AACN-AONE TASK FORCE ON ACADEMIC-PRACTICE PARTNERSHIPS

Summary of Academic-Practice Partnerships Focus Group Results

Members of the AACN Task Force on Academic-Practice Partnerships conducted 8 focus groups with volunteers from key constituencies over a 3-month period in winter 2011. Focus group discussions did not differ dramatically by group, but emphasis within categories differed. Results are summarized below. Focus group participants came from the following organizations:

- AACN doctoral granting institutions-private
- AACN doctoral granting institutions-public
- AACN private institutions
- AACN public institutions
- American Organization of Nurse Executives (AONE)
- Association of State and Territorial Directors of Nursing (ASTDN)
- Long-Term Care Nurse Executives
- National Organization of Nurse Practitioner Faculties (NONPF)

I. Current Practices

Respondents talked about their current effective partnerships as including **shared resources** such as paid faculty time, tuition reimbursement for cohorts of students, simulation equipment, and dedicated education units (DEUs). Grant funding was often sought for collaborative projects. Effective partnerships were able to demonstrate **outcomes** for both partners and to demonstrate **mutual benefit**, such as increase staff education/knowledge, joint appointments, tuition reduction, achievement of Magnet Status and/or school accreditation, publications, and student clinical placements across levels. **Successful partnerships** addressed mutual needs; were often intradisciplinary; were formal with mutual goals; had regular, clear communication between partners; and involved dedicated, committed staff and faculty. Examples of such partnerships included: Consortium of clinicians and educators in a region; clinician faculty academy; preceptor academy; staff nurse buddies; Accelerated BS to PhD and post-doctoral programs; partner for DNP, BSN, and MSN programs; endowed professorship for research at hospital; faculty practice partnerships; research institute co-chaired by dean and CNO; partnerships with free clinics; school based health center with nutrition support; interschool collaboration; and exchange of staff nurse-teaching role.

II. Barriers

Participants identified barriers to forming successful partnerships. Key among these barriers was **lack of resources/finances**, including a lack of faculty; new trends to pay preceptors; lack of
hospital reimbursement; student observation time expensive for clinical staff; state funding cuts for education and health care; lack of financial support from universities; and increased faculty workloads. Other barriers included **Structural Barriers**, such as lack of leadership at the top; lack of ongoing commitment; cultural barriers; academic schedule not a fit with clinical schedules; faculty with lack of appropriate background for clinical sites leading to “dumbing down” of student experiences; lack of instructor on-site with students; lack of acceptance of CNL role in some clinical settings; no outcome data to support partnership; quality indicators not well understood by faculty; and lack of standard curriculum with structured student activities. Additional barriers included lack of time to create and develop **relationships**; and lack of consistent, clear communication. Respondents also identified **competition** as a barrier, as physician sites were sometimes reluctant to work with APRN students; PA programs competed for space with APRN programs; and sites collaborated with non-traditional degree programs.

###III. Dream/Model Partnerships

Respondents eagerly discussed their vision for dream or model partnerships. Such partnerships would be **structured for sustainability and success**, including: committed, sustainable faculty and staff, with direction from the top but delegated to the most appropriate people; joint goals based on mutual needs and mutual trust and communication; joint practice arrangements; regular meetings and sharing; match student learning needs to clinical site needs whenever possible; partners should sit on each other’s boards and committees; joint appointments where possible; student feedback shared for mutual learning; and preceptors recognized and rewarded for their work. These dream partnerships would have **mutually beneficial outcomes**, including: increase level of practice by hiring graduates; clinical sites increase evidence-based practice (EBP); independent practice at full scope; joint research; documented improvement in quality patient care; documentation that students are prepared for the work environment; staff nurses and preceptors get access to what students are exposed to, up to date info on variety of topics; staff link to library system and access to grant writers; summits with academic and practice in attendance to strategize; practice gets to give input into the curriculum; staff development on research, how to read, how to publish and partners would engage in work of CEGAN. To **develop these dream partnerships requires**: Administrators who are risk taking, willing to assume liability; faculty connections with state, local entities and service sites; coordinator who is adept at finding additional funding/grants; college philosophy that values practice and faculty service, and release time for practice; coordinator who handles details and contracts, knows rules and regulations; synergy of timing, right people in right places; liability insurance coverage; faculty promotion track that values practice; and a philosophy of service as integral to the schools of nursing’s goals.
IV. Recommendations

Respondents had a number of recommendations for developing of academic practice partnerships, including: need to restructure organizations to develop articulation agreements and MOUs for the partnerships; look at shared governance; become familiar with each other’s core outcome measures; understand financial impact of decisions on both sides; look at medical school models; and joint meetings with deans, administrators, health department leaders for strategic planning; and structure ongoing collaboration between staff and faculty. Additional recommendations included the need to think outside the box; look at opportunities to bring impaired nurses back into practice; provide refresher courses and CE for staff and; look for new ways to become embedded in clinical sites; and assist staff with EBP understanding.