinical practice from a population rather than a personal health perspective are needed. Community-based nursing practice addresses the health of communities as a whole and utilizes community needs assessment and services planning. Community-based practice, therefore, requires clinical learning opportunities beyond the usual direct practice-type designed for individuals seeking care. It requires partnerships with other disciplines and with community leaders to develop effective interventions for the health of populations.

Clinical practice in community-located sites (e.g., health centers, schools, and community clinics) generally means that site capacity is small and, despite providing a broader-base of services, sites are able to accommodate fewer students than are traditional hospital settings. In addition, the shift to broader-based, more diversified experiences may require that students be distributed geographically with various providers and sites. Challenges exist in coordinating experiences for students across a continuum and mixture of sites. The optimum means of preparing students for clinical practice (e.g., creative simulations in a learning laboratory prior to entering the field laboratory or small group case study discussions) must also be addressed. To be effective and cost-efficient, educators will have to coach and guide students from afar.

Change brings opportunity and challenge. In the changing healthcare milieu, nurse educators must take advantage of opportunities and challenges and must design creative means to prepare highly qualified practitioners for the future health care system. This outcome will require intensive and new dialogue with patients/consumers, other health care professionals, health care administrators, and educators.

The remainder of this paper examines the essential elements of clinical support necessary for undergraduate and graduate nursing education, faculty practice, and research. Barriers and facilitators to attaining these necessary elements also are reviewed. Collaborative models presently being employed to address the changes in nursing education are presented. Finally, recommendations for future actions to expand and strengthen nursing education's clinical resources are presented.

## **II. A. Essential Clinical Resources for Undergraduate and Graduate Nursing Education**

Professional nursing is a practice-based discipline built upon nursing knowledge and theory, as well as knowledge derived from a wide array of other disciplines that is adapted and applied to professional practice. Nurses must be competent to diagnose and treat human responses to actual or potential health problems through the provision of nursing services. To master the discipline of nursing and the increasingly complex skills required to deliver safe and effective patient care, both theoretical and clinical site-based learning are essential for undergraduate and graduate nursing students.

The purpose of clinical site-based learning is to enhance and add relevance to theoretical knowledge through which students:

- develop the essential core competencies of critical thinking, communication, assessment, and technical skills;
- apply the core knowledge of health promotion, risk reduction, and disease prevention; illness and disease management; information and health care technologies; ethics; human diversity; global health care; health care systems and policy;

- develop in the professional roles of provider of care, designer/manager/coordinator of care, and member of a profession; and
- deliver and manage comprehensive, outcomes-based patient care along the health-illness continuum in collaboration with other health professionals.

In addition, students must have the opportunity to develop these core competencies in an environment where the professional values of altruism, autonomy, human dignity, integrity, and social justice characterize the behavior of professional nurses (AACN, 1998b).

To prepare students for future nursing practice, nursing faculties have sought expanded learning experiences to complement those found in hospital settings, hence the increase in the number and variety of community-based learning experiences found in nursing programs. Expanded practice environments have enriched the educational preparation of students. A need continues, however, for students to have site-based clinical learning with a rich variety of learning experiences and professional nurses willing and prepared to serve as role models and instructors. Students are best able to acquire certain nursing knowledge, skills, and roles by observing and practicing in settings that provide these learning experiences and employ sufficient numbers of practicing professional nurse role models.

To maximize experiential learning for undergraduate and graduate students, education and service institutions need a symbiotic relationship that allows an understanding of purposes, possibilities, and constraints. Within this mutually agreed upon relationship, the service institution's primary responsibility is to provide cost-effective care while also facilitating a positive learning experience for students who participate in providing patient care. The educational institution's primary responsibility is to supervise students and communicate the learning goals and expected outcomes for the clinical experience. Specifying these goals and outcomes informs service institution professionals as well as students. The service and education institutions must collaborate to establish, implement, and evaluate the goals and expected outcomes for student clinical experiences. In collaborating to achieve their mutual and respective goals, nursing education and service demonstrate concern for the future nursing profession and the preparation of future practitioners and foster the expectation that all professional nurses have the responsibility to nurture the nurses of the 21<sup>st</sup> century.

The essential elements of clinical resources for undergraduate and graduate nursing education are predicated on the assumption that students are best served by opportunities to work and learn together with professional nurse mentors, preceptors, and role models. Together, nursing education and service can develop models that facilitate this interaction and collaborative learning. As educational institutions assume the responsibility to develop mentors and preceptors for students in the service setting, service institutions can encourage nurses to share in the education of neophyte nurses. Both education and service institutions share in the creation of a supportive learning environment.

The following essential elements for clinical resources for nursing education are those that enrich and maximize learning opportunities for undergraduate and

graduate students. Graduate nursing education requires additional essential elements for clinical site-based learning and these have been delineated further where appropriate.

Clinical site-based learning provides opportunities to:

1. *Provide care along a continuum.*

- The continuum of care includes health promotion, risk reduction, and disease prevention as well as illness and disease management.
- Students provide nursing interventions based on the thorough, systematic assessment of patients and evaluate their effectiveness in achieving the desired outcomes. Nursing interventions vary from advocacy, therapeutic interpersonal communications, health education, to the direct provision of nursing care.
- Students operationalize their theoretical knowledge regarding patients who are experiencing various levels of wellness and plan, implement, and evaluate appropriate nursing interventions.
- Students provide care based on an understanding of ethics and participate in ethical decision making.

2. *Work with interdisciplinary and intradisciplinary teams.*

- Students develop coordination, collaboration, and communication skills when working with members of other disciplines in interdisciplinary health care teams for the purpose of improving the health status of clients.
- As interdisciplinary teams vary in composition and purpose, students also have opportunities to enhance their team building, decision making, and adaptation skills.
- Students experience the role, responsibilities, and scope of practice of other interdisciplinary team members and their relationship to professional nursing practice.
- Students work with intradisciplinary nursing teams whose members have different educational preparation. Students distinguish among the roles, responsibilities, and scope of practice of other nursing team members.

3. *Work within and across diverse health care delivery environments communities.*

- Clinical site-based learning provides a variety of options for students and faculty working within a single health care delivery system or across several systems.
- Within a single health care delivery system, students learn the operation and services of that setting and deliver and manage nursing care to patients requiring different services within that setting/system.
- In non-institutional settings where there is a greater emphasis on prevention or population focused care, clinical site-based learning may be obtained in a variety of community-based settings as well as in acute care settings.
- Community-based settings may provide excellent opportunities for students to develop not only individual patient care skills but also population/group care skills and leadership/management skills. Expanded practice environments include homes, clinics, community centers and shelters, schools, industrial settings, rehabilitation centers, and nursing homes.



4. *Provide care for diverse populations, including diverse ages, gender, ethnicity, healthy-ill, and acute-chronic health states.*
  - Diverse populations challenge students to provide nursing care that is humanistic, culturally competent, and sensitive to variables such as age, gender, culture, race, religion, socioeconomic status, and lifestyle choice.
  - Students develop respect for the inherent worth and uniqueness of individuals and learn to preserve human dignity.
  - Students practice and develop nursing's professional values of altruism, autonomy, human dignity, integrity, and social justice within a practice/professional environment.
  
5. *Exercise delegation/management skills.*
  - Students manage the delivery of care provided by others. Students learn to delegate safely and appropriately based on an assessment of the individual care provider's previous experience, educational background, and licensure status. Delegates may be other members of the nursing team, family members, or lay persons.
  - Students develop their leadership, supervisory, and management skills. Students delegate tasks to other health care personnel and learn to supervise and evaluate personnel performance.
  - Students organize, manage, and evaluate the functioning of a nursing team/unit.
  
6. *Practice case management.*
  - Students practice case management and follow individuals/families who are experiencing various health and illness states in a variety of settings including pre-admission to post-discharge and outpatient care.
  - Students learn to access community resources and coordinate care with other health care providers.
  
7. *Manage health-related data.*
  - Students analyze the type, extent, and management of health-related data generated by health care providers and information management systems.
  - Students manage information by acquiring, interpreting, and utilizing information related to health care, illness, and health promotion.
  - Students learn where to find needed data/information, how to retrieve it, and how to deliver outcome-based patient care.
  - Students learn how to change patient care and nursing interventions based on patient outcomes and use research findings to continuously improve nursing care, patient outcomes, and nursing delivery systems.
  - Students critically analyze information and distinguish between relevant/irrelevant, significant/insignificant, and reliable/unreliable data/information.
  - Students recognize the importance of the factual collection of data/information and document patient care outcomes accurately.
  
8. *Use information technologies to provide nursing care.*

- Students use information technologies to provide comprehensive, humanistic nursing care to patients, families, and groups, which is directed toward achieving specific outcomes and supported by nursing research.
- Students use the latest information technologies, including the Internet and listserves in nursing research, to support evidence-based nursing practice, which prepares them for optimal decision making.
- Students acquire hands-on experience in the use of patient care technology and information technology, which supports diagnosis, treatment, decision making, and patient care.

9. *Participate in nursing research.*

- Students observe and participate in the conduct of nursing research by faculty and nursing staff.
- Students integrate research findings into their practice by observing nurse experts in the clinical setting.
- Students participate in data collection, system input, analysis, and retrieval while preserving patient confidentiality.

10. *Deal with the allocation and management of fiscal and human resources.*

- Students develop leadership and management skills and focus on providing nursing care that is cost efficient in terms of fiscal and human resources and effective in achieving patient outcomes.

11. *Work with role models and preceptors.*

- Students observe and emulate professional nurses who model excellence in providing, designing, managing, and coordinating care, and who incorporate professionalism into their practice.
- Effective role models socialize novices into assuming professional behaviors and inculcating the professional values of altruism, autonomy, human dignity, integrity, and social justice.

***In addition to the above essential elements necessary for both undergraduate and graduate clinical site-based education, graduate education requires additional essential elements. Clinical site-based learning for graduate education also provides opportunities to:***

11. *Work with role models and preceptors (continued)*

- Clinical site-based learning for graduate nursing education requires a sufficient number of educationally and experientially qualified professional practitioners who are willing and competent to serve as preceptors and role models.

12. *Practice in the advanced practice nursing role.*

- Graduate students provide direct care in the advanced practice role to a suitable number of patients whose health care problems/needs are sufficiently representative to prepare them for professional practice in the area in which they are being prepared.

- Graduate students have opportunities to practice more independently and collaboratively with physicians and other health care providers.
- Clinical site-based learning supports independence and collaboration by providing opportunities for students to engage in assessment, decision making, intervention, and evaluation while providing direct health care to patients.
- Graduate students practice in an environment that provides the opportunity to develop the advanced practice nursing role in collegial relationships with other health professionals including, but not limited to physicians, pharmacists, and other advanced practice nurses.

*13. Work with an agency staff committed to the advanced practice nursing role.*

- Graduate students practice in an environment in which the staff is committed to the importance of the advanced practice nursing role in providing health care in evolving health care delivery systems.

*14. Engage in nursing research.*

- Master's students, in addition to the elements listed above, utilize information systems for the storage and retrieval of data; identify potential research problems within the clinical practice setting; and utilize new knowledge to analyze the outcomes of nursing interventions, to initiate change, and to improve practice.
- Master's level students also use research findings as the basis for clinical and organization decision making.
- Doctoral students develop knowledge and skills in the planning, implementation, and analysis of empirical research, historical research, theory development and testing, methodological studies, and philosophical inquiry and analysis.

The preparation of professional nurses for basic and advanced practice requires access to clinical facilities that provide and support these learning opportunities. This is more likely if faculty and clinicians have collaborated in defining respective and mutual goals, expectations, and benefits of nursing education's presence.

## **II. B. Faculty Practice**

The future of nursing in all health care delivery settings, to a major extent, depends on how the entire profession views the significance and impact of nursing practice. If nursing is to continue on its trajectory of major influence on the health of the population, efforts toward enhancing the significance of practice can not be overemphasized. One component of these efforts is the establishment and/or strengthening of collaborative relationships between nursing education and nursing practice. An essential element of such relationships is faculty practice.

Nursing's academic mission will be more fully realized as faculty at all levels reconnect with practice. If the responsibility of nursing education and practice is to collaboratively shape practice, prepare professionals who can participate as full partners in health care delivery, and shape policy, then nursing faculty also have a

responsibility to be highly visible in practice settings as full partners and “shapers” of practice and policy.

Faculty members share responsibility for the quality of nursing care given in clinical agencies with which they are affiliated. The value of faculty practice is enhanced in this context. Given the dynamic nature of the knowledge base for practice, the importance of faculty practice related to theory development, theory testing, and research assumes greater significance, as does the ability of faculty to model expert practice.

In order for faculty practice to develop and flourish, a number of conditions need to exist in both academic and clinical settings.

*In the academic setting there must be:*

- reconceptualization and redefinition of the faculty role and the educational model that integrates teaching, practice, and research. This calls for a major change in nursing academic culture, including reward structures;
- incorporation of faculty practice into the work of the faculty;
- redefinition of the nature of partnership and collaboration with clinical agencies, including mutual goal setting for achievement of the separate and shared missions;
- faculty commitment to the partnership and to practice;
- articulation of faculty contributions to the practice setting and mission (e.g., expert consultation, staff development, direct and indirect provision of nursing services, research collaboration, and mentorship); and
- specification of the educational, research, and practice agendas inherent in faculty practice.

*In the clinical setting there must be:*

- redefinition of the nature of partnership and collaboration with nursing education, including mutual goal setting for achievement of the separate and shared missions;
- agency commitment to the partnership and to education and research;
- articulation of agency contributions to the academic mission;
- provision of access to patient populations (e.g., direct access to individuals, families, groups and communities); and
- access to patient data.

Faculty practice models include not only collaborative relationships with external clinical agencies but also faculty-managed practices under the auspices of the academic institution.

## **II. C. Research**

The continued development of nursing science necessitates a concerted effort by faculty, deans, and administrators in health care delivery systems and the scientific community at-large. These groups must work together to build and maintain environments that foster scholarly inquiry. There is a critical need for resources that

will support the research programs of faculty and for the preparation of future researchers. Essential elements to accomplish this mission include models of intra- and interdisciplinary collaboration, access to patient populations, funding that will support these collaborative efforts, and a clinical environment that values and fosters inquiry, clinical research, and scholarship. Those individuals in academe and in the clinical environments in which faculty conduct research are responsible for developing and maintaining these essential elements.

The essential clinical resources needed to support the research programs of faculty are:

*1. Funding*

- Programs of research developed by faculty include teams of academic researchers and individuals who work primarily in the clinical environment. Individuals in the clinical and academic environments must have access to funding that will support their research.
- Meaningful collaboration on a research team requires involvement of all team members in all phases of the project. Most clinical research programs are time intensive and all team members, including those in the clinical environment, must be supported by protected time for this work.
- Money available for medical research must be available as well to nurse researchers studying clinical phenomena that will generate knowledge and changes in care practices.
- Academic nurse researchers should serve on clinical agency institutional review boards and funding committees in order to influence access to funding and patient populations.

*2. Intra- and interdisciplinary collaboration*

- Much of the clinical research conducted by nurse researchers is conducted with clinical populations. The focus of inquiry is often quite complex and requires the complementary expertise of several team members from both academic and clinical environments. The development and maintenance of these research teams that can successfully conceptualize and implement studies requires a major investment of time and effort on the part of everyone.
- Models of intra- and interdisciplinary efforts are not common and must be nurtured by administrators in both the education and clinical settings.

*3. Access to patient populations*

- Adequate access to patient populations is a complex issue. There are multiple barriers to access. Traditionally, physicians have “owned” patients, and in many settings this is still true. Their “permission” is often required by internal review boards (IRBS) in order to access individuals in clinical populations. In recent years, however, this ownership has transcended the physician. Many HMOs, hospitals and community health agencies restrict access to patient populations. In non-academic settings, where collaborative models and clinical research are not common, these restrictions are often an insurmountable barrier. This is especially true the less “relevant” the setting judges the research to be. Ethically, no one but

the patient (and in some cases the family) owns the patient's right for access to the opportunity to participate in research.

- Involvement and visibility of academic researchers in clinical settings will facilitate the access to patient populations and data for academic research programs at all levels.
- Development and involvement of collaborative research teams made up of researchers from the academic and clinical settings facilitate access.

#### 4. *Clinical environments that support and foster inquiry*

- Successful clinical research programs are conducted within a climate in which a group of health care professionals utilizes current research findings as a basis for practice.
- Clinicians within the setting are willing to work with teams of researchers to build meaningful, clinically relevant studies.
- Clinicians and others in the setting are open to a multitude of research methodologies and approaches and value questioning and evaluation of clinical practices.
- Those individuals in the setting must value the generation of knowledge that is not immediately applicable but will directly influence quality practices.
- Students who return to school to further their education provide an excellent resource in these clinical environments. To foster inquiry now and in the future, faculty must work with these students to build bridges between the university and clinical settings.

#### 5. *Partnerships*

- Partnerships between academic nursing institutions and health systems provide a unique opportunity to foster research collaboration and improve both access and relevant, clinically based research programs.
- Partnerships require both faculty and practitioners to share their expertise and time to nurture joint projects; however, the academic and practice cultures often conflict in terms of schedules, mode and speed of decision-making, and reward systems.
- Individuals at the highest levels within the respective organizations must support the partnerships for them to succeed.

### **III. Barriers to Essential Clinical Resources**

While there is much agreement regarding essential clinical resources for nursing's academic mission, there are many opinions concerning the barriers to achieving that goal. In a recent survey (AACN, 1998a) of AACN members regarding clinical training issues, 84% (183) of responding schools stated they were having problems related to a decline in the number of clinical education and training sites or in placing students at clinical sites. The most frequent barriers or problems cited by the academic institutions were:

- a shortage of new available sites;

- sites not accepting a large enough number of students;
- difficulties in recruiting or retaining preceptors;
- potential preceptors already fully committed to other professional responsibilities; and
- competition for access to clinical facilities with other schools of nursing and other health professional schools.

In a similar survey of nurse administrators (AACN, 1998a), only 34% of the respondents (N=186) stated that the number of clinical training sites available for nursing students had declined at their facility during the past three years. Of those who did cite reductions, 98% said the reductions affected undergraduate students. When asked what factors had affected their ability to provide clinical experiences, the most frequently cited reasons included:

- an overall reduction in volume of patient care activities (39%);
- the overall size of the clinical group (30%); and
- concern about the availability of faculty supervision for students (34%).

Seventy-eight percent of the administrators stated that numerous schools of nursing or other health professional schools compete for access to the clinical facilities.

Differences in educator and administrator responses may be attributable to a self-selection phenomenon. However, differences in the perceptions and needs between nursing practice and education are highlighted by these variations. Many of the real or perceived barriers to obtaining sufficient and quality clinical experiences for nursing students arise out of these differences.

While nursing education and nursing service desire the development of strong, clinically competent and knowledgeable nurses, the segregation of the education and practice domains of nursing has led to a chasm in perceptions and attitudes. This evolutionary phenomenon has resulted in discrepancies in approaches and priorities. Chief elements of the differences appear to stem from the uniquely different cultures that prevail within the service and educational arenas and in nursing's historical zeal to separate the mandates of each. The aftermath of this evolution has been the creation of collegial misunderstandings not simply a demarcation of function.

Barriers to accessing and utilizing clinical resources necessary for clinical education, faculty practice, and research can be divided into several categories. These barriers include:

### ***1. Differences in Regulations and Expectations***

Historically, accrediting bodies developed standards that separated service requirements of agencies and educational requirements of students in an effort to ensure that the education of students was the sole responsibility of nursing faculty. The result has been to distance nurse clinicians from the education of future nurses. Some regulatory requirements related to faculty qualifications have created barriers to participation by many of the most qualified providers of direct care, staff nurses.

As a result, nurse educators are often viewed as elitist in approach and demeaning in their attitude toward staff in the clinical arena. Staff nurses and clinical administrators perceive faculty as entering the clinical domain with a list of requirements and demands (e.g., an oncology unit for 10 students to practice for four hours on Tuesdays and Thursdays for 14 weeks, excluding holidays and snow dates) while making little effort to develop relationships with them or include them in the educational enterprise. While staff nurses are permitted to demonstrate how to accomplish certain technical tasks, they generally are not permitted any formal relationship or status with the students, nor are they recognized by the educational institution for their effort.

The staff may perceive the faculty as external visitors with variable knowledge and clinical expertise. Because of limited experience within a specific agency or setting, faculty may have limited knowledge regarding the functioning of the diverse departments and the specific applications of nursing and other policies and procedures. As a result, faculty members often appear and feel out-of-touch with clinical practice and remote from clinical decision-making.

In addition, faculty members generally demonstrate little awareness of the regulatory policies and parameters under which the staff nurse functions. Staffing patterns, patient-care loads, double shifts, and forced overtime are distant concerns to the faculty. Thus, it is likely that faculty might misinterpret and misperceive the responses of staff nurses to faculty or students.

Faculty members also hold perceptions of staff that are equally counterproductive. They perceive the nursing staff as creating barriers to excellent clinical learning opportunities by limiting access to certain patients, establishing parameters for the experience (such as hours of the day, or days of the week) or mandating elements of the experience that severely limit the student's experience. Theoretical models of nursing practice, espoused by the faculty, may appear to be disregarded or rejected by the staff nurse. Also, sensing that students "get in the way" or "bother the staff" most faculty attempt to filter student interactions with staff and attempt to present students in the most positive, but not necessarily the most accurate, terms. This process is interpreted by the staff to be a negation of their value to students, thereby reinforcing the cycle of misunderstanding.

Specific regulatory barriers or expectations that impede collaboration and partnerships between education and service include:

- state and national criteria related to faculty preparation;
- increasing mandates from the service sector related to student participation in patient care services (e.g., health-status clearances, security checks, minimum prior experience before entering certain agencies or performing specific tasks, minimum expectations regarding length of the experience, and increasingly lower numbers of students being accommodated);
- increasing pressures on the service sector that interfere in the provision of student experiences (e.g., reimbursement policies that threaten student participation in home visits, demands to maintain a certain patient volume, elimination of student



placement coordinator positions, and changing patient populations and demographics);

- increasing pressures on faculty to expand their expertise and time spent in all three of the domains (education, research, and clinical practice) resulting in increasing difficulty for faculty in maintaining clinical expertise and increasing reliance on staff support in the clinical setting;
- inability or unwillingness of educational institutions to provide meaningful and tangible rewards to colleagues in clinical settings; and
- lack of role models and established practices due to a rapidly evolving health care system.

## ***2. Differences in Cultural Values***

While the demands of the nursing practice and education cultures impinge heavily on both faculty and staff, a strong judgmental attitude exists in both cultures about the relative “rightness” of their respective values, beliefs, and actions. This faultfinding within the profession has produced a culture of its own fraught with backbiting, criticism, and negativism. Unfortunately, the student, placed in the middle of this conflict, is usually well aware of his/her tenuous status in the system and is anxious to remain neutral with the faculty and the staff.

Differing functions and the inherent disparity in time orientation are blamed for creating one of the major barriers that impedes collaborative activities between nursing education and nursing service. The primary purpose of nursing service is to provide high quality nursing care to patients when they require it. The time focus is immediate and in the present. Planning for the future occurs when the needs of the moment are fulfilled. The primary purpose of nursing education, however, is to prepare nurses to deliver those services. Consequently, although the education is provided in the present, nursing education is aimed at addressing future needs.

Specific barriers to developing effective partnerships created by differences in nursing practice and education values include:

- The devaluing of education by the nursing profession. This is visible in nursing’s entry requirements that are now lower than all other licensed health care professionals.
- Differences in time orientation between nursing service and education.
- A strong sense of territoriality that prevails among both faculty and staff in clinical settings regarding the respective “ownership” of patients and students.
- A lack of belief in the value of services provided by nurses and pride in nursing education and practice.
- Increasing pressure on individuals in leadership positions in the health care delivery sector to produce efficiencies of scale. Under such pressures, discouraged by the perceived lack of responsiveness and understanding by nursing education, and without a formal role in designing and implementing nursing education, administrators do not make nursing education a priority for the organization.
- A lack of shared vision and commitment to nursing education. Without strong executive leadership within the clinical organization and academia, that

articulates and professes a vision for collaboration and partnering between the education and practice spheres of nursing, there are serious problems attaining clinical placements and the necessary institutional clinical resources to support the nursing academic mission.

- A lack of a strong culture of professional mentoring.

### **3. *System and Organization Issues***

Changes in the way the health care system manages patient needs have had significant impact on nursing education, both content and process. Traditionally, patients were grouped in hospitals for significant lengths of stay allowing students the opportunity to observe an illness pattern over time, develop continuity relationships with patients and families, evaluate the effectiveness of nursing interventions, and develop confidence and familiarity in one clinical setting. Significant pre-admission counseling and preparation for hospitalization, early discharge, and increased emphasis on ambulatory care have greatly reduced and altered the hospital patient population and experience. For example, providing the opportunity for a student to see a patient prior to a surgical intervention and post-operatively requires more coordination and planning on the part of the faculty, staff, student, and patient. Providing this continuity of experiences is necessary for the student to engage in any comparative assessment and develop any depth to a patient-nurse relationship, yet increasingly challenging to obtain.

Changes in how, where, and when health care services are delivered have created significant changes in availability of traditional clinical experiences, which were provided during the traditional workweek within institutional settings. Changes in the health care delivery system also have produced greatly expanded and diverse expectations in the professional nurse role. To address these changes within the health care delivery system, nursing education programs, both at the baccalaureate and graduate levels, have redefined and revised their curricula. Many programs continue to struggle with the necessary changes that also must occur in the clinical components of the education of the future professional nurse.

The potential barriers to sound educational planning created by changes in the health care delivery system include:

- loss of continuity of patient experiences;
- overemphasis on “locale” of learning experience and insufficient attention to the nature of the experience itself;
- increasing transitory student/patient interactions;
- loss of “intimacy” between students and patients, and students and faculty;
- limited patient populations across the health-illness continuum;
- decreased contact with families and other patient resources;
- increased costs in time and resources for student experiences;
- changing patterns of health care delivery, including a shift from institutional to community-based care, increased acuity of institutionalized patients, and an increased focus on population-based care;

- changes in the nursing role and education that require more breadth and depth in clinical learning experiences;
- lack of flexibility by faculty and students in scheduling clinical experiences; and
- lack of creativity in redesigning clinical education to meet the changing expectations of the professional nurse.

#### ***4. Educational Competition***

Competition among nursing education and other health care professional programs for access to sufficient and quality clinical experiences abounds. Competition, while not new, has taken on a new significance as the number of clinical placements has decreased, fewer opportunities for direct student practice are presented, and the number of health professional students grows. In the recent AACN survey of member schools referred to previously (AACN, 1998a), 89% (196) of respondents indicated they were competing with other schools of nursing or other health professional schools for access to clinical facilities. Seventy-four percent (162) of responding institutions with a baccalaureate program indicated they were having difficulties due to competition with associate degree nursing programs, and 61% (134) noted difficulties due to competition with other baccalaureate nursing education programs. Although not as strong a reaction, 78% of the nursing administrators surveyed also indicated competition among health professional programs for access to clinical facilities.

Competition for hands-on learning experiences becomes most acute when nurse educators seek to provide new and more in-depth kinds of experiences. For example, baccalaureate programs increasingly are incorporating time-intensive clinical experiences with a preceptor model. As a result, a one-to-one assignment with a clinician needs to be established for each student. Coupled with the increasing demands of graduate education for experienced preceptors, nursing education programs are placing more demanding and urgent requirements on clinical settings.

The move for associate degree, diploma, and practical nurse programs to provide community-based experiences for their students creates even more competition for a defined number of sites. Hence, the competition for clinical experiences for students extends across all nursing and health professional educational programs and all clinical learning sites. While some regions or population centers have made significant efforts to coordinate the total learning needs of the educational programs, these efforts remain fraught with problems of competition and intrusion on the clinical setting, clinicians, and recipients of patient care.

Competition in many areas becomes even more intense at the graduate level. This competition is spurred on by the need for placement of students in supportive, clinical environments with diverse patient populations and strong clinical and professional role models willing to function as preceptors.

The barriers to providing high quality clinical learning experiences created by competition for clinical learning sites include:

- need for increased number and diversity of clinical sites;

- changes in the location, type, and timing of placements or experiences;
- lack of qualified and willing clinical staff to work with students on a long-term basis or as preceptors;
- increasing need for preceptors in primary care practices; and
- heightened sense of territoriality or unwillingness to collaborate created by the competition.

### 5. *Costs of Clinical Education*

Clinical education is time intensive and therefore expensive. Debates surrounding the distribution and utilization of graduate medical education (GME) monies note the expense to clinical settings of having student placements. Several studies have attempted to discern direct costs for nursing and medical students in clinical settings (Bednash, Redman, & Southers, 1989; Mannle et al., 1994; Boex, 1998). These studies, although difficult to carry out due to the complexity of the variables and inability to control factors in the setting, demonstrate that health professional clinical education is expensive. Who should absorb these costs and how costs for clinical education should be calculated are critical questions at this juncture. With the continued escalation of undergraduate and graduate education tuition costs, is it feasible to expect students to pay for clinical experiences? Likewise, with the rising costs of providing an education and in the face of decreasing state and federal education appropriations, is it feasible to expect the educational institutions to absorb these costs? Or with the increasing emphasis on rising health care costs is it feasible for the payors of health care to absorb the costs of health professional education? If nursing is to meet the 2010 workforce goals established by the Division of Nursing (National Advisory Council on Nursing Education and Practice, 1996), then it must:

- restructure the basic registered nurse workforce, including the preparation of a basic nurse workforce in which at least two-thirds hold baccalaureate or higher degrees in nursing;
- ensure an adequate supply of registered nurses;
- prepare the existing registered nurse workforce to meet current needs;
- enhance the ability of the registered nurse workforce to meet the challenges of cultural diversity in delivery of health care; and
- examine the effect of functions of registered nurses in the provision of quality health care.

Collaborative or shared responsibility for clinical education costs must be developed.

The costs of undergraduate and graduate nursing education differ and are predicated on distinct measures. One of the confounding and unfortunate factors is the lack of data on the cost of clinical education and the benefits to the clinical setting, including how students contribute to the quality and nature of services provided.

Increasingly, clinical institutions have little or no vested interest in the educational enterprise. Employers in many other fields have demonstrated considerable interest in the development of neophytes. The health care industry, however, has focused attention primarily on the funding, development, and advancement of medicine to the

exclusion of most other health professions. Distribution of federal and private health care payor funds must be shifted to include other health professions.

One contributing factor to the inequitable distribution of monies may be the failure of nursing education to include the clinical staff or agencies in the planning and implementation of nursing education programs. This dichotomy, a result of the history or evolution of nursing, limits the degree to which nursing practitioners are engaged in educational planning. In most settings nursing education has given limited recognition to the potential contribution from this cadre of nursing experts. In addition, nursing education has been reluctant to provide financial or other remuneration to clinicians for participation in the educational process. Currently, academic nursing programs do not have the funds to augment the salaries of clinical nursing staff. Lack of involvement by clinical nursing staff in the educational process also stems from the failure of nursing to create a professional culture that embraces the mentoring and instruction of future members of the profession. To date, neither nursing education nor nursing practice has advocated for collaboration and the formation of partnerships.

According to the AACN 1998 Institutional Database, 113 out of 568 institutions reported having a nursing center administered or owned by the school of nursing. The increase in the number of schools that own or operate a clinical facility or center represents a dramatic shift away from the dependence of nursing education on outside clinical agencies. Not only do the nursing centers provide much needed clinical services (frequently in underserved areas), they also provide rich opportunities for both faculty and student practice and research. The financial impact of a nursing center on the school is variable and is dependent upon external sources of funding, contracts with third party payors, and patient resources.

Barriers to obtaining the essential clinical resources for nursing education created by issues related to cost include:

- inadequate funding for clinical nursing education;
- already high tuition and fees for nursing education, which does not make increasing them a viable option;
- an increasing expectation of some clinicians and clinical agencies who contribute to the academic enterprise to be compensated for their effort;
- a traditional lack of investment in nursing education by the health care system as a whole;
- changing health care dynamics that require more widely dispersed and varied clinical placements; and
- changing patient demographics that require broader, more diversified clinical experiences.

#### **IV. An Exploration of Creative Education-Clinical Partnerships and Models**

Availability of clinical teaching sites for graduate and undergraduate students at hospitals, health maintenance organizations, primary care clinics, and other health care delivery sites is decreasing (AACN, March, 1997). Increased caseloads and

demand for greater productivity at managed care facilities have forced many clinicians, long-standing participants in graduate nursing education, to withdraw their commitment to schools of nursing. Changes in the health care system and in nursing education have also caused baccalaureate-nursing programs to experience a scarcity of clinical placements. The search for additional sites has expanded beyond the normal geographic and institutional boundaries. The move into communities poses new challenges as well, including more scattered sites with fewer student placements per site. With these changes, faculty members are challenged to provide adequate instruction and supervision of students as well as the breadth and diversity of experiences needed for quality professional nursing education in today's health care market.

To survive and flourish in the changing health care environment, a re-examination of educational philosophy and traditional approaches to clinical nursing education is required. Schools of nursing have responded by exploring new models of curriculum delivery, clinical training, faculty utilization, and partnering with a variety of private and public agencies.

An innovative approach to nursing education-service partnerships may well hold the key to achieving the goals of nursing education and overall enhancement of nursing practice. Such an approach acknowledges the interdependence of both enterprises and calls for redefinition of the nature of partnership and collaboration.

Deans of schools of nursing and directors of clinical agencies need to lead these efforts and articulate a vision for collaboration. A mutual understanding of each other's mission and goals are critical components of successful collaboration. Relationships that include faculty in the practice enterprise and clinicians in the education enterprise, and recognize the efforts of each will reduce the territoriality and promote cohesion. According to Mundt (1997, p. 315), benefits of genuine partnership and collaboration between education and service include increased visibility of nurse leaders in education and practice, increased opportunities for nursing collaboration in documenting positive patient care outcomes, and preparation of a professional nursing workforce with vision and skills for the future.

(The categories listed here are not definitive but have been created only to facilitate discussion.)

### *Partnership Models*

In the spring of 1998, AACN issued a call to its membership for examples of new models being used or explored for developing partnerships between schools and healthcare agencies. The responses revealed a wealth of innovative and effective models that expanded the traditional boundaries of nursing curricula. Some of the most innovative models were still in the planning stages, others had been implemented less than a year, but a majority had been in effect long enough for member schools to share preliminary results.

### Contractual Arrangements with Governmental Agencies

Several schools contracted with state or county agencies to provide case management services for special populations. These contractual models produced income for faculty practice plans and created opportunities for graduate and undergraduate student clinical placements, faculty clinical practice, and faculty and graduate student research. For example, schools have become accredited case managers under Medicaid waiver plans that provide services to maintain frail and disabled clients in the community. Schools also have contracted with state agencies to provide highly specialized psychiatric care to both community and inpatient clients. Still other schools have partnered with local housing authorities to provide wellness clinics located in housing projects.

These arrangements provide faculty and students with the range of real world educational experience in healthcare delivery. First-hand experience is gained in collaboration and management, managed care, reimbursement, care delivery, and measurement of client outcomes. These experiences also strengthen faculty and student knowledge about the characteristics of the community, and the opportunity to partner with community agencies to secure additional contracts and grants.

### Academic-Corporate Partnerships

Other schools of nursing have developed academic-corporate partnerships to design, oversee, or develop collaborative projects. These schools report the opportunities for placements for clinical education, research, faculty practice, and clinical appointments as being mutually beneficial for education and practice. At one university, corporate partnerships include not only nursing, but also other academic units within health care and human services. This type of partnership creates additional opportunities for multidisciplinary education and interdisciplinary faculty collaboration.

For example, partnerships with proprietary home health agencies have expanded opportunities for clinical placements and faculty and student research. One program developed as a result of this type of collaborative arrangement targeted clients who had been discharged from regular agency caseloads. These clients were followed by undergraduate nursing students with the assistance of graduate student mentors, all of whom were supervised by faculty. Another school created a formal alliance with home care with the goals of advancing knowledge in the area of home health care and preparing masters-level specialists. Several benefits resulted from this alliance including clinical placement for undergraduate and graduate students, faculty and agency staff research collaboration, research opportunities for doctoral students, and the development of sub-specialty tracks in the graduate program.

### Community-Education Partnerships

Still other schools of nursing have integrated their teaching, research, practice, and service missions through the creation of extensive community foci for their activities. These partnerships are usually complex and involve multiple partners. In conjunction with community service agencies, health departments, hospitals, schools, local health care providers and community residents, these schools have established neighborhood centers, healthcare consortia, wellness clinics or nursing

centers and provide a significant portion of their total graduate and undergraduate curricula in the community. These centers and the extended partnerships in the community offer opportunities for faculty and student research, clinical education, faculty practice, and delivery of health services to community residents, frequently in underserved areas.

Several models of community-based or community-oriented education have been developed. Most of them use a variant of faculty and student assignment to neighborhoods or communities for a significant portion of the student's total educational experience. Students develop not only first-hand knowledge of the workings and resources of a community but also a genuine commitment to the community. Graduate nurse practitioner students may also be assigned to these communities for population-based projects. A few of these models partner with community college nursing programs and have the additional advantage of being able to test differentiated practice models as part of clinical education.

#### *Nurse-Managed Clinics*

A number of schools have developed partnerships with community and local government entities to establish nurse-managed primary care and wellness clinics to serve special populations or rural residents with limited access to care. In many instances, the success of these clinics attracted additional funds from federal, state, and foundation sources to support maintenance or expansion of services. These arrangements have several advantages for furthering the schools' missions in clinical education, faculty practice, and service. In addition, they provide access to diverse and special populations. Some of these arrangements are described below.

Schools have partnered with local housing authorities and health departments to establish nurse-run primary health care centers located in areas convenient for community residents in underserved areas. Other schools have established nurse-run clinics in grammar schools, middle schools, and high schools. Often the clinical positions established are based on cost sharing between the schools of nursing and their partners so that faculty resources are expanded without incurring the costs of a full-time faculty member. Schools of nursing also benefit from the expansion of placement opportunities for undergraduate and nurse practitioner students. School systems benefit because services offered to children and youth are expanded through students' clinical rotations.

Other schools of nursing have established rural primary care clinics that provide primary and emergency care to residents who live in isolated areas. A few of these clinics address very specialized needs in rural areas such as the healthcare needs of HIV positive clients. These clinics also serve as interdisciplinary training sites for nursing, medicine, pharmacy and social service disciplines and help to create models for meeting the healthcare needs of rural clients.

#### *Alliances within Academic Health Centers*

A number of schools of nursing, both as members and non-members of Academic Health Centers (AHC), have forged closer alliances with other entities in the AHC. These partnerships produced improved communication among faculty and clinical



staff, new opportunities for clinical education experiences, additional practice sites for nurse practitioner faculty, paid summer internships for students, joint programming, and in one instance, the formation of an interdisciplinary clinic for student clinical education in primary care.

#### *Contracts with Managed Care Companies*

An increasing number of nursing schools are beginning to report partnerships with managed care companies. These arrangements provide for senior undergraduate and graduate student placements in managed care facilities. These partnerships are mutually beneficial for the participants since they provide placements for clinical education and help the managed care companies meet future demand for advanced practice nurses.

#### *Nursing Research Centers*

Schools of nursing also have developed collaborative arrangements with healthcare institutions for the creation of joint nursing research centers. These arrangements encourage joint research to develop and test methods for care delivery, facilitate acquisition of external funding for faculty, provide access to research for graduate students and faculty, promote staff involvement in research projects and research courses, and in some cases provide staff with the opportunity to audit courses. Schools report that the enhanced services created by these partnerships resulted in increased faculty research funding and more opportunities to develop and test practice models.

#### *Summary*

These new collaborative partnerships have greatly expanded the traditional clinical education boundaries and led to new opportunities for nursing education and practice. These models are examples of the creative ingenuity of faculty and administrators in schools and healthcare agencies. The models address the new knowledge, competencies, and skills required of baccalaureate and graduate nurses in today's health care system. In addition, these partnerships increase public awareness of the services nurses provide, offer avenues for nursing research and private funding, provide services to communities and their members, often in underserved areas, and allow students to gain experience with diverse populations.

Information about the models described here is presented in Appendix A.

## **V. Recommendations**

To improve and ensure access to essential clinical resources for nursing's academic mission, strategies must be developed to address barriers created by:

- changes in the system affecting organization and delivery of health care services (e.g., reduced availability and capacity of clinical sites, and reduced availability of clinical preceptors.)
- accreditation and other regulatory requirements (e.g., faculty qualifications, conditions of student participation, reimbursement policies);

- differences in cultural values and expectations between nursing education and nursing practice (e.g., level of preparation, utility of nursing theory and research, vision of nursing, and time orientation);
- separation of education and practice;
- costs of clinical education; and
- competition for resources from other nursing education programs and other health professions education programs.

The following recommendations speak broadly to the issues identified and conclude with suggestions for further steps to be taken. Implicit and explicit in these recommendations is the absolutely critical and central change that must take place, namely, the redefinition of

- the relationship between education and practice
- the nature of partnership, and
- the shared mission of nursing education and practice.

### *Undergraduate and Graduate Nursing Education*

It is recommended that:

1. Leaders in nursing education work to redefine the relationship of nursing education and nursing practice including the nature of partnership, the faculty role, and the educational model.
2. Nursing faculty develop educational models that incorporate clinicians into the formal faculty structure (e.g., clinical faculty tracks, adjunct appointments).
3. Nursing education leaders and AACN develop programs to assist faculty and clinicians in building meaningful partnerships and designing new clinical education models.
4. Nursing educators foster a commitment to nursing education at all levels of nursing practice.
5. Leaders at each nursing educational institution foster collaborative partnerships with clinical agencies that encompass nursing education and practice.
6. Nursing education leaders promote a re-examination of traditional models/approaches to clinical nursing education to include:
  - redefinition of education and service partnerships to promote cohesion between faculty and clinicians;
  - recognition of the worth and contribution of clinical nursing staff to the educational mission of nursing education programs;
  - increase of faculty participation and contributions in the clinical arena; and
  - fostering of innovative and collaborative partnerships with a variety of health and social service institutions.

### *Faculty Practice*

It is recommended that:

1. Nursing leaders encourage and support faculty practice in all of its forms.
2. Educators examine the nursing education culture, including reward systems, with respect to relationships, partnerships, and reconnections with nursing practice.

### *Research*

It is recommended that:

1. Faculty and clinicians serve on research committees in both educational and health care delivery institutions to foster research team collaboration.
2. Faculty request to serve on health care agency institutional review boards to gain visibility and enhance collaboration with interdisciplinary investigators.
3. Leaders at schools of nursing and health care agencies incorporate into grant budgets funding to support clinician and educator research team members.
4. Nursing educators negotiate research partnerships with health care agencies along with clinical education agreements to balance workload and facilitate collaboration.

### *Next Steps*

It is recommended that:

1. Government and professional nursing bodies undertake analysis to predict the number and mix of professional nurses to be educated to match emerging health care markets.
2. Nursing leaders participate with other health care professional leaders to collaboratively plan for equitable distribution, access to, and use of clinical resources.
3. Costs of clinical education be determined to support lobbying for equitable funding for nursing education.
4. AACN take a leadership role in creating dialogue designed to define and develop new approaches to teaching in new clinical environments.

## **Glossary**

*Adjunct Faculty:* Two dominant common uses of this title are applied to individuals who contribute in a significant way to an educational program.

The first usage is applied to the non-traditional employee that is, the faculty member who is not on the tenure track and may have restrictions in their exercise of faculty prerogatives in faculty governance issues, often a part-time employee.

The second use is applied to those individuals who contribute to the educational program in a sporadic or indirect way ( eg., a vice president of nursing at a major clinical agency who facilitates the educational program and or serves on advisory committees). Other examples of nonsalaried contributors to the educational program who may bear the title adjunct faculty are nonpaid preceptors.

*Advanced Practice Nursing:* The manifestation of a high level of expertise in the assessment, diagnosis, and treatment of the complex responses of individuals, families, or communities to actual or potential health problems, prevention of illness and injury, maintenance of wellness, and provision of comfort. The advanced practice registered nurse has a master's or doctoral education concentrating in a specific area of advanced nursing practice, had supervised practice during graduate education, and has ongoing clinical experiences (ANA, 1996). The four dominant titles for advanced practice in a direct care provider role are nurse practitioner, nurse anesthetist, nurse-midwife, and clinical nurse specialist (AACN, 1996).

*Collaborative relationships:* The substantive interchange of human and/or material resources for the purpose of advancing common goals in practice, education, and research (AACN, 1993).

*Faculty practice:* A review of faculty practice definitions from five schools of nursing suggests an emerging comprehensive definition of faculty practice (Taylor, 1996):

Faculty practice includes all aspects of the delivery of health care through the roles of clinician, educator, researcher, consultant and administrator. Faculty practice activities within this framework encompass direct nursing services to individuals, families, groups, and communities. In addition to the provision of service, the practice provides opportunities for promotion, tenure, merit, and revenue generation. A distinguishing characteristic of faculty practice within the School of Nursing is the belief that teaching, research, practice, and service must be closely integrated to achieve excellence. Faculty practice provides the vehicle through which faculty implement these missions. There is an assumption that student practice and residencies as well as research opportunities for faculty and students are an established component of faculty practice (p.474).

*Nurse practitioner:* A skilled health care provider who utilizes critical judgement in the performance of comprehensive health assessments, differential diagnosis, and the prescribing of pharmacologic and nonpharmacologic treatments in the direct

management of acute and chronic illness and disease. Nurse practitioner practice promotes wellness and prevents illness and injury. Nurse practitioners function in various settings for individuals, families, and communities. This includes working autonomously and in interdisciplinary teams as resources and consultants. The role of this provider may include conducting research, providing education, and impacting public policy. The nurse practitioner may focus on a specific area of practice, e.g., family, geriatric, or pediatric, primary, or acute care (ANA, 1996).

*Preceptors:* Health professionals (usually nurses, sometimes physicians) who agree to have a special one-to-one relationship with a graduate or undergraduate nursing student over some portion of the student's clinical learning. During that time the student will work under the direct instruction of the preceptor who will direct and monitor student learning. This learning is evaluated in collaboration with the faculty member from nursing.

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## **Appendix A**

### **Creative Models: Partnerships Among Nursing Education Units, Healthcare Institutions, and Community Agencies**

**Creative Models: Partnerships Among Nursing Education Units, Healthcare Institutions, and Community Agencies \***

\* This list is not all inclusive. Models were submitted by schools as examples of practice-education partnerships. Categories are not meant to be definitive but are to facilitate discussion and provide easy reference. Many of the models could fit under more than one category.

Type of Partnership	Purpose/Description	Outcomes	Status
<b><u>Contractual Arrangements with government agencies</u></b>			
<p><b>University of Oklahoma College of Nursing</b> and the Long Term Care Authority of Tulsa (LTCA)</p> <p>Contact: Margo McRoberts, MSN, CNAA, Case Management Coordinator, College of Nursing</p>	<p>College became an accredited case management provider for Medicaid Waiver program to maintain frail elders and disabled clients in their home environment</p>	<p>1. Faculty Practice opportunities with earned income to support practice in the College</p> <p>2. Clinical education sites for both undergraduate and graduate students with faculty mentors</p> <p>3. Integration of managed care concepts within the curriculum</p>	<p>Implemented September 1995</p> <p>1. Faculty report satisfaction with case management role</p> <p>2. Expansion of clinical sites for all levels of students</p> <p>3. Increased faculty and student knowledge of community, reimbursement systems, and measurement of client outcomes</p>
<p><b>Arizona State University College of Nursing</b></p> <p>Contact: Dr. Betty Gayle, Associate Professor, College of Nursing</p>	<p>Partnership among the College of Nursing, Community Action services, aging service providers, county public health unit, and a local hospital to provide health promotion activities to older adults</p>	<p>Creation of Escalante ElderCARE Coalition that offers:</p> <p>1. Clinical education for graduate nursing students</p> <p>2. Community placements for undergraduate students</p> <p>3. Faculty research site</p> <p>4. Promotion of health and functional status in older adults</p>	<p>Six year history of collaboration and coalition building</p> <p>Program is ongoing</p>
<p><b>Texas Tech University Health Science Center School of Nursing</b> and the Lubbock Regional Mental Health and Mental Retardation Center</p> <p>Contact: Dr. Patricia Yoder Wise, Dean, School of Nursing</p>	<p>The School has a multi-year contract for the provision of psychiatric care for both community and in-patient treatment. The school employs over 50 nurses and assistants as well as utilization of School faculty</p>	<p>1. Major revenue stream for Faculty Practice Plan</p> <p>2. Faculty Practice</p> <p>3. Clinical education in sites for mental health and community health</p> <p>4. Course experiences for teaching collaboration and management</p>	<p>Ongoing, success has led to the development of other contracts and grants and student and faculty opportunities for research</p>

**Academic-Corporate Partnerships**

<p><b>University of Wisconsin-Milwaukee and Aurora Health Care</b></p> <p>Contact: Dr. Sharon E. Hoffman, Dean, School of Nursing</p>	<p>Students will rotate their clinical experiences within one health care system, but across the continuum of care delivery during their junior and senior years.</p>	<ol style="list-style-type: none"> <li>1. Students will experience clinical practica across entire continuum of care- community clinics to inpatient care to home health</li> <li>2. Students who choose employment in Aurora Health Care System will require less orientation time and will more likely be ready to work in more complex settings after graduation, such as ER and ICU.</li> </ol>	<p>First group of students enrolled in two-year clinical practica Fall 1998.</p>
<p><b>University of Washington School of Nursing and ERA Care, Inc.</b></p> <p>Contact: Dr. Nancy F. Woods, Dean, University of Washington School of Nursing</p>	<p>Academic-corporate partnership to design and oversee Healthcare services in retirement communities</p>	<ol style="list-style-type: none"> <li>1. Staff appointments to clinical faculty of School</li> <li>2. Sites for clinical education and conduct of research for faculty and students</li> <li>3. Creation of an Endowed Professorship in Aging</li> </ol>	<p>In effect for 8 years Satisfaction by both partners for opportunities for joint oversight and planning School satisfaction with developing policies and standards</p>
<p><b>Indiana University of Pennsylvania Department of Nursing, VNA of Indiana County, and the VNA Extended Home Care</b></p> <p>Contact: Dr. Jodell Kuzneski, Chair, Department of Nursing</p>	<p>Created to expand health promotion services, extend scope and nature of clinical sites for faculty and students, enhance health services, and extend service learning opportunities</p>	<ol style="list-style-type: none"> <li>1. Establishment of wellness clinics in four housing projects</li> <li>2. Joint practice for faculty, students, and agency personnel</li> <li>3. Family case studies for BSN students</li> <li>4. Graduate student learning in Nursing Education and Administration Tracks</li> <li>5. Faculty practice</li> </ol>	<p>Implemented in June 1997, the partnership has resulted in the funding of three collaborative grants and scholarly joint presentations</p>

<p><b>Old Dominion University School of Nursing</b>  Contact: Brenda Nichols, Dean,  School of Nursing</p>	<p>Partnered with five rural hospitals each contributed \$40,000 in cash/in-kind support for the FNP Program being offered in their community</p>	<p>Partnered with two grade schools to teach health to K-2'ers; partnered with local school for pregnant teens for education and research purposes; partnered with several local elderly centers, adult day care centers, for education and health services</p>	<p>99% of all graduates stay in the HPSA/MUA communities.</p>
<p><b>University of Pennsylvania School of Nursing</b> and the VNA of Greater Philadelphia  Contact: Susan Greenbaum</p>	<p>Created Alliances for Academic Home Care to advance knowledge of home care, improve quality and cost effectiveness of care, and to prepare the next generation of providers to manage and deliver care.</p>	<ol style="list-style-type: none"> <li>1. Faculty and staff research collaboration</li> <li>2. Clinical education for graduate and undergraduate students</li> <li>3. Development of undergraduate coursework in home health <ol style="list-style-type: none"> <li>3. Development of home health track for graduate NP students in adult and gerontology</li> </ol> </li> <li>4. Doctoral student research opportunities</li> </ol>	<p>Implemented in Summer 1997 with establishment of a joint Advisory Board. Four doctoral dissertations have been completed, a peer preceptor program established, and two joint research projects are being developed.</p>

<p><b>University of Texas-Houston School of Nursing</b> with diverse agencies.</p> <p>Contact: Dr Gwen Sherwood, Associate Dean for Community and Educational Outreach</p>	<p>Texas Children’s Hospital, to provide paid positions and independent study credit through faculty led seminars</p> <p>Institute of Religion, faculty partner with area clergy to provide education and care related to addictions</p>	<p>Students have paid positions, earn elective credit, receive tuition reimbursement, and preferential hiring</p> <p>Clinical education with addictions focus including work with drug addicted mothers</p>	<p>Implemented Fall 1997</p>
<p><b>University of Missouri-St. Louis College of Nursing</b>, and BJC Health System</p> <p>Contact: Jerry Durham, Dean, School of Nursing</p>	<p>In 1994, BJC’s Barnes College of Nursing and the School of Nursing at UM-St. Louis merged to form the Barnes College of Nursing at UM-St. Louis.</p>	<p>As a result of that merger, students enrolled in the college’s baccalaureate, master’s and doctoral programs are accorded priority for access to BJC’s area-wide health care facilities for clinical study and research.</p>	<p>An advisory committee, comprised of members appointed by BJC and the University, work closely with the Dean of the College to strengthen the relationship between the college and BJC. The Dean is now in the process of facilitating linkages between BJC’s Center for Nursing Research and the College for the purpose of facilitating research by Barnes College of Nursing students and faculty at BJC.</p>
<p><b>Saint Joseph College</b>, and Saint Francis Hospital and Medical Center (SFH)</p> <p>Contact: Esther Haloburdo Chairperson, School of Nursing</p>	<p>An agreement was made, which gives us top priority for clinical placement for our students. They have facilities across the continuum of care- clinics, long term care, acute care, and home care. SFH provides \$40,000 per academic year for four scholarships of \$10,000 each for full-time undergraduate students.</p>	<p>The school has access to SFH’s facilities. Also, lectures have been co-sponsored at the college.</p>	<p>The school is in the process of participating in an interdisciplinary grant proposal that will create practice sites for students and faculty, as well as service to the community. An implementation committee is set up to explore ongoing activities. There is also an advisory committee that meets once a semester for an update on the implementation of the agreement.</p>

<p><b>Sacred Heart University Department of Nursing</b> and home health care agencies</p> <p>Contact: Dr. Linda Strong, SHU, Department of Nursing</p>	<p>To develop an alternative to hospital-based experiences for the first clinical nursing course by partnering with Home Healthcare Agencies. Model uses a preceptor relationship and on-site supervision by faculty.</p>	<ol style="list-style-type: none"> <li>1. Access to patients with common diagnoses</li> <li>2. Opportunities to practice assessments, insert foleys, do wound care, and learn communication skills</li> <li>3. Opportunity to perform environmental assessments</li> </ol>	<p>Ongoing, evaluated positively by faculty, students, and agency staff</p>
<p><b>Holy Names College</b>, and Kaiser Permanente Health Plan</p> <p>Contact: Arlene A. Sargent, Professor and Chairperson, School of Nursing</p>	<p>Have been involved in a collaborative endeavor since 1995 to provide RN-BSN education to AND and diploma nursing graduates. This program utilizes an interactive teleconference network and currently telecasts to seven sites throughout Northern California</p>	<p>This collaboration has enabled the school to provide RN-BSN education to a significant number of nurses who indicate access and cost as critical barriers to pursuing a BSN degree. This collaborative venture has strengthened both the academic environment and the service setting. It has provided the opportunity for clinical specialists to serve as guest speakers in appropriate classes and for faculty to become more involved with staff.</p>	<p>The first group of 92 students will graduate in May 1998. Beginning in the Fall semester of 1998 this collaborative process will enable us to offer the program throughout the state of California to eleven teleconference sites.</p>
<p><b>University of Connecticut School of Nursing</b> and the VNA and Home Care Agency of Central Connecticut</p> <p>Contact: Barbara Redman, Dean, School of Nursing</p>	<p>Creation of Care Link Program to identify clients who have been discharged from regular case loads and targets them for follow-up by nursing students who develop a plan of care with their clinical instructor.</p>	<ol style="list-style-type: none"> <li>1. Graduate students develop policies and procedures, and analyze needs of populations.</li> <li>2. Clinical experiences for undergraduate education.</li> <li>3. Collaborative care planning between graduate and undergraduate students.</li> </ol>	<p>Have completed first year of implementation.</p>

**Community-Education Partnerships**

<p><b>University of Missouri-Columbia</b></p> <p>Contact: Dr. Toni Sullivan Dean, College of Nursing</p>	<p>A living/care model was developed that combines maintaining frail elders' independence at the highest possible level, privacy, and dignity while also providing high quality care coordination and services that are immediately accessible, responsive to changing needs, multidisciplinary, and affordable. The model will be in a community setting (Tiger Place) made operational by combining on-site-24-hour-a-day nursing and other health care services.</p>	<p>This model will present a desirable option for living and care arrangements for frail older adults and their families. This model, linking services to where people live, has the potential to dramatically change the way long-term care is provided in this country.</p>	
<p><b>University of Texas at Arlington, and the Comanche community</b></p> <p>Contact: Dr. Elizabeth Poster Dean, School of Nursing</p>	<p>The first step of the partnership was an in-depth community assessment to learn the different priorities and perceptions of health care assets and needs of the community. Some specific needs were identified, such as: diabetic teaching, health promotion programs for DWI offenders, training in parenting skills, and a need for lay community health workers.</p>	<p>A nearby nursing school has agreed to let their students have clinical experiences within the community. Opportunities have opened for graduate nurse practitioner students as well as the undergraduate nursing students in nearby schools of nursing to work with the rural community health promotion.</p>	<p>UTA has made arrangements for funding to prepare community volunteer health workers.</p>
<p><b>Gwynedd-Mercy College School of Nursing, Montgomery Co. Community College, Montgomery Co. Public Health Unit, and Mercy</b></p>	<p>The <i>Montco-Mercy Nursing &amp; Community Partnership</i> was established to demonstrate that a collaborative, nurse-managed</p>	<p>1.Clinical education sites for provision of physical and mental health services of domestic violence 2.Opportunities for ADN and BSN</p>	<p>1.Initiated with seed grant money in 1995 has continued to assess the health care needs of Montgomery Co. and develop three projects: Project</p>

<p>Health System</p> <p>Contact: Judith Worrell, MSN,CNS, Director, Montgomery-Mercy Nursing and Community Partnership or Dr. Mary Dressler, Dean, Gwynedd-Mercy School of Nursing</p>	<p>community-based health and wellness program could improve health in the medically underserved.</p>	<p>students to practice within a differentiated model to deliver community health services. 3.Partnerships between <i>Montco-Mercy</i> and other community agencies.</p>	<p>Heal, Project Hope, and the establishment of a Healthy Community. 2. Demonstration of cost-effectiveness, collaboration, and improved access attracts funding from a variety of local government, community agencies, and private industry.</p>
<p><b>The Catholic University of America School of Nursing</b>, and the Adventist Home Health Agency</p> <p>Contact: Sr. Mary jean Flaherty, PhD, Dean, School of Nursing</p>	<p>Faculty at the University are collaborating with the Adventist Home Health Agency to study outcomes of care in patients with congestive heart failure. Research facilitation and improvement of patient care are primary goals of this effort. This is a limited partnership-no funds are exchanged, there are no adjunct appointments, or formal contracts.</p>	<p>Currently five faculty within the school of nursing are completing the first phase of a research study. The work involves a retrospective chart audit, and the administration at the agency have provided assistance in acquiring the necessary records and data. Both parties benefit, the school benefits by having a cooperative site for doing research and one willing to involve them in their plans for improving patient care. The home health agency is getting the research and the data they have requested.</p>	<p>Ongoing</p>
<p><b>Florida Atlantic University College of Nursing</b>, Palm Beach County Health Care District, the School District, the Public Health Unit, and the Ounce of Prevention Fund</p> <p>Contact: Dr. Marilyn Parker, Associate Dean &amp; Director, FAU Community Based Nursing Project</p>	<p>Demonstration project for the integration of practice, research, education, and development grounded in the caring philosophy . The project provides faculty practice, student nursing practice courses, student and faculty research and participation in policy development on many levels.</p>	<ol style="list-style-type: none"> <li>1.Faculty Practice</li> <li>2.Clinical education</li> <li>3.Faculty and student research</li> <li>4.Faculty and student participation in health policy development</li> <li>5.Evaluation consultation</li> </ol>	<p>Begun in 1994, the project is located in 12 schools and 6 multicultural underserved communities. The project is being funded by the Palm Beach County Healthcare district, the School District of Palm Beach County, the Health Department of Palm Beach County, and the Ounce of Prevention Fund of Florida.</p>



<p><b>Northeastern University College of Nursing</b></p> <p>Contact: Dr. Eileen Zungolo, Dean</p>	<p>Establishment of the Center for Community Health, Education, Research, and Service (CCHERS) with 10 Neighborhood Health Centers, Boston Department of Health and Hospitals, and Boston University School of Medicine</p>	<ol style="list-style-type: none"> <li>1.Student assignment to site for majority of clinical education</li> <li>2.Skills in community assessment and program development</li> <li>3.Faculty practice</li> <li>4.Assimilation of faculty and students within neighborhoods</li> </ol>	<p>Implemented in 1991, the program is well established and provides consultation to other Schools. Developing additional clinical relationships as existing centers have reached capacity</p>
<p><b>Graceland College Department of Nursing, Hope House, and Mother's Refuge</b></p> <p>Contact: Susan Hildebrand, Director, Health Promotion Center</p>	<p>Partnership among the School's Center for Health Promotion and two community agencies, one serving battered women and children and the other homeless, pregnant adolescents.</p>	<ol style="list-style-type: none"> <li>1.Clinical education with adolescents during the perinatal period.</li> <li>2.Provision of health promotion and education activities</li> <li>3.Collaboration between faculty and agency personnel</li> </ol>	<p>Ongoing, has resulted in the development of collaborative grant funding to enhance services at both agencies.</p>
<p><b>James Madison University School of Nursing</b></p> <p>Contact: Dr. Vida S. Huber Dean, School of Nursing</p>	<p>Home health nursing students pair with practicing home health and hospice home care nurse preceptors from 5 agencies.</p>	<p>Students perform family focussed assessments, skills and procedures, documentation, and assist with case management activities.</p>	<p>Faculty accompany the dyads on visits and conduct case conferences with students.</p>
<p><b>Hawaii Pacific University School of Nursing, and Waikiki Health Center</b></p> <p>Contact: Dale M. Allison Associate Professor, School of Nursing</p>	<p>To provide health care to native Hawaiian uninsured clients. The clients range from infants to the elderly. Immunizations, school physical examinations, screenings for hypertension, diabetes, eye examinations, maintenance for diabetics and hypertensive clients plus acute and episodic care is provided.</p>	<p>Provides a caravan with medical supplies and equipment to set up clinics; provides medical administrative coverage needed to maintain the clinics; and provides process to collect insurance for insured patients.</p>	<p>Currently looking for funding to maintain the clinics and outcome based research. Waikiki Health Center is looking into local money to support the project.</p>

<p><b>Oregon Health Sciences University School of Nursing</b></p> <p>Contact: Julie Williams</p>	<p>Provide population-based needs assessments and evaluations of effectiveness of services for health agencies where APNs employed.</p>	<p>As part of master's program, 20 week course meets dual goals of providing service to community partners and provides training for graduate students in the conduct of research.</p>	
<p><b>Binghamton University Decker School of Nursing</b>, and the Family Support and Community Education for Alzheimer's Disease Program</p> <p>Contact: Joyce Ferrario</p>	<p>To develop and maintain a diagnostic and case management service for patients and families with Alzheimer's disease or other age related dementias.</p>	<p>The project has led to a close relationship between, the Alzheimer's Disease Assistance Center, the Decker School of Nursing and the Alzheimer's Association. Each year several hundred individuals within the community receive education related to dementia. Examples of the groups served are home care aides, police officers, family caregivers, nurses, social workers, and recreation therapists. Each summer a major conference is presented through the project.</p>	<p>Ongoing; seeking additional collaborative partners in the community.</p> <p>The Alzheimer's Disease Assistance Center has been continuously funded since 1988. School of Nursing personnel serve as clinical staff and it is a learning site for graduate students who practice with faculty.</p>
<p><b>Graceland College</b>, Hope House, and Mother's Refuge</p> <p>Contact: Susan Hildebrand Director, Health Promotion Center</p>	<p>Hope House is a shelter for battered women and children. The college engaged in a cooperative endeavor to support students and provide resources for the shelter. A grant writing project was undertaken when we began having students at the site for clinical experiences.</p> <p>Mother's Refuge is a shelter for homeless pregnant adolescents. The partnership involves working with adolescents during pregnancy, delivery, and post-partum stays at the</p>	<p>Educational materials were provided for the students to do programs at the shelter and supplies to conduct health screening for the children at the shelter's day care.</p> <p>A collaborative endeavor resulted in a grant being funded to support the purchase of educational materials for Mother's Refuge and for our students to use during the monthly educational</p>	

	shelter. Students were paired with adolescents from the shelter and were responsible for engaging the shelter adolescent in therapeutic encounters on a weekly basis.	programs we offer at the shelter. This grant was supported because of the collaborative nature of the project.	
<p><b>Neumann College</b>, and the Chester Health Advocacy Association</p> <p>Contact: Jill Derstine Chair of Nursing and Health Sciences</p>	The Advocacy Association offers health promotion, health education and screening to senior citizens in an underserved area. Home visits are made to very frail clients and others who can not make it to the center.	Over 160 clients have been enrolled in the project.	The Director of Health Promotion supervises the students during their experience at Hope House.
<p><b>Seton Hall University</b> Contact: Linda Strong</p>	A partnership was set up with a non-profit traditional visiting nurse agency and a proprietary home care agency. This partnership was started because of the high acuity nursing needs of hospitalized patients. The foci of the clinical include development and practice of fundamental skills, fundamental assessments, care planning, and beginning teaching and learning. In response to the high acuity care needs and complexity of hospitalized clients we discussed adjunctive/complementary sites through which students could rotate.	Students have on the average seen at least 5 patients per day per week, the students have had a rich experience. Most students administer his/her first injections, perform skilled wound dressings, insert foleys, assess lung sounds/peripheral edema/cardiac status/neuro status in this clinical relation. The staff also develops precepting and teaching skills, and reach a level of collegiality with university faculty.	There is a good working relationship with the staff and the two agencies. This design capitalizes on the best features of a mentoring relationship as it nurtures new students and provides them with the personal one-on-one attention that establishes productive and successful learning patterns.

**Nurse-Managed Clinics**

<p><b>Mount Mercy College Department of Nursing</b>, and Mercy Medical Center with local parochial school, Cedar Rapids, Iowa Contact: Dr. Mary Tarbox, Chair, Department of Nursing</p>	<p>Developed to enhance student pediatric clinical education and hospital outreach, Nursing and the Medical Center jointly provide salary support for a PNP to supervise students in a grammar school. The PNP is both a faculty member and a hospital employee.</p>	<ol style="list-style-type: none"> <li>1. Creation of a Health Promotion Center as the major pediatric experience for students.</li> <li>2. Decreased reliance on inpatient units.</li> <li>3. Parental and school satisfaction with services.</li> </ol>	<p>Implemented in Fall 1995, the Center has been so successful, that a new venture with a regional high school is planned with salary support also. Provided by the high school for an additional center. This center will provide clinical education with the adolescent population.</p>
<p><b>Indiana University School of Nursing</b> Contact: Dr. Angela Barron McBride, Dean</p>	<p>Faculty throughout the state system have developed clinics in partnership with communities. An example is the Shalom Wellness Center which received funding from the Indiana Department of Health, the RWJ and local foundations.</p>	<ol style="list-style-type: none"> <li>1. Faculty practice</li> <li>2. Student clinical education</li> <li>3. Primary healthcare services to the poor and homeless.</li> </ol>	<p>Ongoing. The center is projected to serve 4,500 people in 1998  Nationally recognized with a Premier Care Cash award</p>
<p><b>University of Utah College of Nursing</b> and the University Hospitals and Clinics  Contact: Dr. Sue Huether, College of Nursing</p>	<p>Establishment of a Rural Nurse Managed Primary Care Clinic to serve residents who are below poverty level  Birthcare Healthcare and Birthing Center that includes CNMs, NP, PMHMs, and MDs</p>	<ol style="list-style-type: none"> <li>1. Primary healthcare education for Nursing, Pharmacy, and Social Work</li> <li>2. Primary and emergency care to community residents</li> </ol> <ol style="list-style-type: none"> <li>1. Clinical education in primary and perinatal care for nursing and medical students</li> <li>2. Research opportunities</li> <li>3. Affordable primary and perinatal services for clients</li> </ol>	<p>Established in 1994, has become successful models for interdisciplinary clinical education and research. Provides clinical rotations for over 430 students/year.</p>
<p><b>University of Central Florida</b> and Orange Co. Board of Education, City of Orlando, Orange Co. PH Unit, Central FL Family Health Center, Cocoa Housing Authority, and</p>	<p>Creation of 7 community nursing centers in communities in Central FL. Centers provide health promotion, screening, immunizations, health teaching, and other activities as</p>	<ol style="list-style-type: none"> <li>1. UG clinical sites</li> <li>2. G NP education for population-based projects</li> <li>3. Sites for joint generic and RN-BSN education in the community</li> </ol>	<p>Implemented Fall 1997 with in-kind support from partners (space, telephone, and at one site a healthcare provider.) A grant was obtained to initiate an additional site.</p>

<p>Columbia park Medical Center.</p> <p>Contact: Dr. Errnalyann Kiehl, CNC Coordinator</p>	<p>identified by community residents.</p>	<ol style="list-style-type: none"> <li>1. Provision of services to underserved areas</li> <li>2. Clinical practice for NP faculty</li> </ol>	
<p><b>Wayne State University College of Nursing</b> and Wayne State Public School</p> <p>Contact: Federricka Shea, College of Nursing</p>	<p>Initiation of a Teen Health Center at the University Middle School that provides a PNP prepared faculty member onsite</p>	<ol style="list-style-type: none"> <li>1. Clinical education site for PNP students</li> <li>2. Clinical site for undergraduate students</li> <li>3. Opportunities for research and special projects</li> </ol>	<p>Begun in 1994, the teen center has provided opportunities to receive funding for research, participation in interdisciplinary education, and a forum to influence policy re school health services.</p>
<p><b>Boston College School of Nursing</b> and Harvard Vanguard Medical Associates</p> <p>Contact: Rita Olivieri, College of Nursing</p>	<p>Collaboration between a Managed Care Health Plan and the College for senior undergraduate clinical placements in the Plan's Community based health centers.</p>	<ol style="list-style-type: none"> <li>1. Precepted senior student clinical education in managed care environment</li> </ol>	<p>Implemented Fall 1996, will be expanded to include additional Vanguard community health centers Positively evaluated by students and preceptors</p>
<p><b>University of Florida College of Nursing</b>, College of Medicine Division of Infectious Diseases, and the North Central Florida Health Planning Council</p> <p>Contact: Dr. Dee Williams, Executive Associate Dean, College of Nursing</p>	<p>Creation of two partnerships to deliver services to HIV+ clients, one at the Health Science Center and the VAMC, and the other in a rural area.</p>	<ol style="list-style-type: none"> <li>1. Faculty Practice for Certified ID Specialists</li> <li>2. Clinical education for NP students in final semester</li> <li>3. Provision of comprehensive care to HIV+ patients</li> </ol>	<p>Ongoing, rural clinic received external funding</p>

<p><b><u>Alliances within Academic Health Centers</u></b></p>			
<p><b>University of Delaware College of Health and Nursing Sciences</b></p> <p>Contact: Dr. Betty J. Paulanka, Dean</p>	<p>The school has critical care and perioperative partnerships with a major medical center. In both cases an elective nursing course is offered, which is co-taught with faculty and staff from the medical center at no cost to the department.</p>	<p>In the critical care scenario the best students are offered an honors clinical rotation in the last semester of their senior year. For the past eight years, the medical center has offered all students in this rotation a job upon graduation.</p> <p>In the perioperative elective is slightly different in that it has an optional one-credit clinical experience associated with the course.</p>	<p>Both of these course experiences were negotiated between the department chair and the specialty unit at the medical center. Recently the school is negotiating a similar arrangement with the Visiting Nurses Association, school nurses and occupational health nurses in local corporations. Next year the school will be offering a “legislative fellow” option for students interested in health policy.</p>
<p><b>South Dakota State University College of Nursing</b> and the South Dakota School of Mines and Technology</p> <p>Contact: Dr. Roberta Olson, College of Nursing</p>	<p>The School of Mines contracted with the College of Nursing to manage student health services. Services include immunizations, illness care, athletic physicals, and peer education.</p>	<ol style="list-style-type: none"> <li>1. Graduate NP clinical education</li> <li>2. Clinical site for undergraduate teaching projects</li> </ol>	<p>Contract began Fall 1997</p> <p>Negotiations are underway to develop contracts with two additional universities.</p>
<p><b>University of California at Los Angeles School of Nursing</b> and the UCLA Medical Center for Faculty Practitioners</p> <p>Contact: Dr. Marie Cowan, Dean</p>	<p>Placement of faculty nurse practitioners and CNMs in the following services: occupational health, cardiac-thoracic surgery, and ob/gyn</p>	<ol style="list-style-type: none"> <li>1. Clinical education for graduate students</li> <li>2. Faculty practice</li> <li>3. Participation in multidisciplinary care</li> <li>4. Collaboration with other providers</li> <li>5. Research facilitation for School of Nursing</li> </ol>	<p>Scheduled for implementation 1998-1999 Budget Year</p>

<p><b>Rush University College of Nursing</b>, Rush Primary Care Institute, and Rush Presbyterian Saint Luke's Medical Center</p> <p>Contact: Dr. Linda Hollinger-Smith, Director Rush Primary Care Institute</p>	<p>Rush Homan Health Care Center was developed by partners to provide a safe, stable environment for community residents to receive primary healthcare services. Services include a primary care center, a school-based program, and family education and counseling.</p>	<ol style="list-style-type: none"> <li>1. Clinical preceptorships for students</li> <li>2. Interdisciplinary training and education</li> <li>3. Clinical placements in the school-based program</li> <li>4. Faculty practice</li> </ol>	<p>Implemented Spring 1996. Initiation of services requested by Community Advisory Board and high degree of patient satisfaction with services</p>
<p><b>Wichita State University School of Nursing</b>, and Wichita Area Nursing Network</p> <p>Contact: Dr. Donna Hawley, Director, School of Nursing</p>	<p>To increase the communication between nursing education and clinical agencies and to explore opportunities for joint projects</p>		<p>The current network consists of the Chief Nursing Officer from each of the four local medical centers/hospitals and a nearby community hospital, and the deans and program directors from nine nursing programs: One LPN, four associate degree, and four BSN programs. The group is four months old, and we will be adding representatives from community agencies next month.</p>
<p><b>UNC at Chapel Hill</b> and Dept. of Nursing at UNC Hospitals</p> <p>Contact: Judy Miller, RN, PhD, School of Nursing, UNC at Chapel Hill</p>	<p>Clinical Partnership Program (CPP) is a joint nursing service and education project to develop course content, use clinicians as guest lecturers, joint collaboration on research, and implementation of the clinical preceptor model for senior students.</p>	<p>92% of senior class participates, 90% of clinical preceptors have asked to continue in project, divisions between nursing service and education have blurred. Positive working relationships, reciprocal participation on education and service committees. Increased research that is a priority to nursing unit.</p>	<p>In fourth year of implementation</p>

<p><b>College Misericordia</b>, and Mercy Health Partners</p> <p>Contact: Dr. Helen Streubert, Dean, College of Nursing</p>	<p>The agreement provides for a nurse practitioner whose specialty is children to work in one of Mercy's Hospitals for five hours a week as a consultant. In the role of Consultant, she also acts as a preceptor/faculty member and precepts two graduate students in the advanced practice tract/women and children.</p>		<p>In the fall 1998 the school is planning to continue the arrangement by utilizing another faculty member whose specialty is women to focus on service needs.</p>
<p><b>University of Iowa College of Nursing</b> and University of Iowa Hospitals and clinics</p> <p>Contact: Melanie Dreher, Dean, UI College of Nursing or Judith Ryan, Associate Director, UIHC for Nursing and Patient Care Services.</p>	<p>These two entities have committed to a joint partnership, The University Iowa Nursing Enterprise. The UINE is an integral component of the University of Iowa Clinical enterprise between health science colleges and the U. of Iowa Hospitals and Clinics. Dean and Director have adjunct appointments as Senior Associates to the other entity.</p>	<p>The aim is to manage the delivery of a continuum of clinical nursing services, dissemination of nursing research, and provision of education for future leadership in nursing practice. Result has been a growing understanding of the importance of the nursing profession speaking with one voice at the University of Iowa and a realization of the vast resource available when efforts are joined.</p>	
<p><b>University of Virginia School of Nursing</b> and University of VA Medical Center</p> <p>Contact: Jeannette Lancaster, Dean, U. VA School of Nursing</p>	<p>Nursing Operations Group, leaders from the School of Nursing and U. Va Medical Center collaborate on joint programming and opportunities.</p>	<p>The Group has sponsored a number of initiatives including a mentored RN program, summer practicum for rising 4<sup>th</sup> year students, creation of a chronic care center, position statement for NP utilization, proposal for joint researcher position.</p>	<p>Has met monthly since November 1996</p>



<b><u>Contracts with Managed Care Companies</u></b>			
<b>University of California at San Francisco, and Kaiser Permanente</b>  Contact: Dr. Jane Norbeck, Dean, UCSF School of Nursing	Assist UCSF maintain high enrollment in APN courses, and enable Kaiser to meet demand for APN providers	Expanded opportunities for placement of APN students in managed care sites.	Scheduled for implementation 1998
<b><u>Nursing Research Center</u></b>			
<b>Duquesne University School of Nursing and Allegheny General Hospital</b>  Contact: Dr. Mary deChesney, Dean, School of Nursing	Development of a collaborative Nursing Research Center to provide partners with access to services for conducting and disseminating research.	<ol style="list-style-type: none"> <li>1. Research funding obtained for all full-time faculty</li> <li>2. Appointment of faculty to key hospital committees</li> <li>3. Staff involvement in graduate level research courses</li> <li>4. Access to on-going research projects for masters and doctoral students</li> </ol>	Collaborative partnership was implemented in 1993. A director is in place, an advisory board appointed, and several collaborative projects are underway. A number of services are available including data management, literature searches, and statistical consultation.
<b>University of California at San Francisco and Stanford Health Care</b>  Contact: Dr. Jane Norbeck, Dean, UCSF, School of Nursing	Creation of a nursing Center for Research and Innovation in Patient Care	<ol style="list-style-type: none"> <li>1. Develop and test methods of care delivery and collaborative models of integrated care.</li> <li>2. Access for students and faculty for clinical learning, practice, and research</li> <li>3. Access to institution staff to audit UCSF courses.</li> </ol>	Scheduled for implementation in 1999