American Association of Colleges of Nursing
The Voice of Academic Nursing

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The AACN/AONL Academic–Practice Partnership Playbook:

From Shared Vision to Action

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From Shared Vision to Action

A guide for leaders to create academic-practice partnerships that expand nursing school capacity, improve the practice readiness of new nurses, and build a sustainable nursing workforce.

DEVELOPED BY THE AACN/AONL ACADEMIC-PRACTICE ADVISORY COMMITTEE AND NURSING EXPERTS ACROSS THE NATION

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Introduction

How to Use This Playbook

This playbook is intended as a conceptual guide for leaders in nursing education and practice who are working to build or strengthen academic–practice partnerships. It is written for chief nursing executives, nursing school deans, and leaders who must explain the value of partnerships to boards, executive teams, and university administrators while designing and implementing productive collaborations that can be sustained over time.

The forthcoming chapters describe a range of replicable partnership models that readers can emulate and tailor to their individual needs. Each case example outlines the challenges the partners set out to solve, the resources committed, and the results achieved. By comparing these accounts, readers can see how different organizations approached similar challenges and can use those lessons to guide their own efforts. While many successful partnerships reflect the unique contexts of their communities, the intent of this playbook is to highlight adaptable frameworks that can serve as models that address immediate needs while also offering transferable lessons for other regions and institutions.

Every chapter follows a consistent format that includes: illustrative partnership models with detailed financial structures and outcomes; field-tested implementation strategies and best practices; lessons learned from real-world applications; and resource rich appendices. This playbook also looks ahead, recognizing that partnerships must prepare students for emerging models of care, including community-based practice, virtual care, and other settings beyond the traditional acute care settings.

The following assumptions establish context for interpreting the forthcoming chapters: The Bachelor of Science in Nursing (BSN) and the direct-entry master's is the entry to professional practice; registered nurses (RNs) should be prepared to work to the full scope of their licenses and serve as conveners with other professionals; partnerships are prerequisites—not optional add-ons—for sustainability; and nursing education must be competency-based, technologically capable, and reflective of the populations served. These premises clarify the lens through which the playbook was developed and should be read. They also underscore the need for education that prepares nurses to manage increasingly complex patient needs amid workforce shortages and collaborate across teams to deliver safe, effective care.

In addition to the featured models and frameworks, the appendices include templates to help leaders plan, implement, and evaluate academic–practice partnerships. These resources, adaptable to various settings, include sample Memoranda of Understanding, financial pro formas, formal role descriptions, and outcome-tracking worksheets, as well as a step-by-step planning tool for choosing a partner, clarifying shared goals, planning timelines, identifying space, funding, and regulatory considerations, and organizational contexts.

The appendices also include a Mission Support Agreement, which provides a formal contract framework, outlining payment structures, compliance requirements, reporting expectations, and terms for amendments or termination. These are just some of the tools included, which leaders can adapt for both partnership planning and formalization.

Executive Summary

Academic and practice leaders share responsibility for preparing a qualified nursing workforce, yet both face mounting pressures that constrain their ability to do so. As the nation grapples with a growing shortage of nurses, the U.S. Bureau of Labor Statistics projects the need for an additional 189,000 new RNs each year through 2034 to meet workforce demand. Schools of nursing turned away more than 80,000 qualified applications in 2024 due to an insufficient supply of faculty, classroom space, and clinical placements (American Association of Colleges of Nursing, 2025). At the same time, hospitals and health systems continue to struggle with high turnover among new nurses (NSI Nursing Solutions, Inc., 2024), while many graduates report feeling unprepared for practice (Wolters Kluwer, 2020).

These pressures expose the limitations of current prelicensure clinical education models, which are impacted by both the availability of clinical placement sites and shortages of experienced faculty. As a

result, many graduates enter the workforce with low perceived readiness (Sterner et al., 2023). Perceived readiness is foundational to confidence, and when new nurses feel underprepared, they struggle to apply classroom learning at the bedside—undermining both their professional development and patient safety (Masso et al., 2022; Herron, 2018).

Shared Vision and Playbook Overview

Recognizing the interdependence of these challenges, the American Association of Colleges of Nursing (AACN) and the American Organization for Nursing Leadership (AONL) convened an Afternoon of Dialogue in 2023 to explore opportunities for shared solutions with members from both organizations. Participants described interconnected difficulties: constrained faculty pipelines, heavy workloads, and insufficient clinical placements—as well as high turnover, burnout among preceptors, and curricula that do not always align with the realities of care. Across both groups, core values such as respecting all perspectives and providing care for all, leadership development, and rapid technological change emerged as cross-cutting concerns.

Attendees agreed that while the pressures on academia and practice differ, both sectors share common goals, as they seek to prepare competent nurses, sustain the workforce, and secure resources to support educational capacity and professional development. Participants also recognized that there is no one-size-fits-all solution to these challenges and emphasized that progress will depend on working together, leveraging their combined strengths.

The dialogue was guided by the Shared Vision for Integrating Nursing Education and Practice (see Figure 1, page 8), designed to serve as a unifying framework. Its five domains—transforming healthcare through human-centered care; moving to competency-based nursing education; sustaining the supply of highly educated nurses; leading innovation; and advancing nursing science—form the chapters of this playbook.

Documented Impact of Partnerships

Academic–practice partnerships have demonstrated success in preparing nursing students for specific practice environments, reducing onboarding time, and strengthening readiness for practice (Hoffmann & Kaeberle, 2024). Strong academic-practice partnerships are needed to co-design clinical education that is relevant and reciprocal, ensuring that graduates are prepared to practice throughout the healthcare system while solidifying nursing's influence on efficient and effective care delivery models (AACN, 2019).

Practice organizations benefit financially as well, retaining more new hires and reducing reliance on contract labor or prolonged training (AONL, 2023).

Figure 1 Shared Vision for Integrating Nursing Education and Practice, AACN/AONL 2019

This playbook provides evidence of these benefits. Its models illustrate how academic and practice leaders design learning environments directly connected to workforce needs, helping graduates adapt quickly and contribute meaningfully, lessening the extended orientation periods that strain both new hires and employers.

Examples throughout the playbook demonstrate how these partnerships generate measurable returns for schools and practice organizations. In one large health system, a theory-guided framework for clinical inquiry reduced nurse turnover by more than 50% in a single year, yielding nearly $44 million in projected savings from retention and reduced agency staffing (Gorsuch & Boss, 2024). Other cases highlight how shared teaching roles enhance graduates' readiness while keeping faculty workloads sustainable; how revenue- or tuition-supported faculty positions expand teaching capacity without drawing on base budgets; and how coordinated clinical placements give learners consistent experiences aligned with both their stage of training and unit needs, supporting a faster transition to independent practice.

In this playbook, readers will see both the business and professional case for academic–practice collaboration: partnerships better prepare graduates, help practice organizations retain staff, reduce costly turnover, and enable schools of nursing to expand student enrollment by adding teaching roles and clinical placements. Together, these efforts build a more stable workforce.

Supplementary Resources and Appendices

Additional foundational materials can be found under "Appendices: Introduction" at the end of this Playbook. This section includes the following resources that complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix A: Academic–Practice Partnerships Implementation Toolkit**
  This resource guides partners in defining mutual expectations, desired outcomes, and evaluation methods across each stage of partnership development.
- **Appendix B: Sample Academic-Practice Partnerships Implementation Tool Kit Template**
  This template outlines each step in developing a partnership.
- **Appendix C: Partnership Expectation and Outcome Metrics Worksheet Sample**
  This sample metrics table shows how to measure progress and impact using shared indicators.
- **Appendix D: Guiding Principles for Academic–Practice Partnerships**
  This foundational document, jointly developed by AACN and AONL, outlining the essential elements and shared values that underpin all effective partnerships.
- **Appendix E: Mission and Support Agreement: Mentor and Grant Development**
  This sample memorandum of understanding defines roles, funding structures, and expectations for partnership-based faculty or grant initiatives.

Chapter 1

Transforming Healthcare through Human-Centered Care

Human-centered care broadens patient-centered models by valuing the full humanity of both patients and practitioners in the integration of three dimensions:

1. Individual identity and personhood
2. Social context and community positioning
3. Lived experiences that shape health outcomes

In other words, when delivering care from a human-centered lens, nurses consider patients' clinical needs and broader life circumstances (Bradley & Falk-Rafael, 2011).

In practice, human-centered care is not limited to patient interactions. It also influences how leaders design systems and environments. For example, a truly human-centered electronic health record (EHR) system reflects the workflows and decision-making patterns of nurses, rather than forcing nurses to conform to technology. Likewise, in leadership, human-centeredness means supporting the growth, goals, and well-being of the workforce in alignment with organizational needs.

Human-centered leaders also recognize that people receiving care are more than patients; they are caregivers, workers, immigrants, and community members with intersecting identities. Similarly,

clinicians and other providers lead full lives beyond the clinical setting. Academic-practice partnerships can make care more human-centered by integrating clinical practice, education, and community engagement across diverse care delivery environments, allowing these multiple identities and contexts to shape how providers deliver compassionate, context-responsive care.

Operationalizing Human-Centered Care in Academic-Practice Partnerships

Academic-practice partnerships can incorporate human-centered care by collaborating with community-based organizations (CBOs).

Each partner brings distinct strengths: Academic institutions contribute training and educational resources; CBOs offer insight into community needs and access to populations; and clinical partners deliver care. While not all human-centered care requires a three-way partnership, including a CBO often grounds the partnership in the needs of the community and strengthens outcomes.

These partnerships align closely with the American Nurses Association's Code of Ethics for Nurses, reflecting the profession's commitment to human dignity, social justice, and the full recognition of each person's unique identity.

Human-Centered Leadership Roles in Action

Kennedy, Leclerc, and Campis (2022) describe how human-centered leaders may act as Awakeners, Connectors, and Upholders—three roles that reflect different but complementary ways of advancing dignity and equity across academic-practice partnerships.

For example:

- Awakeners encourage workforce development through service and individualized growth paths.
- Connectors build bridges between systems and communities, especially in areas of inequity and environmental health.
- Upholders design systems that support both educational advancement and better health outcomes (Leclerc & Pabico, 2023).

These roles are not fixed. Leaders often shift between them depending on the needs of their organizations, teams, or communities. The real-world examples in the following sections demonstrate how these roles improve collaboration, learning, retention, and outcomes across settings.

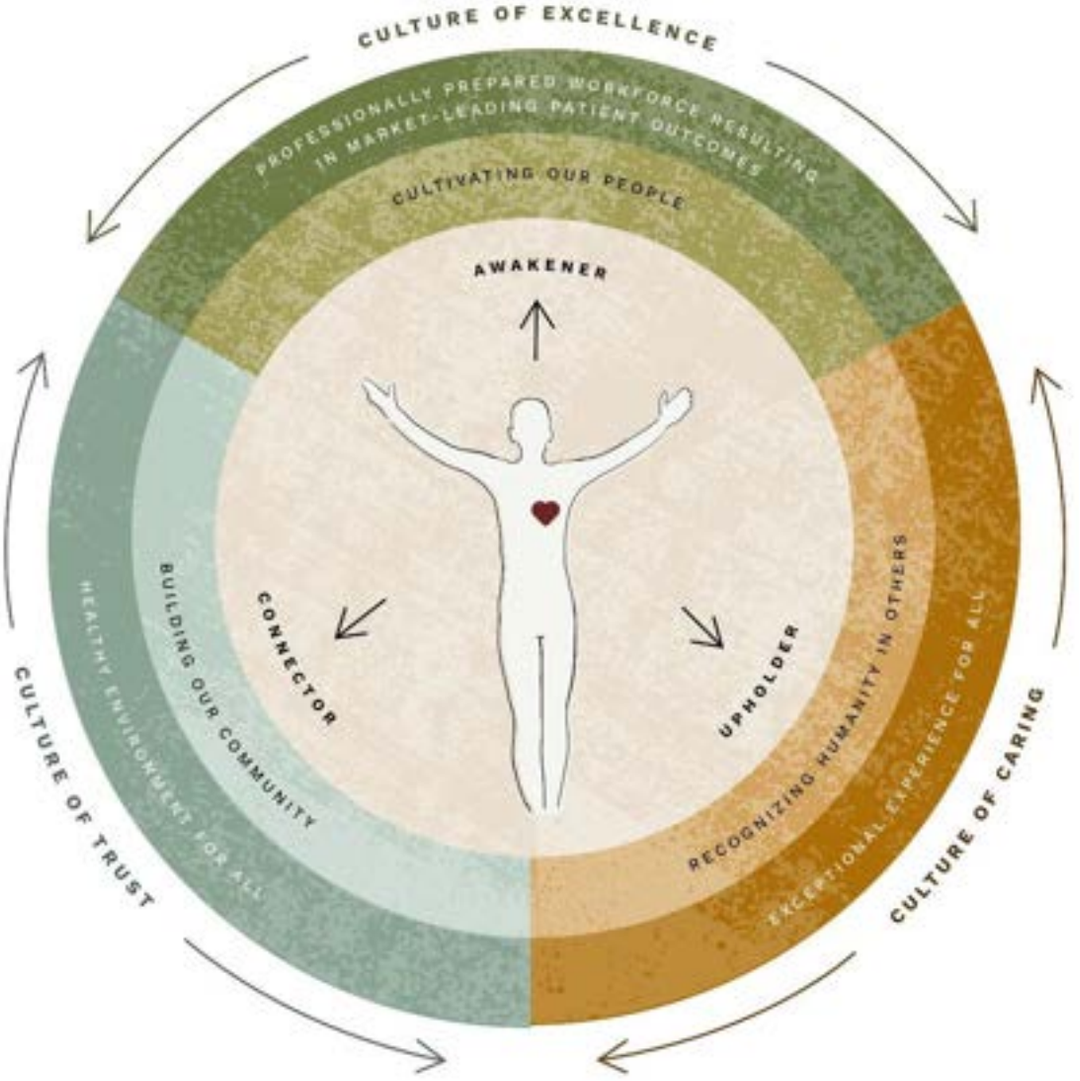

Figure 2 Human-Centered Leadership in Healthcare: The visual framework starts with the leader's mind, body, and spirit as the locus of influence within local and larger complex systems. The Human-Centered Leader realizes success in connecting leadership dimensions of self, Awakener, Connector, and Upholder to cultures of well-being, excellence, trust, and caring. (Reprinted with permission from Leclerc, Kennedy, & Campis, 2021).

Awakeners: Supporting Growth and Development

In the human-centered leadership model, awakeners are individuals who recognize potential in others and create the conditions for that potential to be realized. They take deliberate steps to build environments where individuals can develop professionally. The following example illustrates how academic-practice

partner leaders embodied these characteristics to strengthen workforce development through a sustainable, service-based education model.

Case Model 1: Regional Academic-Practice Partnership in a Southwestern Urban Trauma Center

Note: As of September 2025, leaders are proposing this Dedicated Education Unit (DEU); the University of Nevada, Reno (UNR)–Renown academic–practice partnership and a smaller, formalized undergraduate pipeline to Renown are active, but this DEU configuration is in the idea phase.

Leaders at Northern Nevada Sierra Medical Center and University Medical Center of Southern Nevada demonstrated Awakener attributes by creating formal growth pathways for bedside nurses and investing in their professional development. In response to high practice turnover, faculty shortages, and low perceived readiness among graduates, partners proposed the development of a DEU that positioned experienced bedside nurses as clinical instructors with formal roles and support.

The Model (idea phase): Leaders at the Orvis School of Nursing at the University of Nevada, Reno (UNR) and Renown Health are proposing a DEU informed by their ongoing collaboration. Leaders would jointly appoint four clinical instructors and place them in the hospital's 35-bed inpatient medical-telemetry unit. Each instructor would work two 12-hour shifts per week and would supervise two learners per shift. A university-based clinical coordinator would retain "faculty of record" responsibilities and would continuously mentor the clinical instructors.

Financial Structure: The university and hospital would jointly fund the clinical instructors' salaries through a professional services agreement. The university would pay for 24 hours of instructional time per week, while the hospital would cover the remaining 16 hours, including four hours of protected time for learner documentation. Clinical instructors would receive a 10% pay differential for teaching shifts and would be offered priority admission and tuition support for Master of Science in Nursing (MSN) and Doctor of Nursing Practice (DNP) programs. Leaders would integrate adult-gerontology acute care nurse practitioner students, medical residents, and respiratory therapists in interprofessional rounds. Partners anticipate routing billing revenue from advanced practice services back to the university to help sustain faculty practice buyouts.

Note: See an example table with expenses and planning assumptions in Appendix G: Proforma-Dedicated Education Unit (DEU).

Expected Outcomes: Leaders expect improvements in learner confidence and clinical readiness and aim to engage staff more fully. They anticipate increased enrollment in previously underfilled graduate tracks and plan to reduce traditional faculty workload. In particular, they intend to:

- replace the traditional 1:8 faculty–learner ratio by reallocating workload across the college;
- expand flexibility in faculty teaching assignments; and
- remove the burdensome in-person clinical teaching requirement, supporting faculty well-being and work–life balance.

Implementation Considerations from Planning and the Existing Pipeline:

- Academic and practice leaders identified in planning that they will need to define clinical instructor roles clearly, establish shared funding agreements, and invest in onboarding and mentorship to support clinical instructors.
- Partners anticipate significant upfront investment and coordination. They expect improvements in nurse retention and reductions in faculty workload to help justify those costs.
- Leaders plan to embed professional development in daily clinical operations, rather than rely on occasional training, so they can build a more sustainable approach to long-term workforce development.
- Leaders plan for learners to learn alongside the same nurse educators each shift. They expect this consistent structure to build belonging and familiarity and to make it easier for learners to ask questions.
- Leaders plan to restructure faculty workload so instructors can focus on coaching and oversight rather than managing multiple units, which should help them provide timely, meaningful support.

Leadership Reflection: Are You Acting as an Awakener?

- Have you identified untapped talent among your staff or learners?
- Are development pathways clearly defined and supported financially?
- Have you structured roles that embed teaching or mentoring into daily practice?
- What would it take to shift from episodic to embedded professional development?

Connectors: Building Bridges Across Systems and Communities

In the human-centered leadership model, Connectors unify people across boundaries—linking individuals, teams, and organizations to advance shared goals. In academic-practice partnerships, Connectors bridge gaps between sectors, especially in areas of health inequity, social vulnerability, or cultural disconnect. The following example illustrates how leaders acted as Connectors by aligning clinical, academic, and community efforts to reach an underserved population (Kennedy, Leclerc, & Campis, 2020).

Case Model 2: Academic-Practice Federally Qualified Health Center Partnership for Migrant Farmworker Health

The Nell Hodgson Woodruff School of Nursing (NHWSON) and the Rollins School of Public Health at Emory University partner with the Farmworker Association of Florida (FWAF), based in Apopka, and collaborators such as the University of Florida Levin College of Law to deliver a community-engaged, nurse-led model that addresses heat stress and kidney injury risk among agricultural workers. Faculty and partners provide worker-centered health education at farms and FWAF sites, conduct field monitoring of heat strain, and collect pre- and post-shift biospecimens to evaluate acute kidney injury biomarkers. Results inform prevention tools and guide follow-up pathways (Chicas et al., 2023; Mac et al., 2021; NHWSON, n.d.-a).

Learners across disciplines, primarily nursing and public health, conduct structured interviews and education sessions at FWAF locations and in the field under faculty supervision, Institutional Review Board oversight (IRB), and with informed consent. These studies include the collection of blood and urine samples as well as physiologic data to inform worker-driven interventions (NHWSON, n.d.-a). For direct-care immersion, Emory's separate Farm Worker Family Health Program places prelicensure students in southwest Georgia with the Ellenton Farmworker Clinic, where they provide screenings and episodic care. This clinical program complements the Florida-based research and education model (NHWSON, n.d.-b). Named collaborators on the research team include FWAF leaders and a co-investigator from the University of Florida Levin College of Law (NHWSON, n.d.-c).

The Model: Prelicensure nursing students, under faculty supervision, conducted interviews with farm workers during their clinical rotation at the

Financial Structure: A federal grant covered most costs, including faculty effort, coordination activities, and equipment such as analyzers used

CBO. They assessed knowledge of heat-related illness and hydration needs and gathered basic data on insurance status and access to care. Based on these insights, the team created a mobile education program tailored to the population. The faculty had appropriate ethical oversight from the school's IRB to conduct kidney screenings, ensuring participants' consent and protection during the study.

When nurses identified early signs of kidney injury, they entered the results into the Federally Qualified Health Center's (FQHC) electronic health record system. This ensured that affected workers were connected to follow-up care and allowed the visit to be billed when payer requirements were met, supporting both continuity and sustainability of services.

for kidney screening. This funding allowed the academic team to participate fully in both the research and service components of the project without relying on unpaid time or additional institutional support.

The university counted learner participation toward required clinical hours, so no extra funding was needed for their involvement. A nurse faculty member met their teaching workload by supervising learners on-site. The FQHC contributed billing infrastructure and EHR access as part of its existing operating budget. By delivering care in the field and using the CBO's facilities, the team avoided the cost of setting up a physical clinic.

Outcomes: Learners gained hands-on experience in mobile care, including interviewing, health education, and community engagement. The faculty collected real-time data to inform future occupational health policy. The project showed how nurse-led outreach can meet the needs of underserved populations while preparing learners for practice through integrated education, service, and research.

Lessons Learned:

- Learners, nursing staff, and faculty earned the trust of their patient population by embedding themselves in community spaces and engaging over time. Their continual presence signaled commitment and allowed them to build relationships before offering services or collecting data.
- Designing care and education models around the daily realities of the community being served, especially when working with populations whose time and access are tightly constrained by work or living conditions, helped learners deliver appropriate care. For example, nursing faculty

and learners scheduled education and screening activities during farmworkers' breaks or after their shifts to avoid interrupting their work.

- Academic leaders (Nurse Faculty Supervising Learners) built learner participation into existing teaching roles and clinical hour requirements. Clinical leaders (FQHC partners) used current infrastructure, including EHRs, billing systems, mobile capacity, to support service delivery without added overhead.
- A research grant covered startup needs, but ongoing communication and role clarity across academic, clinical, and community partners made it possible to keep the model running and aligned.
- The faculty created real-world learning opportunities for learners to develop skills in culturally responsive care, mobile outreach, and interdisciplinary teamwork—strengthening both community impact and future workforce readiness.

Leadership Reflection: Are You Acting as a Connector?

- Are community partners part of your design and leadership conversations?
- Are learners gaining real-world experiences in the community?
- Are your programs co-created across sectors or siloed?
- Are partnership goals created from a shared understanding and aligned with mission and vision statements with both partners?

Upholders: Embedding Human Values into Systems

Upholders lead with emotional, social, and organizational awareness, creating structures that support both individual well-being and system-wide improvement (Kennedy, Leclerc, & Campis, 2022). In academic-practice partnerships, Upholder behaviors align with the AACN's guiding principles (AACN, 2023), emphasizing shared goals, mutual respect, and collaborative growth.

Upholders build trust by creating systems that support shared goals across academic and clinical settings. They focus on student learning, patient outcomes, and workforce well-being, and lead in ways that encourage respect, transparency, and ongoing growth (Kennedy et al., 2022; AACN, 2023). More specifically, they:

- see each nurse—whether faculty or staff—as a whole person with both professional and emotional needs, not just an employee;

- understand that nurses may feel torn between mentoring learners or supporting new nurses and providing direct patient care;
- actively recognize this tension and then create opportunities or structures that allow nurses to do both well—support learners while also caring for patients; and
- use their social and organizational insight to bridge gaps across the institution and the community, so nurses are supported as both educators and caregivers, without having to choose one over the other.

Case Model 3: Upper Midwest University and Rural Midwest Practice Partner - Rural Leadership Immersion

Leaders at University of Wisconsin-Eau Claire, and Essentia Health in Duluth, Minnesota, demonstrated upholder characteristics by designing a clinical experience that prioritized inclusion, mentorship, and mutual learning between students and nurse leaders. Grounded in a formal Memorandum of Understanding (MOU) and aligned with AACN/AONL partnership principles, the program immersed learners in real-world leadership practice and community engagement.

Note: See the MOU template at Appendix F: Sample Nursing Academic-Practice Partnership Memorandum of Understanding.

The Model: Learners in the senior-level community health and leadership clinical rotation traveled to the partner hospital sites three times per semester, staying two to three days each visit. The academic and practice partners coordinated lodging arrangements at the sites, in two adjacent cities. Learners and an academic clinical instructor lodged in an area hotel, which Essentia contracted at an established rate, supporting the learner and instructor lodging for a total of 14 nights over the 15-week semester.
Prior to each semester, Wisconsin-Eau Claire's clinical agency coordinator works with Essentia

Financial Structure: Both partners contributed to the financial sustainability of this arrangement through cost-sharing, joint appointment arrangements, and in-kind services.

Health to secure dates and reservations for the learner immersion experiences.
During each stay, individual learners worked with different nurse leaders on a rotating basis, shadowing meetings, engaging with practice partner staff, and gaining exposure to the broader range of professional opportunities. Working in small groups, they developed community-based projects in collaboration with hospital leaders to address local needs.

Outcomes: The structure gave learners a firsthand view of nurse leaders' roles in advocacy, budgeting, staffing, and operations—elements often not obvious from the bedside perspective. Many reported feeling inspired and more confident about pursuing leadership roles. Leaders, in turn, felt validated and energized by the opportunity to mentor and reflect on their own professional journeys.

Lessons Learned:

- Seeing nurse leaders in action helped learners envision new career possibilities and connect clinical practice with broader systems thinking.
- Individual shared time among learners and nurse leaders allowed for meaningful dialogue and mentorship. The focused interaction helped learners gain deeper insights into leadership roles, while nurse leaders found renewed purpose in guiding the next generation.
- Structuring the experience as a short-stay immersion made the rural placement feasible for learners while strengthening the relationship with the practice site.

Leadership Reflection: Are You Acting as an Upholder?

- Do your policies, workflows, and staffing models create an environment where learners, faculty, and staff feel valued and connected to their work?
- Are you supporting educators, learners, and staff in achieving both their career goals and personal development—for example, through mentorship, tuition support, or flexible role design?

- Have you aligned academic expectations (such as teaching loads or student learning objectives) with clinical goals (such as patient care quality or workforce development) in a way that benefits both settings?

Lessons From the Field: Barriers and Success Factors

Across the examples of Awakener, Connector, and Upholder leadership, the following recurring challenges emerged:

- Misaligned institutional priorities across academic, clinical, and community partners;
- Limited protected time for relationship-building and supervision;
- High start-up costs and fragmented funding streams;
- Leadership transitions in both academia and practice that disrupt continuity and threaten long-term sustainability; and
- Minimal preparation for applying human-centered leadership models in practice.

Even with these challenges, the following consistently helped partnerships succeed:

- **Real-world leadership development:** In the Upholder example, learners directly observed nurse leaders making decisions, which helped connect day-to-day practice to systems-level thinking and leadership aspirations.
- **Designated coordination roles:** Every partnership had a dedicated leader, often a faculty or program lead, responsible for aligning teams and managing operations. This integrative work required clear support structures.
- **Early goal alignment:** Partners who defined shared goals upfront, rooted in their organizational missions, were better positioned to secure buy-in, justify resource commitments, and maintain long-term collaboration.

Implementation Strategies

To implement and sustain human-centered academic-practice partnerships, partners should:

1. **Co-develop a shared vision rooted in dignity and justice:** Establish explicit agreements about core values and a shared commitment to addressing community-identified needs. Use these values to guide decision-making across institutions.

2. **Invest in leadership development:** Prepare leaders to act as Awakeners, Connectors, and Upholders.
3. **Prioritize community voice in governance:** Include community-based organizations as equal partners in strategic planning, resource allocation decisions, and program evaluation—not just as sites for implementation. Develop evaluation frameworks together that measure outcomes communities care about.
4. **Integrate care and learning through structured models:** Build educational approaches (e.g., DEUs, immersive rotations) where students contribute to patient care while learning, and where staff development is built into daily operations rather than added on.
5. **Measure relational and experiential outcomes:** Beyond traditional metrics, evaluate learner confidence, staff sense of belonging, interprofessional trust, and community satisfaction with partnership outcomes.
6. **Establish clear roles and accountability from the start:** Define who will teach, supervise, coordinate, and mentor, including specific time commitments and decision-making authority.
7. **Build on existing infrastructure:** Integrate new initiatives into current faculty loads, clinical rotations, and billing systems rather than creating parallel structures. This approach reduces costs and increases sustainability.
8. **Formalize collaboration through agreements and communication systems:** Use MOUs or service contracts to clarify expectations, establish regular communication channels, and create shared planning processes that keep all partners aligned on goals and responsibilities.

Insights for Application

- Start with shared priorities that matter to all partners, such as workforce shortages, learner readiness gaps, or community health disparities. Partners who co-identify these challenges create stronger foundations for collaboration than those who begin with abstract mission statements.
- Invest in relationship infrastructure. Schedule regular check-ins, create conflict resolution processes, and celebrate shared accomplishments.
- Build trust through small wins before attempting large-scale change.
- Integrate human-centered principles into strategic plans, educational curricula and clinical practice, ensuring they survive leadership transitions and budget changes.
- Track metrics such as learner confidence, staff retention, patient outcomes, and community trust to create feedback loops that strengthen relationships and improve outcomes over time.

- Negotiate MOUs, design professional governance structures, and establish joint appointments to create accountability and clarity. *Note: What was once commonly referred to as shared governance is now shifting to professional governance, reflecting a broader emphasis on nurses' autonomy and accountability for their practice (American Organization for Nursing Leadership [AONL], n.d.)*.

Building and Sustaining Human-Centered Partnerships

Human-centered partnerships prioritize relationships, trust, and shared values alongside operational goals. These partnerships align structures, policies, and workflows with the needs and experiences of learners, patients, staff, and faculty, and treat the partnership itself as a living system that requires ongoing communication, mutual respect, and responsiveness to change. The partnerships described in this chapter explore three interconnected elements: structural design, leadership, and sustainability planning. The partnerships described in this chapter explore three interconnected elements: structural design, leadership, and sustainability planning.

1. **Structural Design:** To support human-centered care, academic-practice partnerships need clear structures that reflect the shared goals of academic, clinical, and community partners—often established through formal agreements such as MOUs, professional governance councils, or joint appointments. These structures set expectations, but they don't guarantee trust or alignment. As Leclerc et al. (2023) note, these frameworks must be supported by strong relationships, open communication, and inclusive decision-making processes—the "invisible architecture" that makes real collaboration possible.
2. **Leadership Development:** Human-centered partnerships call for leadership that moves away from top-down hierarchies and embraces unpredictability and change.

   In the most successful partnerships, nursing leaders move fluidly between Awakener, Connector, and Upholder roles, building relationships grounded in trust and mutual respect. Doing so requires working across academic, clinical, and community settings—each with its own culture, pace, and expectations. It also merits self-awareness, humility, and genuine concern for the best interests of learners, patients, staff, and community members.
3. **Sustaining Human-Centered Partnerships:** Sustainable partnerships cannot rely on any one person or grant cycle. For partnerships to be continued over time, they must be grounded in values and reinforced through systems. Across the examples in this chapter, leaders who embedded

human-centered values into their culture were able to ensure that the work could continue and evolve.

Conclusion

The partnerships in this chapter show that success requires relationship building, cultural integration, and systems thinking. Leaders must create environments where human-centered care becomes part of how organizations operate.

This framework offers a roadmap for partnerships that advance nursing education and community health while honoring the humanity of everyone involved. As healthcare becomes more complex, these partnerships demonstrate how authentic relationships and shared values can drive meaningful improvement across the field.

Supplementary Resources and Appendices

Additional foundational materials can be found under "Chapter 1: Transforming Healthcare through Human-Centered Care" at the end of this Playbook. This section includes the following resources that complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix F: Sample Nursing Academic-Practice Partnership Memorandum of Understanding (MOU)**
  This is a non-binding partnership MOU between nursing academic and practice organizations to collaboratively advance nursing education, research, workforce development, and patient outcomes.
- **Appendix G: Pro Forma-Dedicated Education Unit (DEU)**
  This document outlines the financial structure and operational assumptions for a DEU, detailing joint funding, staffing, and revenue streams to support interprofessional, clinical education and training.

Chapter 2

Implementing Competency-Based Education in Academic-Practice Partnerships

Faculty and clinical educators are under growing pressure to ensure new nurses can manage the demands of today's complex care environments. Many graduates enter practice lacking the hands-on experience, clinical reasoning, or confidence needed to care for acutely ill patients.

In response, academic and clinical leaders are co-designing new approaches to training and assessment. Rather than evaluating learners based on time in class or course completion, educators are adopting a competency-based approach to assessing whether learners can properly exercise clinical judgment and meet established practice standards. By co-defining the competencies learners must demonstrate, faculty and clinical instructors better prepare learners for the realities of frontline care settings (Leaver, Stanley, & Veenema, 2022). The 2021 AACN Essentials—the national standards for baccalaureate and graduate nursing education—set an expectation for competency-based education (CBE) as the guiding framework for preparing graduates to demonstrate competence across ten domains of practice, reinforcing the shift underway in many programs (AACN, 2025).

Diverse Models for Implementing CBE

While the following examples focus on learner performance in applied settings, they vary in structure,

environment, and the types of assessment tools used—including clinical placements, simulations, and digital portfolios. *Note: For additional information on how these models may be implemented financially, see Appendix J: Financial Pro Forma*.

Case Model 1: Community-Based Clinical Education

When faculty and clinical leaders form academic-practice partnerships with community health systems—such as Federally Qualified Health Centers (FQHC), rural clinics, and public health departments—they create opportunities for learners to deliver responsive care, navigate social determinants of health, and collaborate with interprofessional teams (Flaubert et al. 2021). Evidence shows that longitudinal, community-based training better prepares learners for equity-focused practice, helping them develop clinical reasoning skills and cultural humility—core elements of AACN *Essentials* Domains 2, 4, and 9 (AACN, 2021).

The Model: One state university applied this approach by partnering with a network of FQHCs. Faculty placed learners in extended primary care rotations across underserved communities. During these placements, learners deepened their understanding of how social and economic conditions shape health outcomes.

Faculty and preceptors jointly assessed learners during extended rotations, focusing on their abilities to deliver person-centered care, address population health needs, and demonstrate professionalism in patient interactions. Evaluating learners during actual patient encounters allowed for timely, context-specific feedback.

To ensure consistency across sites, the university created joint orientation programs for clinical supervisors, faculty, and learners. Students reported that supervisors who received this training gave better feedback and were more consistent in evaluating progress.

Outcomes and Best Practices

- This model helped academic programs expand clinical training capacity and ensured learners gain experience with diverse, underserved populations, better preparing them for contemporary practice.

- Faculty and preceptors assessed learners together during patient encounters, which allowed them to give timely, specific feedback grounded in actual clinical interactions.
- Faculty placed learners in extended primary care rotations in underserved communities, giving them sustained exposure to social determinants of health and patient-centered care.
- The university trained clinical supervisors through joint orientation programs, which improved the consistency and quality of learner evaluation across different sites.

Case Model 2: Hybrid Simulation for Interprofessional Readiness

Communication failures and poor teamwork are well-established causes of medical errors, leading national agencies to call for stronger interprofessional training (Institute of Medicine, 2003; AHRQ, 2019). In response, faculty and clinical leaders are working together to co-design simulation experiences that reflect real clinical workflows, ensuring that training develops skills needed for actual care settings.

The Model: Faculty and clinical staff from nursing, medicine, pharmacy, and allied health programs at the Hofstra-Northwell School of Nursing partnered to co-develop simulation-based learning experiences that mirror real clinical workflows. These scenarios were intentionally aligned with the AACN *Essentials* (2021) and Interprofessional Education Collaborative (IPEC) Core Competencies (2023), allowing learners to demonstrate clinical and interprofessional competencies in settings that reflect complex modern care scenarios.

The Transitions of Care simulation, co-developed for Family Nurse Practitioner and Adult-Gerontology Acute Care Nurse Practitioner students, featured a patient with a ST-Elevation Myocardial Infarction from outpatient care to the ICU. learners practiced critical handoffs and demonstrated skills in urgent response, clinical reasoning, interprofessional communication, and coordination across care settings.

To evaluate performance, faculty and clinical partners created a shared rubric mapped to the AACN *Essentials*. The rubric clarified expectations for communication, documentation, safety, patient-centered care, and cultural humility. *See Appendix H: Transitions of Care Simulation Evaluation Rubric for the full rubric.*

Outcomes and Best Practices

- Learners described increased confidence navigating clinical transitions and felt better prepared for high-stakes communication and care coordination.
- Simulation-based assessments also gave faculty a consistent structure for evaluating competencies before learners entered real clinical environments, helping reinforce patient safety and skill development.
- By using the same scoring framework, faculty and clinical partners ensured consistent, competency-based feedback across learner placements.

Case Model 3: Digital Portfolios to Track Growth Across Settings

Digital portfolios help faculty and preceptors to monitor learner progress, give timely feedback, and identify areas where learners need more support. These platforms serve as shared online dashboards that provide a continuous record of each learner's development across clinical settings. Learners record their clinical work with patients, such as the types of cases they participate in, procedures they assist with, and hours completed, and write short reflections on what they learned and how they applied key skills. Faculty and preceptors review these entries, provide feedback, and assess learner progress in relation to defined competencies. When academic organizations and clinical sites use the same platform, they can easily coordinate expectations and support learners over time.

Research shows these tools are most helpful when they include space for learners to assess their own progress, and regular feedback throughout each rotation (Bramley et al., 2021). Waldrop et al. (2023) found that DNP students used portfolios to show how they were meeting AACN *Essentials* competencies. Tickle et al. (2022) emphasized that when learners are encouraged to think critically about what they're learning—and get consistent input from instructors—they build more confidence and readiness for clinical practice.

The Model: A regional nursing education consortium implemented a digital portfolio system across multiple facilities to support CBE across multiple institutions. The platform allowed learners to document patient encounters, reflect on clinical experiences, and receive feedback from faculty and preceptors. Several vendors offer these systems, which allow learners to document patient encounters, reflect on clinical experiences, and receive feedback from faculty and preceptors. In this

case, the costs were borne by both partners: learners covered fees on the academic side, while the hospital covered costs for its implementation and use.

Learners uploaded case reflections, procedure logs, and encounter summaries, which faculty and clinical educators reviewed using rubrics linked to the AACN *Essentials*. This gave learners a clearer view of their development, encouraged self-assessment, and allowed faculty and clinical educators to tailor support based on individual readiness.

At the University of Wisconsin-Eau Claire's DNP program, learners used a monitoring platform to document important training data—such as diagnoses treated, procedures performed, and clinical hours logged. Multiple such centralized platform systems now exist to manage learner assessments and map competencies along the entire trajectory of didactic, clinical, and experiential education. Before each semester, preceptors reviewed this individualized data to tailor instruction to learner needs.

Outcomes and Best Practices:

- Even at clinical sites that require standardized evaluation forms across disciplines, the digital portfolio helped customize learning and reinforce academic–practice alignment.
- It gave all partners a shared view of learner progress, supported real-time feedback, and strengthened competency-based instruction.
- Faculty used the tracking platform to complete mid-term and final evaluations, which reduced administrative burden.

Case Model 4: Nurse Residency Programs to Extend CBE into Practice

Research shows that new nurses often struggle with the transition from school to practice, citing stress, limited confidence, and gaps in clinical judgment as challenges during the first year of licensure (Najafi & Nasiri, 2023; Davis, 2024). As academic institutions move to CBE, many are now working closely with nurse residency programs that hire their graduates to identify curriculum gaps and recommend revisions. In response, some healthcare organizations offer competency-based residency programs that help novice nurses build skills and confidence.

The Model: The Vizient/AACN Nurse Residency Program™ (NRP) is one of the largest academic–practice partnerships addressing this need (Vizient, Inc., 2023). Developed by academic and clinical leaders, the program supports newly licensed registered nurses during their first 12 months of practice and is used by more than 700 hospitals and health systems. It aligns with the AACN *Essentials* to reinforce professional identity, clinical reasoning, and communication in real-world care settings.

Academic and clinical teams co-designed the NRP to support nurses across the first year of practice. Participants engaged in peer case discussions, one-on-one mentorship, and guided reflections that map directly to the 2021 AACN *Essentials*. For example, nurses applied clinical reasoning and integrated evidence at the bedside (Domain 1), built interprofessional communication skills through collaborative dialogue (Domain 6), and developed professional identity and emotional insight through structured reflection (Domain 10). Nurse residents completed standardized assessments such as the Casey-Fink Graduate Nurse Experience Survey (Casey-Fink Graduate Nurse Experience Survey, 2006, 2023), which measures their perceived confidence, stress, support, and skill development. Residency leaders used the results to monitor each resident's professional development and share insights with nurse managers and quality teams, who used the data to improve staffing, support strategies, and onboarding.

Outcomes and Best Practices:

- Evaluation data from the Vizient/AACN Nurse Residency Program showed that the program improved nurse confidence, competence, and preparedness for clinical practice (Vizient, Inc., 2023).
- Participating organizations reported high retention rates and gains in new nurse autonomy and collaboration.
- By using a standardized curriculum, the program helped new nurses develop consistently across practice and clinical settings.

Field-Tested Approaches

Leaders who successfully implement CBE in academic–practice partnerships apply several interrelated strategies, including:

- **Aligning language across academic and clinical settings:** Clinical evaluators and nurse faculty must work together to develop a shared and uniform language for the descriptive, observable

behaviors associated with sub-competencies and competencies. This collaboration promotes consistency in evaluation and ensures that feedback from clinical educators aligns with academic goals and expectations.

- **Addressing policy and practice constraints:** Academic leaders must coordinate with clinical partners to understand how liability policies and scope-of-practice rules limit learner involvement in higher-risk clinical tasks—such as medication administration, invasive procedures, or unsupervised patient care. These restrictions shape which competencies preceptors can directly observe and evaluate during clinical rotations.
- **Protecting time for faculty–preceptor work:** Academic and clinical leaders must protect time for faculty and preceptors to align on competencies and expectations, provide training on shared evaluation and simulation systems, and ensure both groups can access the same learner performance data.
- **Provide financial or workload support for teaching roles:** Organizations may need to offset lost revenue when preceptors step away from patient care, or adjust faculty workloads when instructors take on clinical duties. These adjustments help ensure that teaching responsibilities are supported rather than added on top of existing roles.
- **Sharing decision-making and adjusting based on feedback:** Leaders who treat faculty and clinical nurse educators as equal partners create more durable and collaborative partnerships. Leaders should regularly gather feedback from learners, preceptors, and faculty to identify what's working and what needs to change.
- **Extending faculty preceptor support beyond graduation:** New graduates may complete academic preparation but still lack the clinical reasoning, confidence, and interpersonal skills needed for practice. Clinical leaders can support early-practice nurses by assigning experienced nurses to serve as faculty preceptors. These nurses are employed by the practice organization—not the school—and unlike unit-based preceptors, they round across clinical areas, observe care, and provide just-in-time guidance and feedback. This approach helps early-practice nurses build confidence and strengthen critical thinking during their first years of practice. To implement this model, leaders should identify qualified nurses, invest in faculty preceptor training, and adjust staffing to protect time for mentorship.

Lessons for Putting CBE Into Practice

Practices to Best Support Learner Skill Development

- **Co-develop curriculum and evaluation tools:** Faculty and preceptors should work together to

design curricular experiential learning opportunities, simulations, and evaluation tools. Regular planning sessions help both groups align on how to assess learner competence. Faculty can lead these sessions by introducing shared frameworks such as the AACN *Essentials* and the *Essentials* Competency Assessment Framework and by walking through specific expectations for learner performance.

- **Provide preceptor development to assess learner performance:** Faculty should work closely with preceptors on curricular expectations, coaching, and giving timely, actionable feedback. When academic and practice partners approach learning and assessment from a similar lens, they can provide learners with more consistent and meaningful guidance.
- **Create joint professional governance structures:** Steering committees, advisory boards, and other professional governance structures give academic and clinical leaders a formal way to plan, make decisions, and solve problems together.
- **Track performance using shared dashboards and digital portfolios:** Faculty and preceptors can improve alignment by using shared digital platforms to track learner performance. These systems—such as dashboards and e-portfolios—allow both groups to view the same clinical logs, reflections, and simulation data in real time. When everyone sees the same information, they can make faster, more informed conclusions about learner readiness.
- **Recognize and compensate clinical educators:** Academic and practice partners must signal to both clinicians and the broader organization that clinical teaching is a respected and integral part of nursing education by conducting formal recognition events, offering continuing education units for preceptor development, or recognizing experienced clinicians with honoraria or academic appointments. Additionally, clinical partners need compensation models that account for their time spent mentoring learners in a competency-based framework. Partners should jointly design these compensation models to reinforce shared ownership of education and strengthen the long-term viability of the partnership.

Modernize Education to Match Needs of New Generations

Millennial and Gen Z learners tend to value digital-first learning, open communication, and clear professional identity development. Gen Z nurses expect open and respectful workplaces, a clear sense of purpose in their work, and support for professional development (Press Ganey, 2023). Faculty and clinical leaders can reach them by:

- **Prioritizing interactive instruction:** Because Gen Z and Millennial students report preferences for dynamic, tech-supported learning, educators can expand their use of tools such as virtual reality

simulations for clinical scenarios, augmented reality overlays for anatomy and procedures, microlearning modules, clicker-based interaction, and streaming platforms in place of passive lectures (Shorey et al., 2021; Hilsmann & Dodson, 2025). Some clinical sites still rely on low-fidelity mannequins or paper-based simulations and describe them as technology-enabled learning. However, newly graduated nurses often expect richer technology integration that mirrors modern clinical environments.

- Transitioning faculty roles toward coaching and facilitation. When faculty guide and facilitate learning, rather than simply lecturing, they create space for learners to explain their thinking, receive feedback in real time, and connect clinical tasks to underlying concepts. Coaching allows faculty to assess how learners apply their skills in practice (Fey & Morse, 2024) and is foundational to the transition to CBE.
- Creating psychologically safe environments to meet Gen Z's values around purpose and growth. Ensure such environments by being open to feedback, offering mentorship, and helping learners build strong professional identities.

Supporting Competency Development in Clinical Settings

The following six practices, inspired by strategies at leading programs, support learner competency development as they move through clinical settings. Each practice aligns with one or more *Essentials* domains, reinforcing key areas of professional competency such as systems-based practice, clinical judgment, quality and safety, and person-centered care (Flott et al., 2022).

1. **Share digital tools:** Preceptors use shared digital guides that learners update with site-specific tips, such as electronic-medical record shortcuts. These living documents help learners engage more actively in clinical sites and improve their understanding of how organizations work and adapt.
2. **Hold regular check-ins with learners:** Faculty, preceptors, and learners should meet during the rotation to reflect on what's working, adjust priorities, and focus on areas where learners need more support.
3. **Provide frequent feedback within DEUs:** In DEUs, clinical nurse educators work directly with a small number of learners on the unit, rather than taking patient assignments themselves. This gives them time to observe learners in real-time and offer immediate feedback. Educators can use standardized competency tools to guide these conversations, helping learners understand what

they did well, where they need to improve, and how to adjust. This consistent support helps learners build confidence.

4. **Introduce learners to multiple preceptors:** By assigning learners to rotate among different types of providers—such as nurse practitioners, physicians, and midwives, faculty and educators introduce learners to various care roles and improve their ability to work on interprofessional teams.
5. **Offer preceptor development programs:** Faculty can support preceptors through formal development programs. These sessions help preceptors model compassionate care and create a supportive learning environment.
6. **Set clear benchmarks for learner progress:** Faculty and preceptors should work together to define what clinical skills, communication behaviors, or decision-making steps learners must demonstrate before they advance. Making benchmarks clear helps learners better self-assess. Competency-based education is learner-centered, ensuring that learners clearly understand what is expected of them through transparent outcomes and observable performance indicators.

Conclusion

As nursing education continues to evolve to meet the challenges of modern healthcare, partnerships grounded in CBE offer a sustainable, scalable model for preparing practice-ready graduates. The integration of academic and clinical expertise ensures that learners achieve competencies that matter most to patient outcomes and system performance.

Looking ahead, innovations such as AI-supported assessment, micro-credentialing, and community-engaged clinical education will further enhance the impact of CBE. Academic-practice partnerships must continue to evolve as co-leaders in designing, delivering, and evaluating nursing education that prepares nurses not just to work, but to lead.

Supplementary Resources and Appendices

Additional foundational materials can be found under “Chapter 2: Implementing Competency-Based Education in Academic-Practice Partnerships” at the end of this Playbook. This section includes the following resources that complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix H: Transitions of Care Simulation Evaluation Rubric**
  This rubric evaluates nursing students' performance in transitions of care simulations across seven domains—including clinical judgment, communication, collaboration, safety, documentation, cultural humility, and health teaching.
- **Appendix I: Sample Memorandum of Understanding Between University and Academic Health Center**
  An MOU between a university nursing program and an academic health center to expand clinical education, support faculty development, and promote nursing workforce diversity.
- **Appendix J: Financial Pro Forma**
  This financial pro forma projects that an academic–practice partnership will achieve strong, scalable net income growth over five years, which is driven primarily by faculty clinical practice revenue and simulation services.
- **Appendix K: Editable Financial Pro Forma Template**
  A fillable, downloadable financial pro forma Excel spreadsheet.
- **Appendix L: Academic-Practice MOU and Dynamic Pro Forma Tool**
  This dynamic financial pro forma models the long-term revenue, expenses, and net income of an academic–practice nursing partnership, allowing users to adjust key assumptions such as practice hours to project the financial impact of the partnership contributions over time.

Chapter 3

Sustaining the Workforce

Nursing programs face persistent capacity challenges that limit how many students they can enroll and how quickly those learners progress. Faculty shortages, competition for clinical placements, and limited classroom space often restrict admissions, even when applicants meet entrance requirements. Once accepted, learners may encounter delayed placements and high tuition costs, all of which can slow their progression or lead to attrition. These barriers not only affect individual learners but also shape the nursing workforce pipeline, influencing how quickly new graduates can enter practice and advance into leadership or faculty roles.

Academic and practice leaders are working together to address these challenges. Some partnerships increase program capacity by jointly funding new faculty roles or creating clinical placements in affiliated care settings. Others reserve clinical placements in advance to prevent scheduling delays as learners move through their programs. Health systems are also offering tuition support in exchange for work commitments after graduation. These efforts help more learners enter nursing programs, progress without delay, and transition into practice-ready roles.

To sustain the nursing workforce, leaders need strategies that support nurses across their careers. This chapter examines academic–practice partnerships as one such approach. It highlights how shared investments, joint faculty roles, and better-integrated clinical training can improve learner outcomes and support long-term workforce development.

Illustrative Models of Academic–Practice Partnerships

The following models show how academic and practice partners have implemented strategies to strengthen the nursing workforce. Each example highlights key drivers of success, outcomes, and structural details that can inform replication or adaptation in other settings.

Case Model 1: Shared Teaching and Joint Appointments

Model Overview: In some academic–practice partnerships, Advanced Practice Registered Nurses (APRNs) take on joint roles that include teaching in DNP programs. In a partnership between Norton Healthcare in Louisville, Kentucky and the University of Kentucky College of Nursing system, the University appointed APRNs who met academic requirements as voluntary adjunct faculty members. The nurses co-taught courses with university instructors while continuing their clinical work. Their dual role helped align course content with practical work experience and strengthened collaboration between the two organizations (Howard et al., 2020).

Drivers of Success:

- Academic-Practice alignment: Dual-role faculty grounded their instruction in current clinical practice, which helped learners apply course content to practical work experience.
- Institutional support: Academic and practice leaders collaborated to design manageable schedules and workload expectations so APRNs could succeed in both teaching and clinical roles without burnout.
- Defined roles and professional governance: Both institutions developed clear agreements that outlined teaching responsibilities, clinical expectations, evaluation processes, and credentialing requirements. Regular communication between human resources, academic affairs, and nursing leadership supported coordination.
- Consistent mentorship across settings: Because dual-role faculty worked with learners in both classroom and clinical environments, they were able to reinforce the same performance standards, support clinical reasoning, and help learners bridge the gap between theory and practice.

Financial Structure:

- This model used formal memoranda of understanding. Both institutions collaborated on human resources functions, such as hiring, payroll, benefits, and faculty credentialing.
  Note: See Appendix M: MOU for Shared Teaching and Joint Appointments.
- Institutions negotiated fair compensation models to account for differences in academic and clinical salary structures, which can otherwise create friction or limit participation.

Outcomes:

- Students benefited from learning with instructors who actively worked in the field, which helped bridge the gap between academic preparation and clinical expectations.
- The program increased clinical placement capacity by creating additional preceptorship opportunities through the joint faculty roles.
- Faculty in dual roles reported higher professional satisfaction, as they could stay engaged in clinical care while advancing their careers through teaching and scholarship.

Case Model 2: Building a Sustainable Nursing Workforce Pipeline Through Early Entry and Tuition-Supported Career Pathways

Model Overview: Norton Healthcare partnered with Kentucky-based Bellarmine University, Galen College of Nursing and local public school districts to create tuition-supported pathways into registered nursing. Leaders from all three sectors defined entry points for high school students and second-degree learners and collaborated to design the curriculum, align funding, and coordinate clinical training. This model provided streamlined pathways and facilitated academic progression from practical nursing (PN) and associate degree (ADN) programs to baccalaureate degree-completion programs.

Drivers of Success:

- High school faculty and program leaders aligned coursework to support nursing prerequisites. Program leaders (human resources from academia and practice) worked directly with high school faculty to align pre-nursing coursework with nursing program requirements.

- Academic and clinical faculty removed barriers by coordinating schedules and curriculum. Partners co-designed the curriculum and coordinated class and clinical schedules to reduce barriers to progression.
- Health system leaders tied tuition support to performance and workforce retention. The health system offered tuition assistance tied to academic performance and required a post-graduation work commitment, increasing both access and retention.
- The faculty created consistent learning environments through dedicated education units (DEU). Faculty placed learners in DEUs, allowing them to develop clinical skills with consistent support and supervision.
- Partnership leaders expanded access by adapting the model for second-degree learners. After expanding the model to second-degree learners, partners used the same tuition structure and DEU support system to triple enrollment in one accelerated BSN pathway.
- Program leaders adjusted offerings in response to early results. Program administrators reviewed initial outcomes and used those insights to phase out the PN track and expand ADN and BSN pathways aligned with workforce goals.

These efforts directly addressed known barriers to nursing entry, such as tuition costs, limited clinical placements, and fragmented application systems that often prevent learners from completing training despite strong initial interest.

Financial and Structural Details:

- The health system provided up to $45,000 in tuition support per learner. The academic partner covered remaining tuition costs.
- Program administrators from the academic institutions and health system jointly managed clinical placements to ensure alignment with didactic instruction.

Outcomes:

- One accelerated BSN program tripled enrollment since its launch; nearly half of incoming learners received tuition support from the health system.
- Learners demonstrated strong National Council Licensure Examination (NCLEX) pass rates and progressed through clearly structured clinical placements.
- The program introduced learners early to multiple clinical environments and specialties across the health system,

- Faculty embedded learners in DEUs to ensure continuity between classroom learning and clinical application.

improving readiness and fit for future roles.

- Program leaders used early results to formalize a long-term pipeline strategy that supports multiple entry points into registered nursing, including high school students and second-degree learners. This approach now serves as a recurring, tuition-supported pathway for growing the workforce year over year.

Case Model 3: Shared Nurse Academic Practice Partnership (SNAPPI)

Model Overview: To mitigate the shortage of nursing faculty available to teach pre-licensure nurses in clinical settings in Texas, four Houston-area hospitals and health systems—HCA Houston Northwest; Houston Methodist The Woodlands Hospital; St. Luke's Health The Woodlands Hospital; Memorial Hermann Cypress Hospital—partnered with Sam Houston State University in Huntsville, Texas, and a nursing technology company, Nurseify, to develop a time buy-out model in which qualified bedside nurses, known as SNAPPI RNs, participated in clinical instruction.

A year-long feasibility study conducted at four sites with more than 50 learners suggested that the model is effective in reducing compensation disparity, work-life imbalance, and excessive coordination burden.

Drivers of Success:

- Throughout the year-long solution-design period, partners included key stakeholders, such as individuals representing human resources, finance, procurement, and legal departments; practice and academic nursing leaders; bedside nurses; nursing clinical coordinators; and nursing faculty from all partners.
- Partners conducted a root-cause analysis to find what keeps bedside nurses from participating in clinical teaching. Then, they designed targeted solutions to address those barriers.

- Partners developed a standardized Memorandum of Understanding and a cost/time-allocation worksheet to align expectations on liability, funding, and SNAPPI RN teaching requirements. *Note: See Appendix O: Shared Nurse Academic Practice Partnership (SNAPPI) Memorandum of Understanding for full template*.
- Partners established a core workgroup during the feasibility study to maintain tight coordination between academic and practice teams.
- Partners provided role-specific training and ongoing support to prepare SNAPPI RNs to serve as clinical instructors for prelicensure students.
- SNAPPI RNs taught on their home units to leverage existing workflows, teams, and patient populations.

Financial Structure:

- Health systems paid all wages and benefits to SNAPPI RNs with no disruption and invoiced the academic partner at the end of each performance period.
- The average cost differential per SNAPPI RN was approximately $4,200.
- State grants for the feasibility study funded orientation, onboarding, training, and academic hours at the clinical pay rate. Additional state awards are funding a statewide demonstration project. Long term, partners plan to secure sustained legislative funding for participating academic and clinical institutions.

Outcomes:

- The partnership eliminated pay disparities for SNAPPI RNs, capped total academic and clinical work at 1.0 FTE, and coordinated teaching schedules directly between the school and each SNAPPI RN's home unit.
- Surveys showed strong Net Promoter Scores, high learner satisfaction, and high SNAPPI RN job satisfaction and intent to stay.
- The feasibility study generated 1.7 FTE of clinical teaching, increasing the school's clinical teaching capacity by 5–10%.

Case Model 4: Full-Ride Program and Shared Commitment to Workforce Development

Model Overview: Leaders at Barnes-Jewish College Goldfarb School of Nursing and BJC Healthcare strengthened their academic–practice partnership by setting clear goals and building the operational

and financial plans to support them. Goldfarb, which has existed for more than 100 years in the region and has a long affiliation with BJC and its top-ranked hospitals, and BJC aligned on a shared objective: improve health in the region.

Goldfarb and BJC chose not to rely on short-term goals, such as hitting enrollment targets or managing staffing shortfalls, and instead pursued deeper solutions that expanded access to high-quality care and built a stable regional workforce.
To do so, they reexamined pathways into the profession and the affordability of a BSN that supports quality goals, Magnet® targets and regional workforce stability.
In 2022, the partners piloted and then formally launched a large-scale full-ride program. Recipients pay no tuition in exchange for a three-year commitment to work at a BJC after graduation and passing the NCLEX. In the first four years, more than 350 learners received full-ride awards.

Note: To safeguard the partners' investment and ensure consistent execution, the program includes a Full Ride Scholar (FRS) Nurse Liaison. The FRS Nurse Liaison supports day-to-day operations, coordinates placement and mentoring, and monitors outcomes and retention. To find the FRS Nurse Liaison Job Description, which defines responsibilities for coordination, coaching, and continuous improvement that help sustain program results, see Appendix P: FRS Nurse Liaison Job Description.

Drivers of Success

- A vision spanning education and career: Universally high turnover rates of new graduate nurses hurt everyone. Young nurses are demoralized, and health systems struggle with staffing. In building the model, the partnership team envisioned connecting the college and health system to give learners a clear path to a career in a top health system and a stable launch after graduation.
- Defined performance indicators and a continuous learning approach: The partnership team established expectations that the model would be operationally effective, marketable, equitable, and financially beneficial. The team structured the model, piloted it, and continuously monitored and fine-tuned it.
- Awards aligned to academic merit and financial need: The partnership considered long-term staffing and regional needs to enable access to a local nursing career. Awards enabled a higher percent of Black learners and male learners to prepare for a nursing career than in the general

learner population. Initial cohorts included 30% minority learners (21% Black), exceeding Missouri benchmarks (23.2% minority; 12.4% Black) and aligning with U.S. levels (31.5% minority; 11.9% Black). Male representation reached 11%, compared with 8.1% in the Missouri RN workforce and 12.1% nationally.

Financial Structure

- Leaders from BJC HealthCare and Goldfarb designed a coordinated funding model. At BJC, nursing leaders and representatives from its finance, human resources, and legal department oversee the program and fund tuition. The Barnes-Jewish Hospital Foundation supports a dedicated nurse coordinator. At Goldfarb, strategy, finance, admissions, and academic affairs teams administer the program and award tuition support according to established criteria.
- Learners sign a service agreement that sets work expectations and a prorated repayment obligation if they do not complete the three-year commitment. BJC's talent acquisition team places new graduates in appropriate roles, and the program coordinator provides mentoring during the early career period and facilitates internal transfers when needed.

Outcomes

- In the first three years, 354 learners received full-ride awards; 170 remain enrolled (program retention 94.4%) and 175 have graduated.
- Among graduates hired at BJC, 0–36-month turnover is 3.5%. For context, the national first-year RN turnover rate is 22.3% (NSI Nursing Solutions, Inc., 2025).
- Recipients' first-time NCLEX pass rate is 98.5%.
- Those who have completed the program have collectively saved more than $17.7 million in tuition costs.
- The 354 scholars will collectively complete approximately 30,000 hours of community and population-health clinical experience—about 85 hours per learner—building their knowledge and reinforcing their commitment to improving health outcomes in the communities they serve.

Additional Published Examples

The next two models, drawn from peer-reviewed case examples, describe additional forms of academic–practice collaboration.

Collaborative Program with Shared Resources

In this partnership, leaders from the college of nursing and the academic medical center developed a collaborative BSN program. The collaborative program utilizes a comprehensive sharing of administrative oversight, teaching duties, resources, and costs. The partners formalize their agreement through a memorandum of understanding, which they review with each new learner cohort. Nursing faculty at the academic medical center teach the courses and serve in clinical, educational, or research roles, with their salaries jointly funded by the academic medical center and the college of nursing. Initial outcomes include increased enrollment, high NCLEX-RN pass rates, high one-year retention for program graduates hired by the academic medical center, and increased numbers of nursing faculty. Building on this success, the partners have expanded their collaboration to include faculty development, research and evidence-based practice projects, interprofessional education, and joint service initiatives (Peterson & Morris, 2019).

Sustainable Faculty Roles that Increase Access to Care

A college of nursing partnered with an affiliated primary care clinic within an academic pediatric hospital to expand clinical education for nurse practitioner students and strengthen the primary care workforce. They created two part-time pediatric nurse practitioner (PNP) faculty positions to staff the clinic during evening hours. The PNP faculty were jointly selected by the partners, hired through the college of nursing, and full members of the clinic faculty medical group. They managed their own patient panels, taught graduate and undergraduate learners, and precepted learners during evening shifts, making full use of clinic space after daytime hours. Leaders from the academic and practice partners endorsed the model and coordinated planning to align goals, operations, revenue tracking, and evaluation. Within four months, revenue from evening visits covered the PNP faculty salaries and benefits, allowing the model to operate sustainably. The model also expanded clinical opportunities for PNP students, generating more than 800 additional clinical hours each year. Through this collaboration, the partners increased faculty and preceptor capacity, supported workforce development, and increased access to pediatric primary care services (Wall & Medina, 2022).

Best Practices and Application Tips

Academic and practice leaders must commit to shared goals, align operations, and create structures that support long-term workforce development. The following best practices reflect lessons from the partnerships featured in this chapter.

1. **Define shared long-term workforce goals:** Academic and practice leaders should meet early to identify common workforce priorities, such as increasing access to care, closing readiness gaps, or expanding the pipeline into nursing. Together, they should lead strategic planning efforts to map how the partnership will support workforce development across career stages, from high school exposure through advanced practice. When health systems invest in structured progression pathways, including those leading to the RN or APRN roles, they often improve long-term retention and ease transitions into the workforce (AACN, 2022; National Academies of Sciences, Engineering, and Medicine [NASEM], 2021).
2. **Assess alignment and readiness before committing:** Executive teams should evaluate whether their organizations share values, trust each other, and are willing to challenge traditional models. Leaders should conduct formal readiness assessments to examine buy-in, operational flexibility, and capacity for co-design. Partnership coordinators can use alignment rubrics and similar tools to determine whether the organizations are prepared to support joint faculty appointments, co-developed curricula, or shared leadership initiatives (AONL, 2023).
3. **Plan proactively for common operational challenges:** Partnership leaders should address known barriers early, including faculty shortages, regulatory hurdles, and staff burnout. Academic leaders can create flexible joint faculty roles that allow practicing nurses to teach in DEUs. Legal teams should collaborate to address regulatory barriers such as licensure restrictions or preceptor-to-learner ratios. Wellness coordinators should build support systems by integrating wellness content into curricula, promoting flexible roles like virtual nursing or RN first assistants, and monitoring workload expectations across the partnership (AACN, n.d.; ANA, 2023; NASEM, 2021).
4. **Use shared metrics to measure progress and guide decisions:** Data teams from both organizations should define and track metrics that reflect educational and workforce outcomes. These may include transitions from entry-level to advanced roles, retention at 12 and 36 months post-hire, satisfaction among learners, faculty, and preceptors, and internal promotion rates. Program leaders should embed evaluation plans at the outset and review them regularly to make timely adjustments. By sharing data openly, partners can strengthen accountability and support continuous improvement.

   When academic and practice leaders apply these practices with intention and clarity, they create partnerships that prepare nurses for real-world demands and improve long-term workforce sustainability.
5. **Start early by aligning pre-nursing pathways with workforce needs:** Programs that engage students in high school or through second-degree entry points and provide academic and financial

support can improve on-time progression and long-term retention.

Conclusion

When partners jointly design and fund academic-practice partnerships, they build reliable pathways to practice. By beginning upstream, such as in high school and in second-degree programs, and by extending onto the units that will hire graduates, leaders create continuous pipelines to employment. This end-to-end approach reduces progression delays, strengthens readiness for practice, and stabilizes retention.

Supplementary Resources and Appendices

Additional foundational materials can be found under “Chapter 3: Sustain the Workforce” at the end of this Playbook. This section includes the following resources that complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix M: MOU for Shared Teaching and Joint Appointments**
  This MOU is between a health organization and school of nursing to educate employed registered nurses in a fully supported Doctorate in Nursing Practice (DNP) program, outlining responsibilities and financial arrangements.
- **Appendix N: Cost/Time Allocation Worksheet: Shared Nurse Academic-Practice Partnership (SNAPPI)**
  This worksheet details the estimated time allocation and cost for SNAPPI RN clinical teaching.
- **Appendix O: Shared Nurse Academic Practice Partnership (SNAPPI) Memorandum of Understanding**
  This MOU describes a program between an academic institution and healthcare program to share registered nurse appointees who divide their time between both teaching and clinical practice.
- **Appendix P: FRS Nurse Liaison Job Description**
  This is a job description for the Nurse Retention Specialist for the Full-Ride Scholar Program.

Chapter 4

Innovation in Academic-Practice Partnerships

This chapter provides a practical guide for developing academic-practice partnerships that drive innovation in care delivery, technology adoption, and practice change.

Innovation, distinct from invention, is not merely the creation of something new; it is the implementation of novel ideas in ways that generate value. While invention is often a solitary act of discovery, innovation thrives through collaboration. In healthcare, this collaboration is best realized when academic institutions and practice settings form intentional partnerships.

From a practice partner perspective, health systems benefit from the scholarly resources, analytical expertise, and the pipeline of future clinicians that academic institutions provide. Practice leaders face ongoing challenges including workforce shortages, the need for continuous innovation in care delivery, and pressures to improve patient outcomes while reducing costs. Academic partners can help design, test, and evaluate new care models, such as nurse-led clinics or interprofessional team approaches, providing a research-informed foundation for decision-making. In partnering with practice organizations, academic institutions create clinical development opportunities for learners, quality improvement (QI) initiatives and research endeavors. Leaders can forge these partnerships across the educational spectrum and prepare future interdisciplinary teams.

Anchored in the AACN *Essentials* and the AONL Guiding Principles for Digital Innovation, this chapter supports academic and practice leaders in creating sustained, strategic partnerships that prepare the nursing workforce for the future of care.

How Academic and Practice Leaders Drive Innovation

Leaders on both sides of a partnership must commit to shared strategies that move ideas from concept to implementation. The following strategies illustrate how partners co-design care models, integrate technology, drive practice transformation, and build the workforce. Each strategy highlights where academic and practice leaders act together, why the approach matters, and how it can be adapted to different settings.

Strategy 1: New Care Models

Academic and practice partners are co-designing new ways to deliver care. These models are scalable by design, and partners rely on shared metrics, rapid-cycle evaluation, and feedback loops to iteratively refine workflows, technology use, and develop their workforce.

This work aligns with AONL's human-centered design competency and AACN's *Essentials* Domain 2, person-centered care, and Domain 3, population health.

Partnerships in Action

Case Model 1: Innovation in Community-Based Care

Many communities face persistent barriers to care such as limited transportation, unaffordable out-of-pocket costs, and mistrust of traditional care systems. To address these barriers, the University of Illinois College of Nursing partnered with a community organization to develop a nurse-led mobile health unit, or a clinic on wheels that brings high-need, often neglected primary and preventive services directly to patients with limited access to primary care. These include rural residents, unhoused individuals, and neighborhoods with significant health disparities. In the care unit, clinicians assess, treat, and coordinate care at the top of their licenses, supported by interdisciplinary teams that often include community health workers and social workers. This care delivery model gives patients immediate access to specialists who otherwise would not be available in their communities.

Electronic health records (EHRs) are updated in real time at the point of care, ensuring that information follows patients across settings and preventing gaps in treatment.

Beyond individual encounters, the data captured in the mobile EHR system feeds into population health tracking. Providers can identify community-level patterns—such as rising rates of chronic illness, localized spikes in infection, or gaps in immunization coverage. These insights allow health systems and academic partners to target interventions, allocate resources, and design prevention strategies tailored to specific populations.

Evaluations consistently show that mobile health units expand access, increase preventive care, improve patient satisfaction, and reduce avoidable emergency department visits. *Note: A template of the MOU used in this partnership is available in Appendix Q: Sample Community Based Care Partnership MOU.*

Case Model 2: School of Nursing–People in Need Ministry Partnership

The Ellmer School of Nursing at Old Dominion University in Norfolk, Virginia partnered with People in Need Ministry (PiN) to expand care access for unhoused community members. The initiative began as a weekly clinic staffed by faculty and learners and quickly evolved into a fully equipped free clinic that delivers integrated care, using telehealth and electronic health records to extend access and support continuity.

Learners from nursing and other disciplines gained hands-on experience managing complex conditions, working in interprofessional teams, and addressing social determinants of health. Faculty conducted research projects that showed reduced emergency department use and more than $3 million in cost savings. Findings also informed practical initiatives such as distributing wound care kits for unhoused patients.

The clinic's success led the city to invite the partners to replicate the model at the local Housing Resource Center. Several learners later chose to work in similar settings, showing how the partnership advanced both community health and workforce development.

Strategy 2: Integrating Technology into Education and Practice

Academic and practice partners are working together to prepare nurses and learners for a rapidly changing digital environment and close digital literacy gaps. They are integrating emerging technologies, such as clinical decision support systems and ambient documentation tools, into education and clinical learning experiences. In some academic-practice partnerships, clinical leaders utilize experiential learning methods, such as simulation, which employ realistic clinical scenarios, often enhanced by technology, including AI, that allow both learners and bedside nurses to practice person-centered care and new care models in a safe, controlled environment. These efforts align with AONL's call to empower clinicians and AACN's focus on systems-based practice and informatics.

Partnerships In Action

Case Model 3: Virtual Nursing and Ambient Documentation

Essentia Health in Duluth, Minnesota partnered with the University of Wisconsin Eau Claire and the College of St. Scholastica in Duluth, Minnesota, to explore how emerging technologies, such as ambient listening tools, could streamline documentation. Ambient listening and documentation tools allow the provider and learner to focus on the patient and their non-verbal cues. They also enable the learner to review the interaction with the patient and reflect upon their experience. Together, practice leaders, faculty and learners co-designed "blue sky" sessions with an electronic health record vendor to examine emerging technologies and plan for workforce needs. Including academic partners in these sessions brought diverse perspectives to the design process and highlighted the need to update nursing curricula.

As a result of the sessions, faculty updated their curriculum, giving learners opportunities to practice describing their care in real time. Speaking in this structured way helps ambient listening tools capture the right details and document accurately. By introducing this competency in nursing education, partners better prepare learners and future nurses to use these technologies in clinical settings.

Case Model 4: Hands-On Innovation Through Clinical Design Lab

UnityPoint Health-St. Luke's Hospital in Cedar Rapids, Iowa partnered with Boston-based MakerHealth® to create an in-hospital program where staff, learners, patients, community and academic partners design and build solutions to clinical challenges. The program provides access to equipment such as 3D printers, sewing machines, and basic fabrication tools, along with technical support to turn ideas into usable prototypes.

Participants from all areas of the hospital system learn new technologies to create or modify devices that solve everyday care challenges. In its first five years, the program completed 1,106 projects, with 660 implemented in practice. Notable projects include weighted chest tube holders that improve safety, a "greenlight" visor under study for migraine relief, and a realistic training model for central line care. Academic partners engage learners through clinical rotations, internships, "pop-up labs", and research projects.

By enabling frontline clinicians, learners and others to solve practical problems directly, this partnership strengthens clinical education and builds a culture of continuous improvement.

Strategy 3: Driving Evidence-Based Practice Change

Academic and practice partners are embedding evidence-based practice (EBP) and quality improvement into daily operations. Students learn to apply evidence in real-world projects, while practice organizations benefit from innovations that advance patient care and operational efficiencies. This work aligns with AONL's call for shared leadership and continuous learning, and with *Essentials* Domain 6, interprofessional partnerships, and Domain 7, systems-based practice.

Partnership In Action

Case Model 5: Tiered Doctor of Nursing Practice (DNP) Project Model

The University of Kentucky College of Nursing partnered with Norton Healthcare to create a tiered model for DNP projects. Faculty, clinical mentors, and practice leaders aligned learner projects with

the health system's strategic goals and built a structure where each new cohort of learners expanded on the work of the previous one.

Faculty advisors helped learners refine project ideas and connect them to theory and system priorities. Committees of faculty and clinical mentors supported each project, while nursing leaders from the practice partner reviewed outcomes and selected projects for continuation by future cohorts. This approach kept projects moving forward, deepened their impact, and reduced duplication of effort.

By engaging learners in a sequential process, the partnership sustained momentum for change, gave learners hands-on experience with systems-level problem-solving, and strengthened collaboration between the nursing school and the health system. Outcomes included measurable improvements in patient and system performance, stronger practice scholarship, and an enhanced DNP program overall. The partnership also resulted in an offering of four DNP specialty tracks which met the needs of the healthcare system and resulted in over 100 DNP graduates within a five-year period, many of which now hold leadership positions within the nine hospital organizations.

Strategy 4: Building and Sustaining the Nursing Workforce

Partnerships are aligning nursing education with workforce needs by co-creating programs that recruit, educate, retain, and develop clinicians. Initiatives include innovation-focused fellowships, clinical placements, updated curricula, and career pathways that strengthen both academic programs and health systems. Through this work, learners are better prepared for real-world practice, while practice partners strengthen and sustain a skilled nursing workforce.

These efforts reflect AONL's call for shared leadership and continuous learning, and AACN's *Essentials* Domain 7 systems-based practice, and Domain 10, personal, professional, and leadership development.

Partnerships In Action

Case Model 6: Digital Health Innovation Residency

Using frameworks from the Agency for Healthcare Research and Quality (AHRQ) Digital Healthcare Research Program (Valdez et al., 2024), nursing schools and practice organizations have created Digital

Health Innovation Residencies to prepare nurses to integrate new technologies safely and equitably into care.

The University of Washington's Digital Health Innovation Hub offers an immersive infrastructure that enables nursing faculty, learners, and clinical partners to collaborate with engineers, data scientists, and IT specialists. Residents co-design digital health solutions to address pressing care challenges, test prototypes in simulation, and implement them in clinical settings. Projects have included AI-supported decision support, virtual care pathways, and equity-driven redesigns of digital interfaces. This model prepares nurses for real-world practice by giving them experience applying new digital tools to improve patient care and safety.

Case Model 7: AI-Enhanced Emergency Department Triage

The University of Florida developed a machine learning–based clinical decision support tool that analyzes electronic health record data, vital signs, and patient-reported symptoms to generate real-time triage risk scores. An AHRQ-funded project, the tool enables emergency department nurses to quickly and accurately identify high-acuity patients. Residency participants could contribute to refining AI algorithms, implementing human factors principles to enhance usability, and leading deployment across diverse clinical settings. Reported benefits include improved triage accuracy, reduced wait times for critical patients, and strengthened nurse confidence in high-pressure decision-making.

Key Takeaways: Conditions That Enable Innovation in Academic–Practice Partnerships

Across case examples, the following lessons emerge:

- First, organizations must be ready. Before formalizing any collaboration, potential partners should also assess their organizational readiness. This includes evaluating preceptors' availability, faculty support, and infrastructure for joint initiatives. As Sherman et al. (2016) point out, groundwork must be in place to support ongoing engagement.
- Reputation matters. A history of collaboration or a reputation for excellence can be a valuable indicator of a potential partner's suitability. Organizations with strong clinical outcomes, a culture

of innovation, and a commitment to staff development are more likely to bring stability and credibility to the partnership.

- Operational fit matters. Ultimately, geographic and operational factors—such as proximity, scheduling flexibility, and technology compatibility—can either facilitate or hinder the implementation process. Reducing logistical obstacles enables partners to concentrate on the strategic and educational objectives at the core of the partnership.
- Alignment and leadership sustain partnerships. Shared priorities, mission, and values give partners a basis for mutual respect and a sense of direction. Leaders at the executive, faculty, and unit levels shape how that alignment plays out through organization, openness to feedback, and steady communication that builds trust. Successful partnerships co-establish measurable objectives and commit to regularly assessing progress.

Practical First Steps and Best Practices

Leaders should take the following steps to launch, manage, and sustain an innovative academic–practice partnership.

1. **Initiate the partnership:** Senior leaders such as associate deans, deans, chief nursing officers and other executive leaders should meet early to shape the vision, allocate resources, and model commitment. These conversations establish trust and align strategic priorities across both institutions.
2. **Define a shared vision:** A central focus of these early engagements should be co-creating a shared vision. Leaders must understand each organization's mission, goals, and challenges, and then collaboratively identify where those aims intersect. This shared vision serves as the guiding framework for all future initiatives, ensuring that the partnership remains focused and mutually beneficial over time.
3. **Engage stakeholders continuously:** Leaders should hold regular, structured meetings to maintain momentum, track progress, and address issues as they arise. They can use these sessions to reassess goals, align priorities, and adapt the partnership to changes in academic and practice settings. During these meetings, leaders should engage frontline staff and faculty early on, and continue to include them in planning and implementation discussions. This ensures that those who are closest to the work are heard and empowered.
4. **Establish shared measures and formal agreements:** Academic and health system leaders should agree on shared measures of success—such as learner readiness, workforce retention, or quality outcomes—so they can guide decisions and track the partnership's impact. Formalizing the

partnership through a Memorandum of Understanding defines roles, responsibilities, resource commitments, and outcome metrics, and serves as a reference point when challenges arise. Senior leaders such as the dean and chief nursing officer should draft the MOU with support from each institution's legal or contracts office.

Academic and practice leaders who oversee the partnership—such as program directors, nursing directors, or associate deans—may find that conducting regular performance reviews together help keep the partnership aligned with its original goals. *Note: A sample MOU that illustrates how partners formalize workforce education collaborations is provided in Appendix R: Workforce Education Tuition Partnership MOU.*

5. **Pilot and scale innovations:** Faculty, clinical leaders, and frontline staff can test innovations on a small scale before implementing them broadly. Pilots show what works and what doesn't, letting participants improve ideas and expand the successful ones without disrupting daily work.
6. **Integrate the partnership into core plans and budgets:** Partnerships can lose momentum when they hinge on one or two leaders. To keep them strong, partner organizations should embed the work into their budgets and strategic plans, so the collaboration continues even as leadership changes.

Conclusion

Academic and practice leaders can fast-track and systematize innovation by co-designing care models, integrating new digital tools across curriculum and workflows, and translating evidence into practice. By setting shared measures, piloting and scaling what works, and embedding the work in budgets, MOUs, and routine operations, partners can collaborate to improve care delivery and to develop a prepared workforce.

Supplementary Resources and Appendices

Additional foundational materials can be found under "Chapter 4: Innovation in Academic-Practice Partnerships" at the end of this Playbook. This section includes the following resources that complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix Q: Sample Community-Based Care Partnership MOU**
  This MOU establishes a partnership to provide free mobile health and wellness services to

underserved populations. It details each party's responsibilities, insurance and liability requirements, logistics, and compliance with relevant laws and regulations.

- **Appendix R: Sample Workforce Education Tuition Partnership**
  This agreement establishes a partnership between a health organization and an educational institution to offer workforce scholarships for nursing programs.

Chapter 5

Partnerships Focused on Advancing Nursing Science

Better care begins with nursing science. Nursing science is a dynamic and evolving discipline rooted in scholarship, in which nurse scientists, faculty, learners, and clinicians conduct research, apply evidence-based practice, lead quality improvement, and drive innovation. Their research ultimately strengthens care delivery and improves outcomes (AACN, 2024; American Nurses Association [ANA], 2023).

Academic–practice partnerships are central to this work. They provide a bridge for academic and practice leaders to connect classrooms, laboratories, and care environments, and empower partners to create, test and implement interventions in real-world settings.

While such partnerships once focused solely on placing learners in practice settings to complete their clinical training, they have since evolved so that academic and practice partners now share expertise, and jointly conduct research and implement evidence-based interventions, with students contributing as active learners and participants in real care environments (AACN, 2024; AONL, 2022). Today's partnerships offer a platform for designing, testing, and translating evidence-informed interventions in real-world settings (AACN/AONL, 2023), building the shared structures that support implementation studies, quality initiatives, and system-level change.

By examining past and present models of academic–practice partnerships, this chapter examines how academic and practice leaders can strengthen future collaborations and advance nursing science.

Frameworks and Foundations for Collaboration

Strong academic practice partnerships start with clear frameworks and committed leadership. These foundations make it possible for partners to ensure that academic inquiry informs clinical practice and clinical experience shapes scholarship.

The following proven models guide integration of research, EBP, and QI in academic and practice settings.

1. **Translational Science Model:** Researchers, educators, and clinicians use the Translational Science Model as a framework to carry findings from studies into clinical care (NCATS, 2023). Often called "bench to bedside," nurse scientists, faculty, and health system leaders apply this approach to test evidence outside research settings and integrate it into practice (Melnyk & Fineout-Overholt, 2023; Titler, 2018).

   Within this framework, academic researchers design and evaluate interventions; nurse educators introduce evidence to learners and clinicians; frontline nurses and interprofessional teams adapt interventions to unit routines and patient needs; and health system leaders support adoption by incorporating effective practices into training, guidelines, and policy.

   At Baltimore, Maryland-based Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, two academic medical centers affiliated with Johns Hopkins University School of Medicine, academic and practice partners formed the Delirium Consortium to coordinate prevention and treatment across two hospitals. Nurse leaders brought together colleagues from medicine, nursing, rehabilitation therapy, psychology, and pharmacy to align research and practice. Together, they developed protocols for early mobilization and orientation, trained staff to implement them, and refined the protocols based on feedback from clinicians. In embedding these practices across units, the consortium demonstrated how nurses and other team members adapted protocols to fit unit culture and workflow (Neufeld et al., 2011; AACN/AONL, 2023).

   For academic–practice partners, the Translational Science Model highlights the need for leaders to support environments where practice-based questions guide inquiry, teams test evidence in real

care settings, and cross-disciplinary collaboration shapes knowledge that directly informs patient care.

2. **Advancing Research and Clinical Practice through Close Collaboration (ARCC Model):** The ARCC Model provides a system-wide framework for implementing and sustaining EBP in practice environments (Melnyk et al., 2021). The model centers on assessing organizational culture and readiness for EBP and building a critical mass of mentors who work directly with point-of-care clinicians to facilitate the use of evidence-based care. A distinctive feature of ARCC is its application of cognitive-behavioral theory to address clinicians' beliefs and attitudes about EBP, which influence adoption and sustainability (Gallagher-Ford & Caramanica, 2022; Melnyk et al., 2017).

   At the Ohio State University Wexner Medical Center, leaders applied the ARCC Model to strengthen EBP culture. They developed a cohort of EBP mentors and integrated them into practice environments, which was associated with improved EBP competencies, greater staff participation in quality improvement, and gains in patient safety outcomes (Melnyk et al., 2021).

   This shared preparation and implementation give academic–practice partners a structure for sustaining evidence-based care.

3. **Iowa Model of Evidence-Based Practice:** The Iowa Model of Evidence-Based Practice empowers nurses and interprofessional teams to systematically apply findings from studies, clinical guidelines, and quality data (Iowa Model Collaborative, 2017) in their care. Clinicians identify triggers for change, such as new national guidelines, safety concerns, or strong research findings, and then decide whether the issue is a priority for their setting. If it is, they gather and appraise the quality and consistency of the available evidence, determine whether it is strong enough to guide practice, determine whether it is strong enough to guide practice, and pilot specific changes. For example, changes may include new protocols to prevent falls or pressure injuries. Teams then evaluate patient outcomes and, if successful, implement the practice more widely.

   Academic and practice partners often use the Iowa Model to influence interprofessional collaboration. At the University of Iowa Hospitals and Clinics, nursing faculty and health system leaders guided DNP students to design projects that addressed the health system's highest priorities, including preventing patient falls and pressure injuries, which improved outcomes (Iowa Model Collaborative, 2017). Participants value the Iowa Model because it allows them to adapt evidence-based interventions to the needs of a specific unit or practice environment while

maintaining methodological rigor. Because of this adaptability, academic–practice partnerships across the country have adopted the model to strengthen the evidence-to-practice pipeline and support a culture of continuous improvement.

4. **Promoting Action on Research Implementation in Health Services (PARIHS Framework):** The PARIHS Framework is a widely recognized model that conceptualizes successful implementation of evidence-based practice as a function of the interaction among three key components: evidence, context, and facilitation (Kitson et al., 1998). Developed in the late 1990s, this framework moves beyond linear models of change and instead embraces the complex, dynamic nature of translating research into clinical practice. Within this model:
    a. Evidence is broadly defined to include not only research but also clinical experience, patient preferences, and local data.
    b. Context refers to the environment or setting in which the change is implemented, including leadership, culture, and evaluation mechanisms.
    c. Facilitation involves the process of enabling individuals and teams to understand and apply evidence in practice, typically led by skilled change agents or facilitators (Harvey & Kitson, 2016).

    Researchers have applied PARIHS widely in hospitals, community care, primary health, and home settings, using it to plan projects, analyze data, and evaluate outcomes (Bergström et al., 2020). Facilitators in these studies often used education, reminders, audits, and team learning, though authors also noted the need for clearer tools to guide facilitation (Bergström et al., 2020). The framework later evolved into i-PARIHS, which emphasizes four elements—Innovation, Recipients, Context, and Facilitation—and provides a clearer structure for tailoring strategies across settings (Harvey & Kitson, 2016; Elam et al., 2022; Wang et al., 2024).
5. **The Center for Clinical Inquiry™ Model:** In academic–practice partnerships, faculty, learners, and health system leaders use theory to shape education, guide care delivery, and connect research to measurable results. Applying theory in practice advances nursing science, improves consistency in care, and supports lasting change (Meleis, 2018; Wei & Horton-Deutsch, 2022; White et al., 2019).

    Summa Health, a large health system in Ohio, created the Center for Clinical Inquiry™ Model in 2022. The model builds on Convergent Care Theory, which emphasizes collaboration, provider well-being, and patient-centered care supported by technology (Wei, 2022). The model moves teams through three steps: Inquire, as nurses and educators identify practice problems and review the evidence; Implement, as leaders and frontline staff integrate the evidence into daily workflows; and Sustain, as executives track outcomes and involve staff in planning to ensure changes last

(Gorsuch & Boss, 2024).

Summa Health introduced the model in three phases. In Phase 1, executive and nursing leaders created new roles such as senior directors of evidence-based practice, nurse educators, and clinical nurse specialists. These leaders also launched resources for staff, including a searchable repository of best practices and an internal website for the Center for Clinical Inquiry. In Phase 2, nursing executives aligned departments, emphasized human-centered leadership, and introduced communication campaigns such as "Campaign the Change" to engage clinicians and staff across the system. In Phase 3, executives and managers embedded the work into the culture by auditing outcomes, prioritizing evidence at the executive level, and holding planning sessions where more than 2,500 nurses generated 43 actionable themes. More than 200 staff members also completed training in evidence-based methods.

The results were substantial. One-year nurse turnover decreased from 22.14% to 10.42%, compared with the national average of 34.16%. By retaining nurses, the health system avoided $10.1 million in costs and saved an additional $22 million through reduced agency staffing, with a projected financial impact of $44 million by 2024. Patient outcomes also improved, including lower infection rates and a Leapfrog Hospital Safety Grade increase from C to B. Staff expanded their scholarly contributions with 42 dissemination activities, including presentations, peer-reviewed publications, and webinars.

Models of Academic–Practice Partnerships

Although academic-practice partnerships take many forms, their purpose is to generate value for both partners by advancing nursing knowledge and improving care. The following examples show various ways organizations can structure and sustain research centered and EBP and QI-focused partnerships.

Funded research programs take time and resources to create and sustain, but the following approaches can support and even fast-track these efforts:

Case Model 1: Investing in Joint Research and EBP Faculty and Leadership Appointments

When faculty shortages make it difficult to fund positions supporting EBP and research, it's important

to consider cost-sharing opportunities that also align efforts between academia and practice. An example is a research faculty member within a college of nursing who is also appointed to oversee nursing research efforts in the practice setting.

Consider the example of a small, private, college that partnered with a medical school with significant research infrastructure to strengthen interprofessional research capacity by advancing nursing research development. The college and medical school identified a physician faculty member with excellent funding history and the college bought out a portion of his time to serve as the associate dean of research at the college of nursing. At Barnes-Jewish College Goldfarb School of Nursing (Goldfarb) and Barnes-Jewish Hospital (BJH), leaders strengthened research capacity by creating a joint faculty role. The PhD program director, an experienced nurse researcher, holds a dual appointment as program director at Goldfarb and nurse researcher at BJH. Reporting to the Goldfarb dean for PhD programming and the BJH chief nursing officer for clinical research, the director advances scholarship across both organizations.

In this role, the director serves as faculty in the PhD program, mentors PhD and Doctor of Nursing Practice students through BJH scholarly projects, and advises nurses on abstract and manuscript preparation. The director also consults with clinical teams on topics including pressure injuries, catheter-associated urinary tract infections, central line–associated bloodstream infections, and airway safety. To support career advancement, the director collaborates on evidence-based practice and research education, develops online courses and a career ladder overview for nursing division leaders and educators, and reviews research and career ladder projects.

The director promotes dissemination of findings by supporting research presentations at Goldfarb and BJH conferences, presenting best practices in programs open to BJC nurses, and representing both institutions in professional organizations. The director also serves as a bridge between Goldfarb and the BJC HealthCare system; keeps learners and faculty informed about hospital initiatives that influence education and research, ensuring that academic efforts align with clinical priorities; and helps learners connect with BJH and BJC leaders, expanding opportunities for mentorship, collaboration, and career development. In addition, the director advises on evaluations of joint initiatives such as the BJC Full Ride Scholar Program. The director represents Goldfarb and BJH on the BJC quality and safety hub team and serves as an institutional review board member, keeping both

organizations apprised of research updates. As an active investigator, the director also conducts clinical research in the hospital, ensuring that academic and practice partners collaborate on studies that improve patient care and nursing career development.

See the following appendices for more information:

- *Appendix S*: *Proposed Collaborative Agreement for Research/Scholarly Project Collaboration*
  Appendix T: Sample MOU for Associate Dean of Research for a full template
- *Appendix U: Sample MOU for Joint Faculty Appointments for a full template*
- *Appendix V: Sample MOU for Joint PhD Programs for a full template*

Case Model 2: Building Joint Research Centers

Academic and practice leaders can create joint research centers to pool funding, align priorities, and build highly productive partnerships. For example, leaders at The Ohio State University College of Nursing and The Ohio State University Wexner Medical Center created a joint research center to advance evidence-based practice and improve patient outcomes and nursing workflow. Academic partners appointed a nurse scientist to work in both settings, and together with practice partners they engaged clinical nurse specialists and frontline nurses to design and test protocols. Using the medical center's research infrastructure, they conducted observational studies and clinical trials on continuous glucose monitoring, measuring outcomes such as glycemic control, the amount of personal protective equipment required, and time nurses spent checking glucose levels. Partners trained more than 150 ICU nurses, implemented the practice across all ICUs, and produced evidence that shaped national consensus statements and guidelines. Their work reduced nursing burden, improved patient outcomes, and earned the ANCC Magnet Prize®, positioning the center as a national model for translating research into routine care.

Case Model 3: Linking Research and Magnet Designation

Practice partners can strengthen their ANCC Magnet Program® designation when they involve nurses and other staff in research and evidence-based practice projects. Magnet® recognition identifies

hospitals as centers of nursing excellence, acknowledging organizations that demonstrate exceptional performance in areas such as clinical practice, leadership, professional development, and nursing innovation (American Nurses Credentialing Center [ANCC], n.d.). Partnerships with schools of nursing formalize these opportunities and create clear pathways for bedside staff to participate in scholarly inquiry. *Note: See Appendix W: Magnet Nursing Research Readiness Checklist for a full template.*

Applied Partnership Models

The following models demonstrate different ways that leaders embed research into practice, create structures for nurse engagement, and sustain nursing science through academic–practice partnerships.

Case Model 4: Embedding Nurse Scientists to Integrate Research and Practice

At the University of Alabama at Birmingham, School of Nursing and Medicine, leaders embedded a nurse scientist role to connect research, quality improvement, and education across institutions. By integrating academic research with clinical teams, they reduced hospital-acquired pressure injuries from nearly 2,000 per year to fewer than 10 each month. Research also drove the creation of permanent heart failure and diabetes clinics that now sustain evidence-based care.

The impact extends into education and workforce development. A year-long study of the nurse–patient–care technician model produced two published papers, and a DNP student now applies those findings across multiple units. Studies on nurse burnout informed a redesign of role-based care models, while research on neurology provider shortages led to new training for specialized nurse practitioners.
An executive committee meets monthly to track outcomes and retention, ensuring accountability. Leaders plan to leverage this success to secure funding for additional nurse scientist positions, expanding the reach of research-driven care.

Case Model 5: Fellowship Model for Clinical Nurse Research Engagement

Through the Linking Infrastructure for Nurses' Knowledge (LINK) Program, New York–Presbyterian

Hospital and Columbia University established a two-year fellowship that trains bedside nurses to conduct research while continuing in practice. Of the 33 graduates, one-quarter have advanced into doctoral programs. Fellows' work has led to peer-reviewed publications, policy changes, and recognition as an American Academy of Nursing Edge Runner.

Nurse scientists in the program act as bridges between academia and practice, helping identify pressing clinical needs. A COVID-19 workforce study conducted by fellows has been cited in more than 1,000 research papers, underscoring the program's influence.

The program also creates pathways for engagement: clinical teams propose research questions through workshops, lectures, and unit councils. Weekly meetings between research and clinical leaders ensure alignment, while strong executive sponsorship positions the hospital as a living research laboratory.

Service-Specific Nurse Scientist Model

In a partnership between the UK HealthCare and the University of Kentucky College of Nursing, partners deployed service-specific nurse scientists to mentor clinical nurses and lead both quality improvement and Institutional Review Board-approved (IRB) research projects. In 2023–2024, the ambulatory nurse scientist supported more than 30 national conference presentations and contributed to three journal articles.

Nurse scientists facilitate staff-led studies and extend their roles into education, where clinical nurses serve as instructors to integrate practice-based insights into coursework. The partnership also tracks research outcomes alongside workforce development results, using findings to inform program redesigns. For example, feedback from learners about the externship experience led to structural changes that improved both learning and patient care.

Sustaining Partnerships Through Evidence and Evaluation

Practical Lessons for Long-Term Success

The previous exemplars show that successful partnerships require flexibility, mutual respect, and a shared vision. Beyond those experiences, the literature offers additional recommendations for sustaining academic–practice partnerships:

- Clear communication keeps partners aligned day-to-day, and leadership buy-in provides the authority and resources to move initiatives forward (Otts et al., 2024).
- Research also highlights the importance of formal agreements, such as memoranda of understanding developed after a needs assessment—and regular joint meetings. These practices strengthen accountability and adaptability.
- Partners further improve outcomes when they align technology infrastructure early and embed evaluation mechanisms from the start, making it easier to incorporate real-time feedback and continuous development (Otts et al., 2024).

Measuring Partnership Impact

Partners can measure the impact of their collaboration through quantitative and qualitative assessments. Partnerships demonstrate value when they can measure both outcomes and impact. Strong evaluation approaches combine quantitative and qualitative measures:

- Quantitative metrics capture scholarly outputs (e.g., joint publications, funded research, learner placements) and practice outcomes (e.g., nurse retention, transition into practice, improvements in nursing-sensitive quality metrics, compliance with standards) (Davis et al., 2019; Halili et al., 2023; McConkey et al., 2023; Shepard-Battle et al., 2018). For example, during the COVID-19 pandemic, one academic-practice partnership launched a nurse-led call center that reduced unnecessary emergency department visits and improved parental satisfaction by providing timely guidance, helping ease nurse workloads while maintaining continuity of care (Gustin et al., 2024).
- Qualitative measures assess stakeholder satisfaction, the perceived value of the partnership, and the strength of interprofessional collaboration. Leaders also look for evidence of sustained engagement, mutual growth, and adaptability to new practice needs. Ultimately, a partnership is successful when it achieves its stated objectives and continues to evolve in response to future challenges in nursing education, practice, research, and policy (Albert et al., 2022; McConkey et al., 2023).

Building Governance for Sustainable Partnerships

Without clear governance structures, collaborations can drift, depend too heavily on individual champions, or collapse when leadership changes. Governance provides accountability, continuity, and a shared decision-making process that allows academic and practice partners to pursue nursing science together in a way that endures. The following strategies can help leaders to translate governance from an abstract principle into concrete practices that sustain academic–practice partnerships:

- **Design Structures to Fit the Partnership:** Governance in academic–practice partnerships is not one-size-fits-all. Each organization brings its own culture, priorities, and resources, which means partners must design structures that reflect their specific context. In some settings, this may take the form of standing committees or joint steering groups; in others, less formal mechanisms may be more effective. What matters is that the structure provides clarity about decision-making, accountability, and how resources will be shared, so the partnership can function consistently even as circumstances change.
- **Formalize Agreements for Clarity:** Formalization is often an early step toward stability. Academic and practice leaders set clear roles and responsibilities, then capture them in memoranda of understanding, financial agreements, or other binding documents. These agreements help partners move from informal collaboration to a structured, accountable relationship that can pursue shared research goals and strategic plans (Brooks Carthon et al., 2017).
- **Plan for Sustainability:** Leaders strengthen long-term partnerships by sharing responsibility, risk, and reward, and by planning for leadership succession to reduce reliance on individual champions. Ongoing evaluation, continuous learning, and flexibility allow the partnership to adapt to changing environments, ensuring that nursing science initiatives remain relevant and effective over time (Breslin et al., 2011).
- **Strengthen Governance Through Leadership and Succession:** Senior leaders sustain governance by setting direction, securing resources, and ensuring accountability. They work through joint governance councils to set, revise, and share the strategic vision for nursing science in line with each organization's policies, mission, and values. Because nursing leadership turnover is high, senior leaders should also build succession plans for both academic and clinical roles to ensure continuity.
- **Build Ownership Through Shared Decision-Making:** Academic and practice leaders align goals and policies through shared decision-making. Joint governance councils or nursing science committees give leaders and stakeholders a voice in decisions and ensure shared ownership of outcomes. This foundation enables faculty and clinical nurses to co-develop and co-lead

scholarship initiatives, integrating both educational and clinical perspectives. Nurse scientists and directors of nursing research in both academic and clinical settings, along with multi-level committees, add expertise and broaden engagement. Their participation helps scholarship grow within each organization and sustains long-term progress (Baptiste, Whalen, & Goodwin, 2021; Breslin et al., 2011).

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- **Sustain Progress by Sharing Resources:** Academic and practice leaders also sustain partnerships by pooling resources. They co-fund joint appointments, support faculty scholarship, and invest in research infrastructure such as seed grants and evidence-based practice centers. They also extend funding by leveraging grants, endowments, and state initiatives. For example, Maryland's Nurse Support Program, the University of Maryland's Dean's Scholars, and joint UMNursing seed grants have sustained UMNursing for 17 years.

Guiding Questions for Leaders

To ensure partnerships reach their full potential, leaders should ask:

- Are partnerships structured and governed in alignment with the mission, vision, and values of both organizations?
- What common structures, processes, and outcomes are needed to meet shared goals?
- How can partners share high-cost resources such as joint faculty positions, research centers, or workforce development programs?
- What strategies ensure all partners are empowered and none marginalized?
- How can partners share risks equitably, such as through joint IRBs or workload distribution on grants?
- Which internal and external leaders must advocate for the partnership to strengthen its authority and legitimacy?

Addressing Challenges that Undermine Partnerships

Partners can overcome common barriers to teamwork by creating a shared culture, protecting time and resources, addressing logistical hurdles, and planning creative funding strategies. The best solutions are intentional, collaborative, and tailored to local contexts.

Barrier A: Institutional Silos and Cultural Disconnects

Silos between academia and practice often slow progress. Gaps in communication, limited commitment, and external pressures—such as staffing shortages and financial strain—weaken collaboration. In some partnerships, individual champions drive the work, but without formal structures or institutional support, their efforts are difficult to sustain. (Albert et al., 2022).

Potential Solutions:

- Build a shared nursing culture of inquiry. Use models such as the ARCC (Melnyk et al., 2021) to demystify scholarship and strengthen relationships.
- Invest in intentional team building. Encourage early, open discussions about roles, leadership, time commitments, and conflict management (Bacon & Jenkins, 2023; Rothenberg et al., 2025).
- Create and commit to a shared vision. Align on system values or a focused clinical priority (Bacon & Jenkins, 2023).
- Leverage external programs. Initiatives such as the Magnet Recognition Program® and The Beacon Award for Excellence can reinforce excellence, collaboration, and scholarship.

Barrier B: Time and Workload Constraints

High workload and staffing pressures make it difficult for academic and practice leaders to prioritize partnership activities. Without protected time, partnerships can feel optional, leading to weak commitments and reinforcing negative stereotypes.

Potential Solutions:

- Develop innovative compensation models, which may use startup seed money, faculty buy-outs, or the updating of job descriptions so roles such as mentoring, teaching, or leading joint research are recognized as official responsibilities (Otts et al., 2024).
- Create joint appointment contracts. These roles balance financial and scheduling demands while embedding leaders in both institutions.

- Launch research affiliate programs. Unpaid pathways can formalize collaborations, provide access to resources, and demonstrate institutional commitment, as seen at Mayo Clinic (Mayo Clinic Health System, n.d.).

Barrier C: Institutional Review Board, Data Sharing, and Intellectual Property

Complex requirements for IRB approval, data sharing, and intellectual property slow down collaborative scholarship, especially with digital health information.

Potential Solutions:

- Strengthen IRB collaboration. Involve IRB representatives early and use shared forums or newsletters to clarify processes.
- Establish data-sharing agreements. Formalize processes that allow secure, timely access to needed data. *For an example of such an agreement, see: Appendix X: Data-Sharing Agreement Example*.
- Include legal and informatics teams. Engage them from the start to anticipate and resolve barriers.
- Integrate cyber analysis. Build cybersecurity into all projects to safeguard protected health information, ensure compliance, and strengthen trust.

Barrier D: Lack of Sustainable Funding

Securing funding remains one of the toughest challenges, particularly for sustaining long-term partnerships.

Potential Solutions:

- Capitalize on existing programs. Federally Qualified Health Centers (FQHC) can serve as collaborative funding platforms.
- Start small. Seed grants, foundation funds, and professional organizations provide entry points for early projects.
- Build funding into the collaboration. Some programs—such as Maryland's Nurse Support Program—provide dedicated support. Others were created around funding sources.

Supplementary Resources and Appendices

Additional foundational materials can be found under "Chapter 5: Partnerships Focused on Advancing Nursing Science" at the end of this Playbook. This section includes the following resources that

complement the concepts introduced here and provide detailed guidance for planning, implementing, and evaluating academic–practice partnerships:

- **Appendix S: Proposed Collaborative Agreement for Research/Scholarly Collaboration**
  An agreement that outlines the structure and collaborative expectations for conducting a research or scholarly project among multiple organizations.
- **Appendix T: Sample MOU for Associate Dean of Research**
  This agreement outlines the sharing of a faculty (from college of medicine) for the role of Associate Dean of Research, specifying responsibilities, compensation, and duties focused on research leadership interprofessional collaboration.
- **Appendix U: Sample MOU for Joint Faculty Appointments**
  An MOU that establishes a joint appointment for a faculty member between a school of medicine and a school of nursing, detailing responsibilities, financial arrangements, and terms for collaboration.
- **Appendix V: Sample MOU for Joint PhD Programs**
  An MOU that establishes a joint PhD in Nursing Science program between a school of nursing and a school of medicine, detailing shared responsibilities for admissions, curriculum, advising, and graduation processes to prepare nurse scientists for research careers.
- **Appendix W: Magnet Nursing Research Readiness Checklist**
  This checklist outlines the critical criteria for Magnet nursing research readiness, including nurse involvement in research, institutional support, and alignment with Magnet goals.
- **Appendix X: Data-Sharing Agreement Example**
  This template outlines requirements and procedures for managing, sharing, and preserving scientific data to ensure transparency and accessibility for research projects.

Cross-Cutting Themes and Lessons Learned

Academic and practice leaders who successfully build sustainable partnerships share common approaches, regardless of their specific focus areas. These partnerships require intentional relationship-building, aligned governance structures, and commitment to shared outcomes that benefit learners, faculty, staff, and the communities they serve.

- **Success hinges on early alignment and sustained commitment:** Partners who co-develop shared visions, establish clear roles, and embed collaboration into their strategic plans create foundations that survive leadership transitions and budget pressures. Leaders must invest time upfront to assess organizational readiness, negotiate resource commitments, and design governance structures that support joint decision-making.
- **Collaborators address known barriers proactively:** When leaders anticipate and resolve challenges around faculty workload, clinical placement capacity, funding sustainability, and more, they can strengthen collaboration. Partners who protect time for coordination, create joint appointment structures and establish shared evaluation systems position their initiatives for long-term success.
- **Partners systematically track outcomes:** When academic-practice partners track both

quantitative outcomes—such as learner readiness, retention rates, and quality metrics—and qualitative indicators including stakeholder satisfaction and partnership durability; they create feedback loops that strengthen partnerships over time. Partners who regularly monitor their work can systematically adapt their approaches, demonstrate value, and secure ongoing support.

- **Partnerships also remain dynamic:** Leaders who build in quality checks, facilitate ongoing conversations, and commit to continuous improvement ensure that these collaborations evolve alongside the health care system. Systematic outcome tracking, including quantitative metrics such as learner readiness and retention rates and qualitative indicators like stakeholder satisfaction, creates feedback loops that demonstrate value and secure ongoing support.

In sum, academic–practice partnerships succeed when leaders share accountability, respect each other's expertise, and treat the collaboration as a living system that grows and adapts over time. By fostering these relationships, nursing leaders not only strengthen education and practice environments but also shape the future of the profession and improve care delivery for all communities.

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Appendices

Chapter 3, cont.

Chapter 4: Innovation in Academic-Practice Partnerships

Chapter 5: Partnerships Focused on Advancing Nursing Science

Appendix A: Academic-Practice Partnerships Implementation Tool Kit

The information below should be used alongside Appendix A: Academic-Practice Partnerships Partnership Expectation and Outcome Matrix: Step-by-Step Planning Tool.

Players

A: Selecting Partners

1. How do you identify your partners?
    a. If you are a dean in an academic health center, you have many well established potential partners in the schools of medicine, pharmacy, business, and allied health. If you are a dean or director in a school or department of nursing that is not in an academic health center, are there schools of medicine, pharmacy, etc in your city or surrounding area that you could partner with? You should think about what partnerships do you want to expand around a focused area of interest.
2. Why is this partner a good fit?
    a. Does your potential partner understand your programs, your goals, your vision? Do you have a common ground and shared vision? Is this partner approachable and available? Have you tried to reach out to this partner?
3. How do you approach your potential partner? How do you make the appointment with the right person? Who is the right person?
    a. The first step is finding out who the right contact person is. Use your networks to collect this information. Then, pick up the phone or send an email. Be clear on why you are contacting the potential partner.

B: Preparing for Your First Meeting

1. Where do you meet?
    a. Offer to host the first meeting… but basically meet wherever is most convenient for your potential partner.
2. What do you need to know about your potential partner and his or her organization? What does your partner need to know about you and your organization?
    a. Be sure to come prepared having read anything you can on your potential partner and organization to assess a fit for partnership and shared vision. Bring information about your organization with you to the first meeting. Think in advance about your vision and goals for the partnership and what you bring to the table. Think about what your potential partner brings to the partnership in advance.

Partnership Activities

A: Initial Meeting

1. What is the right partnership activity for you and your partner?
    a. There may be many possibilities for partnership initiatives. Which ones fit into your strategic plan? What are your priorities? What are your strengths that would augment the partnership?
2. What documents about your organization might be helpful to bring to the first meeting?
    a. Some relevant documents may be your strategic plan, curriculum, list of faculty and staff roles, accomplishments and ongoing projects.

3. What do you have to offer?
    a. This could include faculty and staff expertise, an established curriculum, a grant writer, budget assistance, track record in publication, contacts/networks.
4. What is the mutual benefit?
    a. Identify what you want to accomplish for your strategic vision and what might be of benefit to the partner. This could be joint programming, clinical experiences, leadership opportunities, professional development, or a larger scale organizational commitment.
5. What is your vision?
    a. Be sure to identify this before the first meeting and be able to clearly communicate this.
6. Does your potential partner share this vision?
    a. Ask this question directly. If the answer is no, address related possibilities for partnership or decide that the partnership would not be strategic at this time.
7. What is the potential initiative/activity and who else needs to be involved in both organizations?
    a. Have some initial ideas before the first meeting. Be prepared to brainstorm, prioritize, and compromise.
8. Who is the top leadership in the organization? Are you talking to them?
    a. Be sure to be talking to the person in the organization who is the decision maker. If at the first meeting, you determine that the person with whom you are speaking is not the decision maker, ask for guidance on who this person may be.
9. What is the business case for the partnership?
    a. Once you decide together on the inter-professional initiative, together discuss the ROI. Determine how much the initiative will cost each organization and what the return on investment is for each partner. Determine whether or not there is financial value to each partner. If not… abort the plan and start over.
10. What are the next steps? Do you have a timeline established at the end of the first meeting?
    a. Identify these together with your partner before you leave the first meeting. Write them down!
11. Be sure to send a thank you note with next steps delineated.
    a. One good next step is to begin to draft a memorandum of understanding where you articulate the shared goals and vision as well as potential partnership activities. Be clear on who is responsible for what and how costs will be shared. Another idea is to spend some time getting to know your partner personally. Partnerships based on personal relationships ten to thrive due to shared commitments on many levels. Share a dinner or lunch to discuss next steps.

B: Subsequent Meetings

1. Do you have clarity on goals and vision?
    a. Are your goals written and clearly defined?
2. What are the details and timeline of the initiative?
    a. Do you have clarity and mutual understanding?
3. What resources are needed?
    a. Who will provide them? Are the resources shared?
4. Whom can we call for expert consultation if need be?
    a. Will there be an official MOU?
5. What are the expected outcomes of the activity?
    a. How will they be evaluated? How will results be disseminated? What is the order of authorship?

Environment

A: Time

1. Is this the right time for this partnership?
    a. This needs to be determined early in the discussions. Partners should determine if there are sufficient resources to support the partnership at this time.
2. What are the issues that will facilitate or impede the development of the partnership?
    a. Leadership support and a shared vision are essential to the success of the partnership. Be sure to address any historical relationship issues between the partners.
3. What is the time commitment for the partners?
    a. Create a timeline for the partnership activities and identify time needed for ongoing work. It is important that the time commitment is shared equally by both partners.
4. Whose time will be required?
    a. Break out responsibilities for those involved, so not everyone need attend every meeting. Clarify roles and link time to the role expectation and expected outcomes. Each partner should determine who on their respective teams should participate. This may be difficult for small organizations with few staff. For skilled nursing facilities it may be difficult to identify staff who can work with academe.
5. When will the meetings be scheduled? Are they on a regular basis and frequent?
    a. Distinguish between meetings that must take place to perpetuate the partnership and those ongoing meetings among the players and partnership participants. Limit meetings to an agreed upon time depending on purpose. Keep in mind that schools and health care facilities are not on the same calendar.

B: Space

1. What space is required for the activity?
    a. Explore specific needs: access to computer; alternating meeting sites, etc.
2. What equipment or supplies are needed?
    a. This will vary depending on the particulars of the partnership and the project activities.
3. What money is needed?
    a. Identify "real" versus in kind resources needed for each aspect or phase of the project/partnership. Create a business plan that addresses resources needed.
4. Where are we meeting?
    a. Alternating between partners' facilities may be ideal but not practical. The site for each meeting should be determined based on the focus of the meeting and the participants.
5. Where will we present outcomes?
    a. Present "globally" and locally—at both the school and the facility, with the partners from each organization in attendance at each presentations.

C: Regulation

1. What are the policies or regulatory issues that will impede or facilitate development of the partnership on both sides?
    a. Each partner has its own unique regulatory issues that the other may not be aware of. Share relevant policies as needed to inform practice and academic partners of the unique requirements of each.

D: Context

1. How will the partnership be funded?
    a. This must be determined early on, in the initial stages of the partnership. Discuss resources, resource sharing, in kind contributions, and potential funding opportunities. Develop a plan for funding the partnership. Depending on the nature of the partnership, consider a formal business plan.
2. What are the constraints of both partners?
    a. Identify time, space, and human resource constraints and develop strategies to address them.
3. What history do the partners have with each other and each others' institutions?
    a. Be knowledgeable about the historical and current political and personal relationship. A history of collaboration between the two organizations can go a long way in supporting the success of the project.

To view exemplars, please visit AACN's Academic-Practice Partnership page at **www.aacnnursing.org/academic-practice-partnerships**.

Appendix B: Sample Academic-Practice Partnerships Implementation Tool Kit Template

Reference this sample when developing your academic-practice partnership summary document.

PLAYERS
Selecting Partners

Academic School:	
Contact:	
Phone Number:	
E-mail Address:	

Practice Setting:	
Contact:	
Phone Number:	
E-mail Address:	

Preparing for Your First Meeting

Date/Time of Meeting:	
Place of Meeting:	

PARTNERSHIPS
Initial Meeting

What is the right partnership activity for you and your partner?

What documents about your organization should you bring to the meeting?

What do you have to offer?

What is your vision for this partnership and does your partner share this vision?

Who else needs to be involved in both organizations? Is top leadership involved?

What is the business case for the partnership?

Subsequent Meetings

Do you have clarity on goals and vision?

What are the details and time line of the initiative?

Whom can we call for expert consultation if needed?

What are the expected outcomes of the activity?

ENVIRONMENT

Time

Is this the right time for this partnership?

What are the issues that will facilitate or impede the development of the partnership?

What is the time commitment for the partners?

Whose time will be required?

When will the meetings be scheduled?

What are the expected outcomes of the activity?

Space

What space is required for the activity?

What equipment and supplies are needed?

What money is needed?

Where are we meeting?

Where will we present outcomes?

Regulation

What are the policies or regulatory issues that will impede or facilitate development of the partnership on both sides?

Context

How will the partnership be funded?

What are the constraints of both partners?

What history do the partners have with each other and each others' institutions?

Appendix C: Partnership Expectation and Outcome Metrics Worksheet Sample

This worksheet is designed to facilitate robust and effective academic-practice partnerships by providing a method to 1) establish partnership goals, 2) identify action steps for implementation by both the practice and academic partners, and 3) specify expected outcomes and their timeframe. By use of this intentional planning and evaluation process, the successes of a partnership can be documented, changes made as appropriate, follow-through assured.

Partnership Goals	Activities	Outcomes
*PP & †AP representatives mutually establish partnership goals	PP nurse liaison & designated AP faculty collaboratively plan & implement the partnership activities	PP & AP representatives mutually establish target outcome thresholds
Increase the number of well qualified new graduates seeking employment at the PP facility	Implement a partnership that enables nursing students to complete the majority of their clinical experiences at the PP facility. • Student clinical placement: ◦ PP liaison will take the lead in identifying the units for students' experiences. ◦ A cohort of students will "match" with PP; AP faculty will take the lead for student recruitment & selection. ◦ Students will be oriented to PP during their first clinical rotation. Additional aspects of orientation will be added as appropriate over the semesters with a goal that most of the new hire orientation will have been completed by the students' graduation. ◦ PP nurse liaison will take the lead in design of the orientation components. AP faculty will participate in the delivery.	__% of partnership graduates will seek employment at AP (within 6 months of graduation) __% of partnership graduates will be considered excellent candidates by nurse managers for new graduate hires at AP (at graduation) __% of those who apply will secure employment at AP (within 6 months of graduation) __% of partnership new hires that will required a reduced period of orientation as reported by the nurse education department (within 6 months of hire)

*Practice Partner
† Academic Partner

Partnership Goals	Activities	Outcomes

Increase the collaborative approach to nursing clinical education among nursing staff and faculty such that the expertise of each is effectively utilized
 	
Provide excellent clinical experiences for AP students with a focus on quality & safety
 	
Minimize the gap between AP graduates' clinical competency and the expectations for new graduate practice
	Collaborative Relationships
	• Nurses work closely with students to facilitate learning based on semester goals.
	• Nurse preceptors will partner 1:1 with students in their final semester.
	• Preceptors will be identified by PP liaisons
	  ◦ Preceptor training will be a joint effort, with the AP faculty taking the lead.
	  ◦ AP faculty will offer preceptor-training classes for PP nurses.
	• AP faculty will provide nurses and nurse managers a weekly overview of student clinical expectations & learning goals.
	• PP nurse managers will provide AP faculty & students an overview of unit priorities for nurse sensitive measure and update the as appropriate.
		__% of staff nurses accurately report that they know the AP faculty, lead faculty, and the goals for a given clinical placement (at the end of the semester)
		__% of AP clinical faculty accurately report the unit priorities for nurses and the manager regarding nurse sensitive measures (at the end of the semester)
		__% of nurses who work with PP-AP partnership students will report they would like to work with them in the future (at the end of the semester)
		__% of nurse preceptors who work with PPAP partnership students will report they would like to work with them in the future (at the end of the semester)
		__% of managers will report that they prefer to host students from the partnership program (at the end of the semester)
		__% of nurses who worked with partnership students will provide feedback on clinical assignments and curricular components re. to quality & safety (at the end of the semester)
		__% of AP faculty will make recommendations about clinical assignments and curricular components based on staff nurse feedback (at the end of the semester)

Partnership Goals	Activities	Outcomes
Facilitate student & faculty contributions to the PP interprofessional team	Establish a timeline and plan for intentional interprofessional experiences: grand rounds; post conference; student interviews.	__ # of interprofessional events/semester (yearly) __% of students will report effective interprofessional communication while at PP (at the end of the semester)
Inform the AP nursing curricula with high quality expectations of PP practice outcomes	Develop a year-long schedule for PP & AP interaction and partnership promotion. • Planned Yearly Kick-Off Events: Each year AP will host a kick-off event for PP nurses, managers, and educators and/or designated clinical liaisons. The event will allow for an overview of what to expect in the partnership and a review of the previous year's successes. • Joint PP-AP Nursing Practice Showcase: Each year the partnership will hold a showcase of innovation in nursing practice. Poster presentations will be made with the goal that joint project will be the base for national presentations and publications. AP faculty and the PP educators will take joint responsibility for the event. • AP Faculty Info Sessions: Each semester AP will host info an information session about teaching opportunities for PP nurses. ◦ Part of the hiring of clinical faculty will not only include the preceptor and faculty orientation, but access to a graduate certificate in educational leadership (classroom, clinical, online and simulated clinical teaching). • Informal AP Info Sessions: Each semester AP will host information sessions about advanced educational opportunities at AP for PP nurses.	__% of nurses who work with partnership students will collaborate on a poster for the annual showcase (yearly) __% of the posters will be prepared and submitted for publication (yearly) __% of nurses/managers will participate in evidence-based post conferences with students (yearly) __# of PP nurses who attend the showcase (yearly) __# of AP students who attend the showcase (yearly) __# of PP nurses who attend the info sessions (yearly) __# of PP nurses who complete the certificate in educational leadership (yearly)

Partnership Goals	Activities	Outcomes
Integrate "academic" approaches at AP to clinical practice with PP standards of practice and vice versa Strengthen the standard of evidence-based practice in the clinical and academic setting	Implement educational enrichment strategy & timeline. • AP lead faculty will work closely with nurse liaisons to outline a yearlong program of educational presentations and clinical simulation training programs. ◦ Topics and areas for programming will be identified collaboratively and the AP faculty will take the lead in securing the presenters. • AP lead faculty & PP liaison will work closely with nurse managers to identify priorities for collaborative development of evidence-based protocol.	__% of AP partnership faculty will participate in one educational offering for PP nurses in a given year (yearly) __% of nurses who work with partnership students will attend one educational offering in a given year (yearly) __% of nurse managers will identify issue to be addressed though development of an evidence-based protocol (yearly) __# of the question/issues for the evidence-based assessment and protocol development (yearly) __% of evidence-based protocols submitted for peer review (yearly)

Appendix D: Guiding Principles for Academic-Practice Partnerships

These guiding principles were developed by the AACN-AONL Task Force on Academic-Practice Partnerships in January 2012.

The recent passage of the Affordable Care Act (ACA) has created the greatest change in the American healthcare system since 1965. The goal of the ACA is to improve the health of the population through expanded coverage, controlled healthcare costs and improved healthcare delivery systems. Donna Shalala, PhD, Chair of the RWJ/IOM Future of Nursing Committee emphasized that "transforming the nursing profession is a crucial element to achieving the nation's vision of an effective, affordable healthcare system that is accessible and responsive to all".

Academic-Practice Partnerships are an important mechanism to strengthen nursing practice and help nurses become well positioned to lead change and advance health. Through implementing such partnerships, both academic institutions and practice settings will formally address the recommendations of the Future of Nursing Committee. Effective partnerships will create systems for nurses to achieve educational and career advancement, prepare nurses of the future to practice and lead, provide mechanisms for lifelong learning, and provide a structure for nurse residency programs.

According to the Task Force, an academic-practice partnership is a mechanism for advancing nursing practice to improve the health of the public. Such intentional and formalized relationships are based on mutual goals, respect, and shared knowledge. An academic-practice partnership is developed between a nursing education program and a care setting. Such relationships are defined broadly and may include partnerships within nursing, and other professions, corporations, government entities, and foundations. Key principles guiding such relationships include the following:

1. **Collaborative relationships between academia and practice are established and sustained through:**
    a. Formal relationships established at the senior leadership level and practiced at multiple levels throughout the organization
    b. Shared vision and expectations that are clearly articulated
    c. Mutual goals with set evaluation periods
2. **Mutual respect and trust are the cornerstones of the practice/academia relationship and include:**
    a. Shared conflict engagement competencies
    b. Joint accountability and recognition for contributions
    c. Frequent and meaningful engagement
    d. Mutual investment and commitment
    e. Transparency
3. **Knowledge is shared among partners through mechanisms such as:**
    a. Commitment to lifelong learning
    b. Shared knowledge of current best practices
    c. Shared knowledge management systems

   d. Joint preparation for national certification, accreditation, and regulatory reviews
   e. Interprofessional education
   f. Joint research
   g. Joint committee appointments
   h. Joint development of competencies
4. A commitment is shared by partners to maximize the potential of each registered nurse to reach the highest level within his/her individual scope of practice including:
   a. Culture of trust and respect
   b. Shared responsibility to prepare and enable nurses to lead change and advance health
   c. Shared governance that fosters innovation and advanced problem solving
   d. Shared decision making
   e. Consideration and evaluation of shared opportunities
   f. Participation on regional and national committees to develop policy and strategies for implementation
   g. Joint meetings between regional/national constituents of AONL and AACN
5. A commitment is shared by partners to work together to determine an evidence based transition program for students and new graduates that is both sustainable and cost effective via:
   a. Collaborative development, implementation, and evaluation of residency programs
   b. Leveraging competencies from practice to education and vice versa
   c. Mutual/shared commitment to lifelong learning for self and others
6. A commitment is shared by partners to develop, implement, and evaluate organizational processes and structures that support and recognize academic or educational achievements:
   a. Lifelong learning for all levels of nursing, certification, and continuing education
   b. Seamless academic progression
   c. Joint funding and in-kind resources for all nurses to achieve a higher level of learning
   d. Joint faculty appointments between academic and clinical institutions
   e. Support for increasing diversity in the workforce at the staff and faculty levels
   f. Support for achieving an 80% baccalaureate prepared RN workforce and for doubling the number of nurses with doctoral degrees
7. A commitment is shared by partners to support opportunities for nurses to lead and develop collaborative models that redesign practice environments to improve health outcomes, including:
   a. Joint interprofessional leadership development programs
   b. Joint funding to design, implement, and sustain innovative patient-centered delivery systems
   c. Collaborative engagement to examine and mitigate non-value added practice complexity
   d. Seamless transition from the classroom to the bedside
   e. Joint mentoring programs/opportunities
8. A commitment is shared by partners to establish infrastructures to collect and analyze data on the current and future needs of the RN workforce via:
   a. Identification of useful workforce data
   b. Joint collection and analysis of workforce and education data
   c. Joint business case development
   d. Assurance of transparency of data

The Institute of Medicine (2010) report, *The Future of Nursing: Leading Change, Advancing Health* frames these guiding principles and serves as a platform for all strategies to build and sustain academic-practice partnerships.

Appendix E: Mission and Support Agreement: Mentor and Grant Development

MISSION SUPPORT AGREEMENT
(Mentor and Grant Development)

THIS MISSION SUPPORT AGREEMENT (the “Agreement") is made and entered into effective as of [Insert Date] (the "Effective Date"), by and between the [Insert School of Medicine], a [Insert State] benevolent corporation created by special act of the [Insert State] general assembly, on behalf of its [Insert School of Medicine], Division of [Insert Division] ("[Insert School of Medicine]") and [Insert School of Nursing] at [Insert Hospital], a division of [Insert Hospital], a [Insert State] nonprofit public benefit corporation ("College"). [Insert School of Medicine] and College are sometimes referred to herein individually as a "Party" and collectively as the “Parties."

WHEREAS, College, educates health care professionals awarding bachelors, masters and doctoral degrees in nursing.

WHEREAS, [Insert School of Medicine] is a medical school that offers a wide array of academic departments and programs for its students, including the Division of [Insert Division]

WHEREAS, College and [Insert School of Medicine] have entered into a Support Services Agreement dated [Insert date] (Support Services Agreement") whereby [Insert School of Medicine] provides faculty members to assist in developing grants and mentoring College's faculty, graduate and undergraduate students in [Insert service] (the "Services").

WHEREAS, as part of the funding of the Support Services Agreement, College agrees to provide financial support for faculty members in the Division of [Insert Division] to promote such grant development and mentoring in the area of research and grant development for College students (the "Joint Mission").

NOW, THEREFORE, in consideration of the mutual covenants and conditions set forth below, [Insert School of Medicine] and College agree as follows:

ARTICLE I
GRANT IN SUPPORT OF JOINT MISSION

1.1 Grant by College. College hereby contributes to [Insert School of Medicine] the sum of [Insert Dollar amount] (the "Grant") to support and promote the Joint Mission. The amount of the Grant is not conditioned on, and does not (and shall not) take into account, the volume or value of any referrals to, or other business generated for, College by [Insert School of Medicine], Faculty, any Faculty Physician, or any other individual or organization.

1.2 Payment of Grant. The Grant shall be paid by College to [Insert School of Medicine] in [Insert Number] equal annual installments on or before [Insert date] of each year.

ARTICLE II
TERMS AND CONDITIONS FOR USE OF GRANT FUNDS

2.1 Maintenance of Grant Funds. Grant funds shall be deposited and maintained by [Insert School of Medicine] in an account segregated from other [Insert School of Medicine] funds.

2.2 Support of Joint Mission. Grant funds shall be used solely to support the Joint Mission of the Parties. [Insert School of Medicine] shall provide a quarterly accounting to College outlining the allocation and use of the Grant funds.

ARTICLE Ill
REPRESENTATIONS. WARRANTIES AND COVENANTS

3.1 Organization and Corporate Authority. Each party has all requisite power and authority (corporate and other) to conduct its business and to enter into and perform its obligations under this Agreement.

3.2 No Inducement of Referrals. In connection with this Agreement, neither Party has promised or agreed to, and shall not (I) refer patients or business to, order, purchase or lease health care items or services from, or recommend that others (or arrange for others to) order, purchase or lease health care items or services from Hospital, or (2) cause or influence Faculty or any Faculty Physician or any other individual or organization to make any such referrals, orders, purchases, leases, recommendations or arrangements.

ARTICLE IV
TERM AND TERMINATION

4.1 Term. The term of this Agreement shall be [Insert Number] years (the "Term"), commencing on the Effective Date. On or prior to the expiration of this Agreement, the parties shall determine whether additional grants shall be provided to [Insert School of Medicine] in support of the Joint Mission and in such event an amendment to this Agreement shall be executed by the Parties.

4.1 Termination.

4.2.1 Bv Mutual Agreement. This Agreement may be amended or terminated at any time by mutual agreement of the Parties.

4.2.2 For Breach of Agreement. College may terminate this Agreement in the event that [Insert School of Medicine] materially breaches any of the terms, provisions or conditions hereof to be observed, kept or performed by it and does not cure the breach within [Insert Number] days following receipt of written notice thereof.

4.2.3 Upon Exclusion. Debarment or Suspension.

4.2.3.1 Of a Party. In the event that either Party is excluded from participation in any

federal health care program, as defined in 42 U.S.C. $ 1320a-7b(f), or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency, or is the subject of any formal adverse action (whether threatened, pending or actual), as that term is defined in 42 U .S.C. § 1320a-7e(g), then such Party shall notify the other Party of such action in writing within two [Insert Number] business days of its occurrence (the "Exclusion Notice"), and the other Party shall be entitled to terminate this Agreement immediately upon receipt of the Notice.

4.2.3.2 Of a Faculty Physician. In the event that a Faculty Physician, or any other employee or agent of either Party, is excluded from participation in any federal healthcare program, as defined in 42 U.S.C. $ 1320a-7b(0), or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency, or is the subject of any formal adverse action (whether threatened, pending or actual), as such term is defined in 42 U.S.C. § 1320a-7e(g). then [Insert School of Medicine] or College, as appropriate, shall provide an Exclusion Notice to the other Party, and the other Party shall be entitled to exclude such Faculty Physician or other employee or agent from participation in any program, research or other activity to which Grant funds have been allocated.

ARTICLE V
STATUS OF THE PARTIES

5.1 [Insert School of Medicine] and College shall at all times be independent contractors of one another. It is expressly understood and agreed by the Parties that nothing contained in this Agreement shall be construed to create a joint venture, partnership, association, or like relationship between the Parties with respect to the services provided hereunder. In no event shall either Party be liable for the debts or obligations of the other of them, except as otherwise specifically provided in this Agreement.

ARTICLE VI
COMPLIANCE WITH LAW

6.1 Changes in Law. This Agreement is intended to comply with all applicable federal and state laws and regulations. In the event that there are subsequent changes to or clarifications of laws or regulations that may render any term or condition of this Agreement noncompliant, or either Party determines in good faith that this Agreement is not in compliance with applicable laws or regulations, then the Parties shall negotiate in good faith to modify the terms and conditions of this Agreement to achieve compliance and remedy any prior noncompliance, but if compliance cannot be achieved reasonably, within [Insert Number] days, then this Agreement shall terminate at the election of either Party and neither Party shall have any further rights or obligations thereunder.

ARTICLE VII
MISCELLANEOUS

7.1 Maintenance of Records. To the extent applicable, for the purposes of implementing Section 1861 (v)(I)(I) of the Social Security Act, as amended, and any written regulations thereto, [Insert School of Medicine] agrees to comply with the following statutory requirements governing the maintenance of documentation to verify the costs of services rendered in connection with this Agreement:

7.1.1 Until the expiration of [Insert Number] years after the furnishing of such services in connection with this Agreement, [Insert School of Medicine] shall make available upon written request to the Secretary of Health and Human Services or upon request to the Comptroller General of the United States or any of their duly authorized representatives the contracts, books, documents, and records of [Insert School of Medicine] that are necessary to certify the nature and extent of such costs.

7.1.2 If [Insert School of Medicine] is requested to disclose any books, documents or records relevant to this Agreement for the purpose of an audit or investigation, [Insert School of Medicine] shall notify College of the nature and scope of such request and make available upon written request of College, all such books, documents or records.

7.2 Notices. Notices or communications required or permitted to be given to the respective Parties by hand or by registered or certified mail shall be at the following addresses unless a Party shall otherwise designate its address by notice in writing.

TO COLLEGE:	TO [Insert School of Medicine]:
[Insert School of Nursing] [Insert address]	[Insert School of Nursing] [Insert address]
with a copy to:	with a copy to:
[Insert Healthcare] [Insert address] Attn.: [Insert Name]	[Insert Healthcare] [Insert address] Attn.: [Insert Name]

Notices are effective upon hand delivery or deposit, postage prepaid, in the U.S. mail.

7.3 Section Headings. The section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

7.4 Governing Law. This Agreement has been executed and delivered in, and shall be construed and enforced in accordance with, the laws of the State of [Insert State]

7.5 Entire Agreement. This Agreement supersedes all previous agreements between the Parties with respect to the subject matter hereof, and constitutes the entire Agreement between the Parties with respect to the subject matter hereof.

7.6 Amendment. This Agreement may be amended by mutual consent by an instrument in writing signed by the Parties, effective as of the date stipulated therein.

7.7 Waiver. A waiver of the breach of any terms or conditions of this Agreement by either Party shall not constitute a waiver of any subsequent breach or breaches.

7.8 Severability. If any clause or provision herein shall be adjudged invalid or unenforceable by a

court of competent jurisdiction or by operation of any applicable law, it shall not affect the validity of any other clause or provision, which shall remain in full force and effect. Each of the provisions of this Agreement shall be enforceable independently of any other.

7.9 Assignment and Delegation of Duties. Neither College nor [Insert School of Medicine] shall assign its rights or delegate any of its duties under this Agreement without the express written consent of the other.

7.10 Counterparts. This Agreement may be executed in one or more counterparts, which together shall constitute one document.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be signed by their duly authorized officers as of the day and year first above written.

[INSERT SCHOOL OF MEDICINE]	**[INSERT SCHOOL OF NURSING]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

Appendix F: Sample Nursing Academic-Practice Partnership Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING
(Nursing Academic Practice Partnership)

[Name of College/University] and [Name of Healthcare System]
[Date]

This Memorandum of Understanding ("MOU") entered into by and between [Name of College/University] and [Name of Healthcare System] is intended to facilitate the parties working together in the generation, dissemination, and application of knowledge for the improvement of nursing practice, education, workforce and patient outcomes. Based upon common goals, mutual respect, shared knowledge, and the terms of this MOU, this collaboration is designed to be a nursing "think tank" and an incubator for creativity and innovation that endeavors to engage nursing faculty, nursing leadership, nursing staff, and nursing students in the development of strategies and tactics to enhance nursing education, research, and practice.

The mutual strategies of this collaboration will be reviewed and renewed annually, centering around these areas:

- Fostering innovative undergraduate, graduate and post graduate educational and clinical experiences at [Name of Healthcare System] and rural healthcare;
- Advancing nursing knowledge to improve and support the health of individuals and their families through research and evidence-based practice;
- Addressing nursing workforce needs of [Name of Healthcare System] throughout its service area in the states of [State Name] and [State Name] supporting a smooth transition of graduates into practice;
- Addressing shared issues as these emerge such as NCLEX passage rates, workforce development differentiators, transitions to practice, etc.

And, with keen focus on the following mutual goals:

- Growth in student volumes
- Expansion of faculty capacity/clinical instructor role development/joint appointments
- Innovative care delivery designs
- Recruitment strategies that grow student and professional practice roles
- Retention strategies including transitions to practice, residency program and well-being that support personal and professional career growth and development
- Longitudinal career planning including formal educational growth and 'loop' plans
- Collaborative nursing research and evidence-based practice projects conducted to address patient, family, and system needs and advance nursing science and the science of nursing practice.

Operating Structure

Steering Committee "Think Tank"

Individuals holding the following roles will have membership on a Steering Committee "Think Tank":

[Name of College/University] [Name of Nursing School]	[Name of Healthcare System]
Dean, [Name of Nursing School]	System CNE
Associate Dean, [Name of Nursing School]	[Department] CNO
Chair, [Name of Nursing Program]	[Department] CNO
Professor of Nursing	System Director Nursing Professional Development Leaders/Designees
Program and Simulation Directors, [Name of Nursing Program]	System Nursing Directors: Nursing Informatics, Nursing Workforce Development, Nursing Research and Innovations, Nursing Quality
	Magnet Nursing Directors

The Steering Committee "Think Tank" will meet monthly; frequency may be adjusted, when needed, based on focused work time frames that have been mutually established. Each organization will provide staff support for meeting notices, agendas, and meeting minutes. Each year the Steering Committee "Think Tank" will set the annual goals and a plan to carry out those goals. At each meeting, progress on goals will be reported.

Appointed Workgroups

The Steering Committee "Think Tank" will appoint work groups as needed to carry out the goals and functions generated from the collaboration.

Committees and Councils for Each Organization

The Steering Committee "Think Tank" will provide input on representation recommendations on each organization's relevant committees and councils to support communication, synergy, and collaboration. Each organization will retain the authority to determine the composition of its own committees and councils.

Shared Complimentary Appointments

[Name of Healthcare System]'s Steering Committee "Think Tank" members will hold an

appropriate faculty status in the [Name of College/University][Name of Nursing Program]. [Name of College/University]'s Steering Committee members will hold appropriate roles and/or committee/council appointments at [Name of Healthcare System].

Nature of MOU

This MOU shall be non-binding upon the parties.

Term and Termination

This MOU will commence upon the date of last signature below (the "Effective Date"), and will continue for an initial three (3) year period ("Initial Term"). Thereafter, this MOU shall automatically renew for additional periods of 1-year (each, a "Renewal Term"). (The "Initial Term" and all "Renewal Terms" are collectively referred to herein as the "Term.") Either party may terminate this MOU upon thirty (30) days advance written notice.

[Name of College/University]	**[Name of Healthcare System]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix G: Proforma-Dedicated Education Unit (DEU)

Example based on the proposed partnership between Renown Health and Orvis School of Nursing, University of Nevada, Reno, to illustrate financial structure and assumptions.

Assumptions

- DEU is a 23-hour short stay, 35-bed unit
- Projected at 80% of bed capacity
- Nurse to Patient Ratio= 1:4
- 40hrs/week, 45 weeks/year

Expenses

Category	Description	Annual Cost ($)
Clinical Nurse Educators (4)	Median salary $90,000[a]; jointly funded (SSU 24 hrs, Hospital 16 hrs). Includes fringe (31.6%), 10% teaching differential, tuition support for MSN/DNP.	284,256
Clinical Coordinator (SSU)	Median salary $120,000[b]; fully funded by SSU. Included in faculty role (teaching load).	SSU absorbs cost
Dr. F (SSU Faculty)	Median salary $135,000[c]; service allocation (40% FTE). Supported by AGACNP billing revenue.	SSU absorbs cost
Prelicensure Students	8 students/shift; no direct cost.	0
AGACNP Students	Billable services; revenue flows back to SSU.	Net neutral
Total Direct Expense		**284,256**

[a]variable based on experience, geographic location; [b]variable based on experience, geographic location; [c]median salary selected to reflect various levels of NP experience and time of service at university.

Notes

- University & hospital jointly fund Clinical Instructors via a professional services agreement (e.g., protected documentation time, teaching differential, graduate tuition incentives)
- Joint-appointment highlights shared institutional commitment.
- DEU integrates AGACNP students, medical residents, respiratory therapists, prelicensure nursing students in interprofessional rounds.
- Billing revenue from advanced practice services sustains faculty buyouts and strengthens financial viability.
- Core SSU faculty roles (Clinical Coordinator, Dr. F) are absorbed into the academic budget and not direct DEU operating costs.
- Braided funding streams could lessen reliance on institutional funding support (e.g., grants, billable NP student services, philanthropy).

Appendix H: Transitions of Care Simulation Evaluation Rubric

Transitions of Care Simulation Evaluation Rubric

Aligned with the AACN *Essentials* (2021)

Total Points: 100 | Passing Score: 75

Domain	Performance Criteria	Essential(s)	Exceeds Expectations (4)	Meets Expectations (3)	Approaching Expectations (2)	Below Expectations (1)
Clinical Judgement	Identifies priority problems, anticipates complications, and adjusts plan of care accordingly during the care transition.	Domain 1: Knowledge for Nursing Practice	Anticipates patient needs, applies evidence-based strategies, and adapts plan in real-time.	Identifies most patient needs and applies appropriate strategies.	Recognizes some patient needs but applies limited evidence-based strategies.	Misses key problems or delays decision-making.
Communi-cation	Provides clear, organized handoff using SBAR or similar format; uses therapeutic communica-tion with patient and family.	Domain 6: Interprofessi-onal Partnerships Domain 8: Person-Centered Care	Delivers seamless handoff; engages patient/family with empathy and clarity.	Delivers complete handoff; uses effective patient/family communica-tion.	Handoff lacks structure or detail; communica-tion is inconsistent.	Handoff is incomplete or disorganized; communica-tion is ineffective.
Interprof-essional Collabora-tion	Engages team members appropriately, demonstrates respect, and solicits input during care transitions.	Domain 6: Interprofess-ional Partnerships	Initiates collaboration and integrates team input proactively.	Collaborates effectively with team members.	Limited engagement with interprofess-ional team.	Minimal or no collaboration observed.
Patient Safety & Quality	Demonstrates use of checklists, confirms medication reconciliation, and applies safety protocols during handoff.	Domain 9: Quality and Safety	Consistently applies all safety protocols and advocates for patient safety.	Applies most safety practices appropriately.	Some safety measures are missed or inconsistently applied.	Safety risks are present due to poor adherence to protocols.

Domain	Performance Criteria	Essential(s)	Exceeds Expectations (4)	Meets Expectations (3)	Approaching Expectations (2)	Below Expectations (1)
Documen-tation	Accurately documents discharge plan, referrals, follow-up, and patient teaching.	Domain 7: Systems-Based Practice	Thorough, timely documentation with rationale.	Complete and timely documenta-tion.	Incomplete or delayed documentation.	Inaccurate or missing key documentation elements.
Cultural Humility & Equity	Addresses social determinants of health, respects cultural preferences in discharge planning.	Domain 2: Person-Centered Care Domain 4: Scholarship for Nursing Practice	Proactively integrates cultural and social needs into plan of care.	Considers cultural needs in planning.	Acknowledges but does not integrate cultural or equity concerns.	Ignores cultural or social context in care planning.
Health Teaching & Learning	Provides individualized education for self-care, medication, and follow-up needs.	Domain 5: Population Health	Uses teach-back, adapts education to patient literacy and context.	Provides standard education using appropriate tools.	Education is overly generic or rushed.	Education is minimal or absent.

Scoring Guide

- **Exceeds Expectations (4):** 90–100
- **Meets Expectations (3): 75–89**
- **Approaching Expectations (2):** 60–74
- **Below Expectations (1):** <60

Students scoring below 75 must receive formative feedback and repeat simulation or remediation session.

Appendix I: Sample Memorandum of Understanding Between University and Academic Health Center

MEMORANDUM OF UNDERSTANDING
BETWEEN
[UNIVERSITY NURSING PROGRAM] AND [ACADEMIC HEALTH CENTER]
Effective Date: [Insert Date]

This Memorandum of Understanding ("MOU") is entered into by and between [University Nursing Program], a division of [University Name], and [Academic Health Center], collectively referred to as "the Parties."

ARTICLE I: PURPOSE

The purpose of this MOU is to establish a sustainable and collaborative academic-practice partnership to:

- Expand clinical education opportunities for nursing students.
- Facilitate bi-directional faculty development and shared expertise.
- Create pathways for student employment and workforce integration.
- Promote excellence in nursing education, research, and service.
- Enhance community health and nursing workforce diversity.

ARTICLE II: SCOPE OF COLLABORATION

2.1 Clinical Placement

- The Academic Health Center agrees to serve as a primary clinical training site for undergraduate and graduate nursing students from the University Nursing Program.
- Clinical placements will include, but not be limited to, medical-surgical, primary care, obstetrics/women's health, behavioral health, and community/public health settings.
- Students shall be supervised by qualified preceptors who are either employed by the Health Center or hold joint faculty appointments.

2.2 Mutual Faculty Learning and Appointment

- The Parties will identify and appoint clinical experts from the Health Center as adjunct or joint faculty in the Nursing Program.
- Faculty development opportunities, including workshops, grand rounds, and simulation training, will be co-developed and open to both university and clinical faculty.
- Faculty exchange and collaborative curriculum development shall be encouraged.

2.3 Employment Pipelines for Students

- The Health Center will participate in nursing job fairs, interview days, and talent pipeline initiatives targeting nursing graduates.
- The Parties will explore residency or transition-to-practice programs that support student employment post-graduation.
- Employment opportunities will be prioritized for graduates from underrepresented backgrounds to advance health equity.

ARTICLE III: RESPONSIBILITIES

3.1 University Nursing Program

- Ensure that students meet health, immunization, background check, and educational prerequisites.
- Provide faculty support, course syllabi, and learning objectives for clinical rotations.
- Maintain liability insurance for enrolled students and faculty.

3.2 Academic Health Center

- Provide qualified clinical learning environments consistent with accreditation standards.
- Orient students to facility policies, procedures, and expectations.
- Participate in the evaluation and feedback of student performance in coordination with nursing faculty.

3.3 Mutual Responsibilities

- Collaborate to identify community-based health initiatives for student involvement.
- Engage in regular partnership review meetings to assess effectiveness and resolve challenges.
- Comply with all federal, state, and accreditation requirements (e.g., CCNE, ACEN).

ARTICLE IV: GOVERNANCE

A Joint Nursing Partnership Committee will be formed to oversee this agreement, comprised of:

- Two representatives from each party (one academic, one administrative).
- One representative with expertise in diversity and workforce development.
- The Committee will meet quarterly to review clinical placement data, employment metrics, and faculty engagement outcomes.

ARTICLE V: TERM AND TERMINATION

- This MOU will remain in effect for five (5) years from the Effective Date.
- It may be amended upon mutual agreement.
- Either party may terminate this MOU with 120 days written notice.

ARTICLE VI: GENERAL PROVISIONS

- This MOU does not create a legal partnership, joint venture, or employer-employee relationship.
- All intellectual property developed jointly shall be subject to a separate agreement.
- Each party shall comply with all applicable non-discrimination, FERPA, HIPAA, and Title IX requirements.

IN WITNESS WHEREOF, the undersigned have executed this MOU as of the Effective Date.

[University Nursing Program]	**[Academic Health Center]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix J: Financial Pro Forma

Narrative Analysis: Academic–Practice Partnership Financial Outlook

N*ote: Clinician salaries may vary widely by state and local regions. The cost of administrative/clinical support staff is another area of negotiation between the academic and practice partner, as this model assumes that administrative/clinical support staff costs will remain in the institution primarily responsible for their role.*

The leaders of an academic practice partnerships (e.g. Dean and CNO) can use projections to guide long-term planning, align faculty workload models, and prioritize reinvestment in infrastructure and professional development ensuring that both institutions benefit equally from shared expertise, revenue, and impact.

For the Academic Dean and CNO, a data-driven view should emphasize three key strategic levers:

1. Faculty Productivity: Optimizing billable practice hours directly enhances partnership revenue while showcasing faculty expertise.
2. Simulation and Training Investments: Continued development of simulation offerings and faculty workshops is not only revenue-positive but also positions the organization as a regional training hub.
3. Pipeline Development: The partnership's ability to generate income while simultaneously advancing workforce diversity and health equity justifies reinvestment into student recruitment, clinical residency programs, and faculty pipeline initiatives.

We present the following five-year example of a Pro Forma (revenue, expenses and net income) where each institution shares one faculty member each. Revenue is calculated based upon the academic contribution of faculty development and simulation resources and the faculty practice performed in the practice partner. Assumptions are built around practice hours, faculty count, student numbers, credits, and rates.

Formulas:

- Faculty practice revenue = hours per week × hourly rate × weeks per year × number of faculty
- Tuition revenue = students × credits × tuition per credit
- Estimate: Simulation and faculty development revenue grow at 10% annually.

Financial Proforma (in USD)

Year	Faculty Practice Revenue	Simula-tion Training Revenue	Faculty Develop-ment Revenue	Total Revenue	Faculty Salary Costs	Simula-tion Ops Costs	Training Dev Costs	Admin Overhead	Total Expenses
2025	$250,000	$50,000	$25,000	$325,000	$200,000	$30,000	$15,000	$20,000	
2026	$300,000	$60,000	$30,000	$390,000	$220,000	$35,000	$18,000	$22,000	$295,000
2027	$350,000	$70,000	$35,000	$455,000	$240,000	$40,000	$20,000	$25,000	$325,000
2028	$400,000	$80,000	$40,000	$520,000	$260,000	$45,000	$22,000	$28,000	$355,000
2029	$450,000	$90,000	$45,000	$585,000	$280,000	$50,000	$25,000	$30,000	$385,000

The return on investment (ROI) offers a clear picture of the sustainability and scalability of this academic–practice partnership. Over the five-year projection, total revenue is expected to increase from **$325,000 in 2025** to **$585,000 by 2029**, reflecting growth in both faculty practice productivity and academic services. Expenses rise more modestly over the same period, primarily driven by faculty salaries, simulation operations, and administrative overhead. The slower rate of expense growth indicates a strong operating model where additional revenue streams, particularly from faculty practice hours and expanded simulation services, offset the costs of faculty development and operational support. For leadership, this suggests that the partnership is financially stable and capable of scaling clinical placements and training offerings without jeopardizing margins. The growth and development of faculty on both sides leads to higher rates of satisfaction and the ability for nursing faculty to focus on clinical and academic teaching.

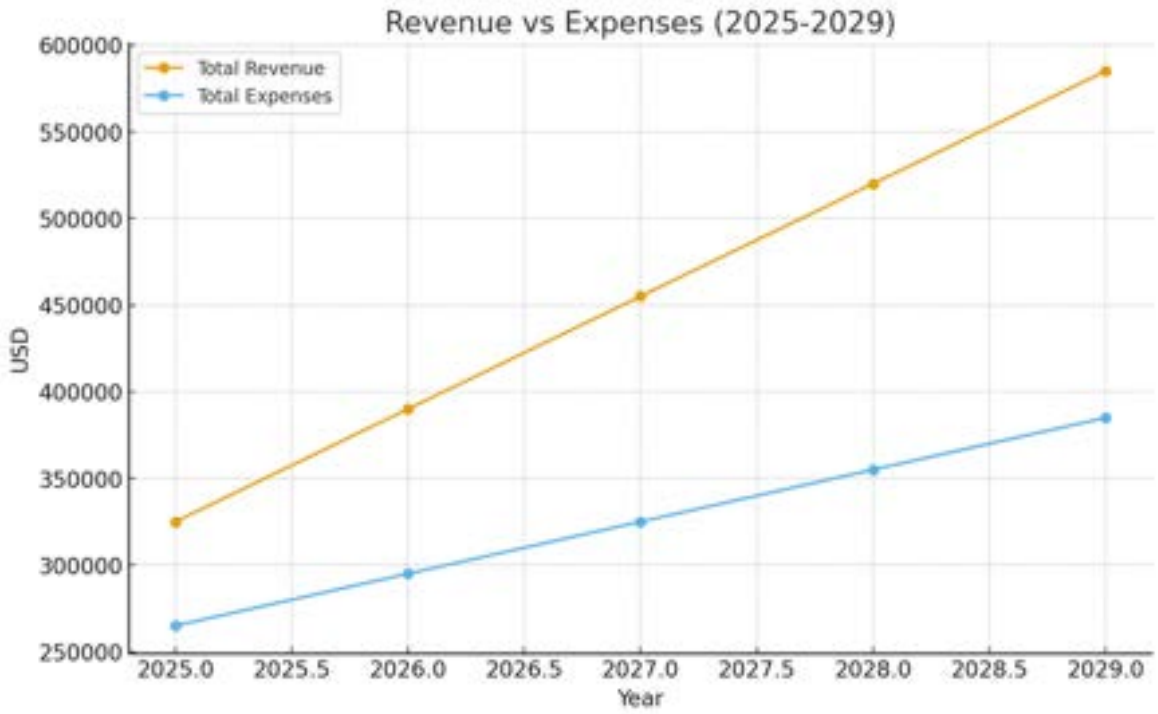
The net positive income trend reinforces this positive trajectory. Net income nearly triples over five years, from **$60,000 in 2025** to **$200,000 by 2029**, underscoring the financial return on investment in faculty clinical engagement and joint programming. This upward trend is particularly important for reinvestment in innovation, such as advanced simulation technology, faculty development initiatives, and pipeline programs to grow the workforce. The CNO and Dean should view this trajectory as an opportunity to strategically allocate surplus funds toward expansion, talent retention, and future accreditation preparation.

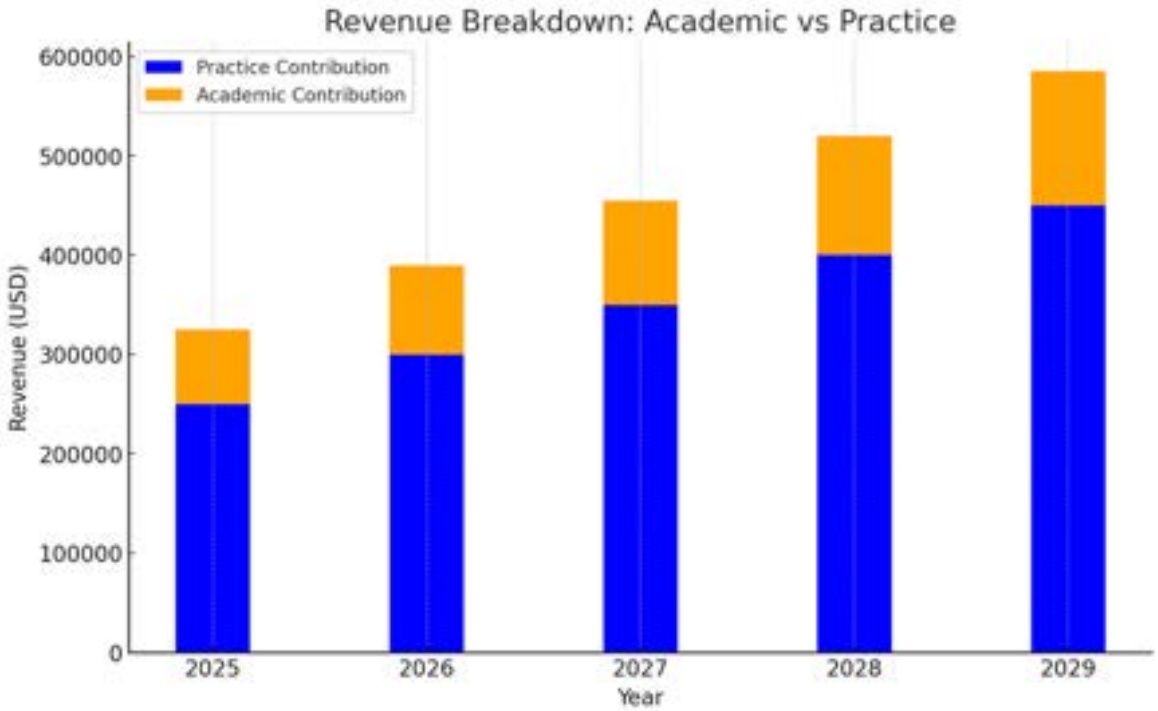
A breakdown of academic versus practice contribution demonstrates the partnership's diversified revenue model. Practice revenue, largely driven by billable clinical hours for faculty, comprises the majority of income, providing a steady and predictable stream that aligns with the hospital's operational strengths. Academic contributions, from simulation training and faculty development workshops, account for approximately one-quarter of total revenue but serve a strategic purpose by strengthening the workforce pipeline, supporting faculty excellence, and positioning the health system as a leader in nursing innovation. This balance highlights that both parties are bringing unique strengths: the health system monetizes faculty practice, while the academic institution drives growth in educational programming and staff upskilling.

Here are the key insights:

1. **Strong Net Margin Growth:** Net income nearly triples over five years, driven by expanding faculty practice revenue and simulation services.
2. **Revenue Mix:**
    - ~ 75% from faculty practice (billable clinical work).
    - ~ 20% from simulation and faculty training services.
3. **Scalable Model:** Revenue growth outpaces expenses due to fixed-cost sharing between the university and health center.
4. **Strategic Value:** Partnership improves faculty development, creates student employment pipelines, and leverages simulation to upskill staff.

Revenue Charts





Appendix K: Financial Proforma Template

This sheet models a five-year financial outlook for academic–practice partnerships. Built-in formulas calculate revenue, expenses, and net income based on user inputs such as faculty FTEs, practice hours, tuition, and simulation costs. Leaders can adjust assumptions to evaluate sustainability and growth under different partnership structures.

Financial Proforma in USD

Year	Faculty Practice Revenue	Simula-tion Training Revenue	Faculty Develop-ment Revenue	Total Revenue	Faculty Salary Costs	Simula-tion Ops Costs	Training Dev Costs	Admin Overhead	Total Expenses
2025	$250,000	$50,000	$25,000	$325,000	$200,000	$30,000	$15,000	$20,000	
2026	$300,000	$60,000	$30,000	$390,000	$220,000	$35,000	$18,000	$22,000	$295,000
2027	$350,000	$70,000	$35,000	$455,000	$240,000	$40,000	$20,000	$25,000	$325,000
2028	$400,000	$80,000	$40,000	$520,000	$260,000	$45,000	$22,000	$28,000	$355,000
2029	$450,000	$90,000	$45,000	$585,000	$280,000	$50,000	$25,000	$30,000	$385,000

An editable spreadsheet can be downloaded at aacnnursing.org/APP-Resources.

Appendix L: Academic–Practice MOU and Dynamic Proforma Tool

This worksheet combines a Memorandum of Understanding (MOU) framework with a financial projection model. Users can enter faculty roles, salary splits, tuition incentives, and workload allocations to generate financial estimates and clarify shared responsibilities. The tool supports planning for Dedicated Education Units, joint appointments, and other partnership types.

The worksheet can be downloaded at aacnnursing.org/APP-Resources.

Appendix M: MOU for Shared Teaching and Joint Appointments

Memorandum of Agreement between
[Practice Organization] and [Academic Organization]

Effective Date: [Insert Date]

This Memorandum of Agreement ("Agreement"), entered into this first day of [DATE] ("Effective Date"), is to establish a compact between a participating health organization and a participating college of nursing. This Agreement sets forth certain understandings in principle with respect to a collaboration to educate baccalaureate-prepared registered nurses employed by the participating health organization in a fully articulated Doctorate in Nursing Practice (DNP) Program. The basis for and terms of the Agreement between the parties are defined herein.

I. General Agreement
The academic partnership is a collaboration for educating baccalaureate-prepared registered nurses employed by the participating health organization at the DNP level. It is agreed upon and understood that the organization will engage baccalaureate-prepared registered nurses employed in their organization who meet the admissions requirement, in the DNP Program.

The DNP Program is approved by the state board of nursing and accredited through 2022 by the Commission on Collegiate Nursing Education (CCNE). The program includes specialty options that prepare BSN-DNP graduates for certification as nurse practitioners in Adult-Gerontology Acute Care (ACNP), Adult-Gerontology (ANP) primary care, Family (FNP) primary care, Pediatric (PNP) primary care, Psychiatric Mental-Health (PMH-NP) and Adult-Gerontology Clinical Nurse Specialist (Adult-CNS). Graduates will be eligible for licensure as Advanced Practice Registered Nurses (APRNs). At this time pediatric acute care and women's health options are under consideration. Policies and procedures for the DNP Program are applicable throughout the education process, admission through graduation.

The DNP curriculum is based on The Essentials of Doctoral Education for Advanced Nursing Practice (AACN, 2006); Criteria for Evaluation of Nurse Practitioner Programs (National Task Force on Quality Nurse Practitioner Education, 2012); Practice Doctorate Nurse Practitioner Entry-Level Competencies (NONPF, 2006); and other policies and guidelines related to doctoral education and advanced practice nursing. The curriculum is logically structured and builds on knowledge gained in a BSN program.

II. Responsibilities
A. Jointly, both parties will:
1. Plan, implement, and evaluate the academic partnership and collaboration as agreed upon in the program proposal.
2. Select classroom and clinical sites adequate for administering the program.
3. Negotiate resolution of unanticipated program needs.

B. The participating health organization will:

1. Uphold and adhere to any curriculum changes necessary during the program within the three-year agreed-upon plan.
2. Remit payment for tuition and fees for all employees enrolled as students prior to the beginning of each academic period.
3. Financially support all students admitted in each cohort throughout their entire enrollment period.
4. Provide external support such as classroom space, clinical sites, faculty office space, and necessary supplies.
5. Provide qualified personnel for faculty and staff positions according to the terms of its request for proposals.

C. The participating college of nursing will:

1. Annually admit up to five cohorts of 20–30 students who meet DNP Program admission criteria.
2. Assign qualified faculty for administering coursework, advising responsibilities, and guiding practice inquiry projects.
3. Use formative and summative evaluation measures to determine student and cohort progress.
4. Maintain or revise curriculum according to accreditation and competency standards.

III. Admission

Employees who apply for admission to the DNP Program will be those seeking the degree. Policies and procedures for the DNP Program are applicable from admission through graduation.

IV. Description of DNP Program of Study

The focus of the DNP Program includes leadership in practice, population-focused perspectives, and integration of evidence-based practice to inform decisions and facilitate healthcare improvements. The BSN-DNP option builds on coursework in health assessment, pathophysiology, and pharmacology. The 80–81 credit program is designed for full-time students to complete in three years, assuming progression requirements are met. The curriculum culminates in a practice inquiry project guided by an advisory committee. The delivery model is hybrid, combining online content with 4–5 in-person meetings per semester.

Degree requirements include:

- Minimum of 80 credits, with at least 17 in lab/clinical/residency courses (600 clinical and 420 lab/residency hours).
- Minimum 3.0 GPA overall and in nursing courses.
- Completion of a Practice Inquiry Project.

V. Faculty Description

All faculty hold valid RN licensure and meet regulatory requirements. Faculty composition includes full-time, part-time, and adjunct members with expertise across disciplines. Clinical assignments maintain a 1:1 student-to-preceptor ratio and a faculty-to-student ratio averaging 1:6.

VI. Finance

A. The participating health organization will:

1. Confirm enrollment, manage invoices, and provide payment letters.
2. Cover tuition even if students drop a course (subject to policy).

B. The college of nursing will:

1. Assess tuition at published rates and apply scholarships as outlined.

C. The financial aid office will:

1. Invoice the organization and issue refunds directly when necessary.

VII. Evaluation of Collaboration

Formative and summative evaluations include course evaluations, graduate surveys, performance data, and student achievements. Feedback informs curriculum and teaching improvements. Organization-specific evaluations will be analyzed separately.

VIII. Amendment: Waiver

Changes require written agreement by both parties.

IX. Entire Agreement

This Agreement supersedes all prior discussions, written or oral.

X. Public Announcements

All announcements will be jointly planned and approved.

XI. Liability Statement

The academic institution maintains sovereign immunity and self-insurance as per state law and holds commercial liability insurance. The health organization is responsible for claims arising from its agents, provides indemnification, and maintains comparable liability coverage.

XII. Duration and Review of Agreement

This Agreement is effective [DATE], and remains valid for seven years with annual review. Either party may terminate with 60 days' notice.

[Practice Organization]	**[Academic Organization]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix N: Cost/Time Allocation Worksheet—Shared Nurse Academic Practice Partnership (SNAPPI)

SNAPPI: Time & Cost Allocation Worksheet – Fall 2024
[Clinical Partner], Level S1, OB/PEDS Combo

Estimated Time Allocation

	When	Activity	Hours	Rep's	Total
PREPARATION	Jul 31, Aug1	Preceptor Bootcamp	12	x1	12
	Aug 20	New Employee Orientation	8	x1	8
	Aug 21	Clinical Orientation with AD	4	x1	4
	TBD	Course Clinical Coordinator (CCC) Orientation	2	x1	2
	Aug 22	Level Course Orientation	6	x1	6
	Aug 26	AD Start-Up Meeting	2	x1	2
	Aug 19, TBD	Assembly	4	x2	8
		Total			**43**
TEACHING	Sept - Nov	In-semester Meetings w/CCC	1	x3	3
	Aug 27	Skills Day	8	x1	8
	Sept - Nov	Clinical Shift*	12	x10	120
	Sept - Nov	Academic Support	4	x10	40
	Nov 11	AD Wrap-Up Meeting	2	x1	2
		Total			**173**
				Grand Total	**215**

Estimated Cost

1	**Total Hours**	215	**At the end of each semester, the Healthcare Partner to issue an invoice to [Academic Institution] for total cost of Participating RN time (line 5).
2	**Est. Clinical Wage**	$68.38/hour	
3	**Total Wages**	$14,701.70	
4	**Est. Clinical Overhead**	26%	
5	**Clinical Wages + Overhead****	$18,524.14	
6	**SHSU Adjunct Pay (MSN prepared)**	$12,375	
7	**Difference between lines 5 and 6**	$6,149.14	

Eligible SHSU SON Courses

Level	**Course**	**# of Shifts (12-hour)**	[Academic Institution] **FTE (internal use only)**	[Academic Institution] **Compensation (MSN-prepared Adjunct Faculty)**
S1	Peds	4	.33	$8,168
S1	OB	6	.33	$8,168
S1	Peds + OB (combined)	10	.5	$12,375
S2	Critical Care (AH2)	9-11	.5	$12,375
S2	Leadership (precepted)	8-11	.33	$8,168

Appendix O: Shared Nurse Academic Practice Partnership (SNAPPI) Memorandum of Understanding

Memorandum of Understanding

This Memorandum of Understanding ("MOU") is hereby entered into by and between [Academic Institution] ("University" or "[ACADEMIC INSTITUTION]"), an agency and institution of higher education authorized under the laws of the State of [State Name], and member institution of The [State] State University System, and [CLINICAL PARTNER], ("Clinical Partner") as of the date of full and final execution below (the "Effective Date").

1. **Performance Period.** The period for performance of this MOU shall commence on the Effective Date and shall be in effect for the duration of the [DATE] and [DATE] Spring 2025 semesters.
2. **Scope of Work.** This MOU is a non-binding statement that memorializes the collaboration between [ACADEMIC INSTITUTION] and Clinical Partner to implement the Shared Nurse Academic Practice Partnership Initiative ("SNAPPI") pilot project, a feasibility study to evaluate the use of shared registered nurse appointees ("Participating RNs") who divide their time between practice and academic responsibilities. The parties agree to the following proposed scope of the SNAPPI pilot project:

   2.1 **Point of Contact.**
   a. Clinical Partner shall provide a single designated point of contact ("POC"). The POC shall act as a champion for the SNAPPI pilot project in their organization.
   b. The POC is responsible for effectively distributing information to the appropriate contacts in their organization, following through on action items, attending all SNAPPI workgroup meetings, and leading their organization in the implementation of the SNAPPI pilot project.
   c. Clinical Partner shall notify [ACADEMIC INSTITUTION] of any change in POC.

   2.2 **Qualifications of Participating RNs.**
   a. Participating RNs must be MSN or doctoral -prepared or be eligible to qualify for a [State] Board of Nursing ("BON") waiver (BON 3.5.1.a, Education Guideline, TAC 22.11.215.7).
   b. Participating RNs must have a background check conducted and paid for by [ACADEMIC INSTITUTION], as well as verification of licensure and academic degree, and approval by [ACADEMIC INSTITUTION]'s Human Resources Department.
   c. Participating RNs should be subject matter experts in patient care, integrated into daily hospital operations, and interested in professional growth.
   d. Participating RN's recent performance reviews must meet minimum expectations, should be strong performers with a preference for bedside nurses, and adaptable based on institution requirements.
   e. Participating RNs shall be collaboratively selected by both [ACADEMIC INSTITUTION] and Clinical Partner.

   2.3 **Orientation & Onboarding of Participating RNs.**
   a. [ACADEMIC INSTITUTION] will provide new faculty orientation, preceptor bootcamp, and

additional training specific to SNAPPI.

b. Activities related to orientation, onboarding, and other training will be compensated on an hourly basis per the agreement outlined in the section titled "Compensation and Transfer of Funds."

2.4 **Duties of Participating RN.**

a. When performing activities on behalf of [ACADEMIC INSTITUTION] teaching assignment, Participating RN's job duties and performance requirements are detailed in Appendix A, [ACADEMIC INSTITUTION] Performance Requirements for "Participating RN."

b. When performing activities on behalf of Clinical Partner clinical assignment, Participating RN's job duties and performance requirements are detailed in Appendix B, Clinical Partner Role Description for "Participating RN."

2.5 **Distribution of RN's Time.**

a. Each Participating RN will dedicate 1.0 Full-Time Equivalent ("FTE") to practice and academic responsibilities.

b. Each Participating RN will work with a group of ten (10) or fewer nursing students each semester, focusing on Senior 1 or Senior 2 students engaged in clinical courses.

c. Each Participating RN will retain current employment status throughout the SNAPPI pilot project, subject to Clinical Partner's employment policies.

d. Detailed description of Participating RN's time allocation for orientation, onboarding, and clinical teaching are documented in Appendix N, Time & Cost Allocation Worksheet.

2.6 **Clinical Placements by Clinical Partner.**

a. Clinical Partner commits to guaranteeing two (2) semesters of placements for [ACADEMIC INSTITUTION]'s School of Nursing ("SON") students working with Participating RNs, ensuring that clinical experiences are appropriate to meet the learning objectives of the course the appointee is supporting.

b. Clinical Partner agrees to prioritize student experience, create a valuable learning experience for SON students, and maintain a culture of feedback and transparency.

2.7 **Compensation and Transfer of Funds.**

a. The compensation of the Participating RN shall be maintained at the level set by Clinical Partner during activities performed for [ACADEMIC INSTITUTION]. Changes in compensation made by the Clinical Partner will be adjusted between, but not during, semesters.

b. [ACADEMIC INSTITUTION] shall not pay overtime, shift differential, or any other type of multiplier for services provided under this MOU.

c. Following the completion of [ACADEMIC INSTITUTION] duties each semester, the Clinical Partner will invoice [ACADEMIC INSTITUTION] and [ACADEMIC INSTITUTION] will transfer funds equal to the FTE reallocation from clinical activities to [ACADEMIC INSTITUTION] activities noted in Line 5 of Time and Cost Allocation Worksheet (see Appendix N).

2.8 **Non-Compensatory Enhancements.**

Both parties agree to make a good faith effort to provide non-compensatory enhancement(s) to provide tangible benefits that meaningfully target nurses and help maintain and protect nurses' quality of life.

2.9 **Ongoing Commitment to Performance Evaluation and Data Collection.**

a. [ACADEMIC INSTITUTION] and Clinical Partner agree to use best efforts to implement the formative and summative evaluation plan designed by the SNAPPI workgroup.
b. [ACADEMIC INSTITUTION] and Clinical Partner agree to share data for the purpose of program evaluation.
c. The SNAPPI pilot project is designed to evaluate the program for feasibility with the long-term goal of dissemination for the good of all healthcare and nursing education in [State]. To this end, and to the extent allowed by law, [ACADEMIC INSTITUTION] and Clinical Partner agree to the dissemination of de-identified and aggregated data in the form of publication, presentation, and other means.
d. [ACADEMIC INSTITUTION] and Clinical Partner will ensure that all participating parties have the right to review any materials related to the SNAPPI pilot project prior to dissemination. Written permission from all parties is required prior to dissemination of any information.

2.10 **Commitment to Collaborative Problem-Solving.**

a. As a pilot project designed to test feasibility, one of the main goals is to uncover problems. [ACADEMIC INSTITUTION] and Clinical Partner commit to elevating identified problems in a timely manner.
b. [ACADEMIC INSTITUTION] and Clinical Partner commit to using collaborative problem-solving methodologies to discover and implement solutions.
c. [ACADEMIC INSTITUTION] and Clinical Partner commit to making a good faith effort to honor commitments through the end of the semester to ensure the integrity of the student learning experience.

2.11 **Liability and Risk Management.**

a. Existing Affiliation Contracts between [ACADEMIC INSTITUTION] and Clinical Partner remain in force. The SNAPPI pilot project operates within the stipulations of the existing affiliation.
b. The parties agree to mutually indemnify each other for any legal or financial risk associated with the SNAPPI pilot project arising from the other parties' acts or omissions to the extent allowed by law. The parties maintain their own insurance coverage to protect against certain potential liabilities. Notwithstanding any provision of this MOU, nothing herein constitutes a waiver of the constitutional, statutory or common law rights, privileges, immunities, or defenses of [ACADEMIC INSTITUTION].

3. **General.**

3.1 **Compliance.**

a. Nothing in this MOU shall be construed to violate any provisions of the laws and/or regulations of the United States of America or the State of [State], and all acts done hereunder shall be done in such manner as may conform thereto.

3.2 **Severability.**

a. In the event that any word, phrase, clause, paragraph, sentence, part, portion, or provision of this MOU is later determined to be invalid, void, or unenforceable, then the remaining terms, provisions, covenants, and conditions shall remain in full force and effect, and shall in no way be affected, impaired, or invalidated.

3.3 **Modifications.**

a. The MOU may be modified by mutual written approval of the parties.

3.4 **Dispute Resolution.**

a. The dispute resolution process provided in [State] Government Code, Chapter 2260 shall be used by the parties to resolve any dispute arising under this MOU.

3.5 **Governing Law and Venue.**

a. The MOU and all claims arising from the MOU shall be interpreted and construed in accordance with the laws of the State of [State], without regard to its conflict of laws principles. Any judicial action or proceeding between the parties relating to the MOU and all claims arising from the MOU shall be brought in the federal or state courts serving [County] County in the State of [State].

3.6 **Force Majeure.**

a. Except as otherwise provided, neither party shall be liable to the other for any delay in, or failure of performance, of a requirement contained in this MOU caused by Force Majeure. Incidents of Force Majeure include but are not limited to the following: acts of God, strikes, epidemics and pandemics, war, riots, flood, fire, sabotage, or any other circumstances of like character. The existence of such causes of delay or failure shall extend the period of performance until after the causes of delay or failure have been removed, provided the non-performing party exercises all reasonable due diligence to perform.

3.7 **FERPA Compliance.**

a. Some of the University Records Clinical Partner receives, creates or maintains for or on behalf of the University may constitute "Education Records" (as defined by FERPA), or "Personally Identifiable Information from Education Records" (as defined by FERPA) (collectively, "FERPA Records"). Clinical Partner will hold the University FERPA Records in strict confidence. Clinical Partner will not use or disclose FERPA Records received from or on behalf of the University, except as permitted or required by this MOU in order to execute required Services to the University. Clinical Partner will use the administrative, technical and physical security measures, including secure encryption in the case of electronically maintained or transmitted FERPA Records, approved by the University and that are at least as stringent as the requirements of Title 34, Part 99 – Family Educational Rights and Privacy noted at https://www.ecfr.gov/current/title-34/part-99 to preserve the confidentiality and security of all FERPA Records received from, or on behalf of the University, its students or any third party pursuant to this MOU. Clinical Partner agrees that no later than thirty (30) days after the expiration or termination of this MOU, for any reason, or within thirty (30) days after the University's written request, Clinical Partner will halt all access, use, or processing of FERPA Records and will return to the University all FERPA Records, including any copies created by Clinical Partner or any subcontractor; and Clinical Partner will certify in writing to the University that all FERPA records have been returned to the University. Clinical Partner will restrict disclosure of FERPA Records solely to those employees, subcontractors, or agents of Clinical Partner that have a need to access the FERPA Records in order for Clinical Partner to perform its obligations under this MOU. If Clinical Partner discloses any FERPA Records to a subcontractor or agent, Clinical Partner will require the subcontractor or agent to comply with restrictions and

- obligations that align with the restrictions and obligations imposed on Clinical Partner by this MOU, including requiring each subcontractor or agent to agree to the same restrictions and obligations in writing. [This clause may be replaced by existing clause in Affiliation Agreement]

3.8 **Nondiscrimination.**

a. In their execution of the MOU the parties and others acting by or through them shall comply with all federal and state laws prohibiting discrimination, harassment, and sexual misconduct. To the extent not in conflict with federal or state law, the parties agree not to discriminate on the basis of race, color, national origin, age, sex, religion, disability, veterans' status, sexual orientation, gender identity or gender expression. Any breach of this covenant may result in termination of the MOU.

In WITNESS WHEREOF, the parties have executed this MOU as of date ("Effective Date") set forth below their signatures.

[Clinical Partner]	**[Academic Organization]**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix P: FRS Nurse Liaison Job Description

Position Description: Nurse Retention Specialist for Full-Ride Scholar Program

The **Nurse Retention Specialist (NRS)** is a doctorate-prepared nurse with experience in large health care systems, including direct care nursing, clinical education and professional development, research, public speaking, formal mentorship, and the management of multi-disciplinary, enterprise-wide projects and programs across community, long-term, and acute care settings. The retention specialist meets with all FRS scholars one on one, at least one time per year while they are students and biannually with new graduate nurses for the first three years of their practice.

The three (3) major components of the role include expertise in program management, research, and mentorship.

Program Management

- Serve as an ambassador
- Direct program operations
- Track recipients' status

Mentorship

- Provide holistic, individualized support to recipients
- Create a sense of belonging and build community
- Organize events
- Enhance engagement using a system feedback optimization model

Research

- Conduct qualitative and quantitative program research
- Identify and track key indicators for retention
- Disseminate research findings

Key to the Nurse Retention Specialist's success is the joint reporting structure to nursing senior leadership at both the hospital and the college. The role was funded for the first two years with foundation grants; once the model was proven effective, the FTE was incorporated into nursing operations at the hospital.

Appendix Q: Sample Community-Based Care Partnership MOU

Health And Wellness Mobile Services Community Partnership Memorandum of Understanding

This Memorandum of Understanding (the "MOU) is entered into between **[redacted]** a public body corporate and politic of **[redacted]** (hereinafter "University") **[redacted]** (hereinafter "Facility"). University and Facility shall be collectively referred to herein as "the Parties" and individually as "a Party".

In furtherance of their respective healthcare and public service missions, it is the intent of the Parties to work together to bring access to care to underserved, uninsured, and underrepresented individuals who would not otherwise be able to access care due to geographical or other mitigating factors. To that end, University owns and operates a Mobile Health and Wellness Unit (the "MHU") that will travel to Facility and will be used for the delivery of certain health care services (the "Services") by, without limitation, a University nurse practitioner (the "Practitioner") who will oversee and provide the Services at Facility's site(s) (the "Services Event"). The Services Event shall be no longer than one (1) day, and may be less than one (1) day. Facility has members, attendees, and participants ("Participants") who desire, and would benefit from, without limitation, various health care services, health screenings, and health education.

There are no fees or other charges payable by one Party to the other under this MOU. The operation of the **[redacted]**.

In consideration of the mutual promises contained herein, the Parties agree as follows:

1. **Responsibilities of University**
    a. Assure that Practitioner and any other University **[redacted]** have met all applicable licensure and University eligibility requirements prior to the Services Event.
    b. Identify priority service areas to be addressed during the Services Event.
    c. Suggest primary services to promote during the Services Event.
    d. Assure that Practitioner shall abide by Facility policies and procedures, rules and regulations, including, without limitation, those pertaining to HIPAA compliance and any other confidentiality requirements of the Facility which are communicated to the University.
    e. Travel with the MHU to various locations **[redacted]**.
    f. Comply with all applicable state and federal laws.
    g. Participants will not be charged by the University for Services provided through the MHU.
    h. Communicate in advance with Facility regarding scheduling and logistics.
2. **Responsibilities of the Facility**
    a. Work collaboratively with University to schedule Service Events at mutually acceptable locations, dates, and times.
    b. Promote the Service Event in advance among the target population of Participants using the University-provided materials regarding services for the three (3) weeks immediately prior to the Services Event.

c. Inform University of the Facility's policies, procedures, rules, and regulations with which Practitioner and other University personnel are expected to comply.
d. Provide a secure parking space for the MHU during agreed-upon Service Event hours which can meet the following requirements:
    i. Parking space must be at least 50 feet long and 30 feet wide, which includes the dimensions of the MHU (40 ft long and 10 ft wide) and a clinical patient waiting area directly outside of the MHU as weather permits (the MHU includes an attached outside awning that measures 20 feet by 20 feet).
    ii. Must be in an area that is safe for the operation of a 15 KW gas generator, which powers the MHU.
    iii. Facility shall obtain all required licenses and permits related to the Services Event and parking for the MHU.
e. Communicate scheduling and logistical procedures to the University at least five (5) business days in advance of the Services Event.

3. **Effective Date and Renewal**
    a. This MOU shall become effective on or from the date of execution of this Agreement, whichever is later, and continue for one year, and thereafter shall automatically renew from year to year for a period not to exceed three (3) years, unless terminated earlier by either Party. The Parties agree to work together to schedule a maximum of four (4) Service Events per twelve-month period, with the first twelve-month period beginning on the effective date of this Agreement. Either Party may terminate this MOU for any reason upon ninety (90) days written notice to the other.

4. **Insurance**
    a. During all times relevant to this Agreement, each Party shall maintain general liability insurance, whether through a commercial policy or through a program of self-insurance, with minimum limits **[redacted]** per claim or occurrence and **[redacted]** aggregate. If services provided under this contract include any professional services, each Party shall also maintain professional liability insurance, whether through a commercial policy or through a program of self-insurance, with minimum limits of **[redacted]** per claim or occurrence and **[redacted]** aggregate. Each Party shall comply with applicable state laws governing workers' compensation and mandatory insurance for vehicles. Within seven days of request, a Party shall provide to the requesting Party a certificate of insurance evidencing the coverage required by this Article 4.

5. **Liability**
    a. Neither Party to this Agreement shall be liable for any negligent or wrongful acts, either of commission or omission, chargeable to the other, unless such liability is imposed by law. This Agreement shall not be construed as seeking either to enlarge or diminish any obligation or duty owed by one Party to the other or to a third party.

6. **General Terms and Conditions**
    a. Non-discrimination. University and Facility agree to comply with all applicable federal and state nondiscrimination, equal opportunity, and affirmative action laws, orders, and regulations.
    b. Compliance. Both Parties agree to comply with all applicable laws, regulations, rulings, or enactments of any governmental authority. Both Parties shall obtain (at their own expense) from third parties, including state and local governments, all applicable licenses, permissions, and accreditations necessary to maintain their respective operations.
    c. No Publication. Except for materials promoting the Services Event, neither Party shall use the name of the other in any oral presentation or written material, including but not limited to brochures, webpages, advertisements, letters, and circulars, without the prior written consent

of the other Party.

d. Third-Party Rights. Nothing in this MOU is intended to or shall create any rights or remedies in any third party.
e. Independent Contractor. The relationship of each Party to the other under this MOU shall be that of independent contractor, and not partners, joint venturers, or any similar common enterprise.
f. No Assignment. This MOU may not be assigned by either Party without the prior written consent of the other Party.
g. Claims against University. [redacted]
h. Notices. All notices required herein shall be in writing and shall be sent via registered or certified mail, return receipt requested, or by an overnight courier service to the addresses and persons listed below, or to such other person or addresses as may be specified in writing by a Party from time to time. A notice shall be deemed to have been given when received by the Party at the address set forth below: [redacted]

Entire Agreement. This MOU, attachments, and incorporated references shall constitute the entire agreement between the Parties with respect to the subject matter herein and supersedes all prior communications and writings with respect to the content of said MOU. No modification, extension, or waiver of any of the terms of this MOU shall be binding upon either the Facility or the University unless reduced to writing in the form of a mutually written amendment and duly executed by both Parties. This MOU shall not be binding until signed by the duly authorized representatives of both Parties. This MOU may be signed in counterparts. Facsimile signatures constitute original signatures for all purposes.

By:
Date:

Appendix R: Sample Workforce Education Tuition Partnership MOU

Education Workforce Partnership Agreement
Effective Date: [Insert Date]

This Education Workforce Partnership Agreement ("Agreement") is made and entered into by and between **[Healthcare Partner]** ("Healthcare Partner") and **[Education Partner]** ("Education Partner"), and hereby amends, supersedes, restates, and replaces all prior agreements between the parties as of the Effective Date.

Description of Partnership
The Education Partner maintains schools of nursing offering pre-licensure nursing education programs in multiple locations, as well as online post-licensure nursing education programs. The Healthcare Partner manages health care facilities and desires to enter into an agreement that allows, but does not require, students participating in its workforce scholarship program ("Scholars") to enroll in an available nursing program to advance their careers. In exchange, the Education Partner agrees to accommodate Scholar applicants in each admitting class quarterly at the applicable tuition rate provided in this Agreement.

Details of Agreement

- **Designated Number of Admissions**
  - The designated number of Scholar applicants may vary from quarter to quarter.
  - The Education Partner agrees to make available adequate admission spots each quarter for the enrollment of all applicable Scholars.
  - Scholars must be enrolled 15 days prior to the start of the term, or designated slots may be released to other applicants.
  - The Healthcare Partner does not guarantee it will place or refer any minimum number of applicants.
- **Marketing and Recruitment**
  - Throughout the partnership, the Healthcare Partner may distribute promotional materials related to the Education Partner's nursing programs consistent with its workforce development processes.
  - The Healthcare Partner will direct interested and qualified individuals to the Education Partner for purposes of recruitment and admission activities, which may occur in person or virtually.
- **Cost**
  - During the term of this Agreement, the total charge to the Healthcare Partner (or shared with the Scholar, as applicable) shall not exceed the following for each program:
    - Licensed Practical Nursing (LPN): $19,000 (Includes tuition, books, fees, uniforms, background screening, and registration fees.)
    - LPN to ADN Bridge: $30,000 (Includes tuition, books, fees, uniforms, background screening, and registration fees.)
    - Associate Degree Nursing (2-Year): $42,500 (Includes tuition, books, fees, uniforms, background screening, and registration fees.)

- **Billing**
  - The Education Partner will bill the Healthcare Partner directly for approved tuition, books, and fees per Scholar enrolled full-time, not to exceed the amount available for each Scholar through the scholarship program.
  - If a Scholar is allowed to enroll part-time, a modified billing and payment schedule will be mutually agreed upon.
  - The maximum billing amount is limited to one attempt at each course needed for the applicable program. Repeating a course due to a failed grade or other failure to complete is not included; in such cases, the Scholar will be billed directly by the Education Partner unless other arrangements are made.
  - Balances will be reconciled quarterly and at the end of the program or Scholar's last term. Overpayments must be refunded or credited to the Healthcare Partner within thirty (30) days of the applicable quarter's end.

Term of Agreement

- This Agreement shall be in effect for two (2) years from the signing date.
- At the end of the initial period, program pricing will be reviewed and every two (2) years thereafter.
- If pricing changes, a new Partnership Agreement will be executed; if not, the Agreement automatically renews for another two (2) years.
- Either party may terminate the Agreement with ninety (90) days' written notice.
- Termination does not adversely affect the enrollment status of any Scholar already admitted; however, unless otherwise agreed, the Healthcare Partner is only obligated to pay tuition for Scholars who continue to meet eligibility requirements through the remainder of the current quarter.

Miscellaneous

- This is a non-exclusive arrangement.
- Participation in this program is a benefit offered by the Healthcare Partner to qualified applicants, subject to its plan documents and policies.
- If a Scholar no longer qualifies for participation, the Healthcare Partner will notify the Education Partner, which will (i) credit the Healthcare Partner for any prepaid tuition, (ii) release the Healthcare Partner from further responsibility once balances are satisfied, and (iii) directly bill the Scholar for any remaining costs.
- The Education Partner will provide the Healthcare Partner with written notice if a Scholar fails, withdraws, or is suspended/expelled from a class or program.
- The Education Partner releases the Healthcare Partner from all responsibility and/or liability for the actions or inactions of any Scholar, including costs or expenses beyond the tuition/fees/uniforms payment set forth in this Agreement.

Notices

- Copies of this Agreement and related notices shall be provided to designated representatives of each party.

[Healthcare Partner]	**[Education Organization]**
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix S: Proposed Collaborative Agreement for Research/Scholarly Collaboration

Proposed Collaborative Agreement for Research/Scholarly Project Conduct
Collaboration Representatives and Members

Name of Study/Project:

This agreement is between [{Names}, representatives of {Organization}] and [{Name}, a representative of {Organization}]
Or
This is an agreement between members of the [Organization]

Members of the collaboration from the [Organization] are the following:

1. [Name]– (PI/Co-PI)
2. [Name] - [Role]

Members of the collaboration from [Organization] are the following:

1. [Name] - [Role]

Research/Scholarly Project Elements

Background: [Brief statement of what is known and what is to be the focus of the project]. The project is "[Project Title]"

1. This project aims to:
2. The anticipated outcome of the project is [Date].
3. Data for this project will be collected by [Organization]. The screened participants will [how participants will enter/provided data and what is the time period of involvement].
4. Data will be stored in [Organization]'s secure, protected online system.
5. Documents related to the project will be filed in shared folders with the possibility of being edited by collaborators.
6. Data will be shared following [Organization] research standards. A separate data-sharing agreement may be needed, as negotiated.
7. After the study, data will be stored in [Organization] system's secure online system for as long as necessary complete statistical analysis of the data. If data analysis is not completed in the time period approved by the IRB, an extension of the IRB application will be needed. If an extension is required, the PI/Co-PIs will initiate this request.
8. All collaboration members will have access to study/project data. Study staff will provide access to data requests via email from the collaborators. Data will be shared via export from [Organization] as a spreadsheet that does not include identifiable data.
9. If changes are made in the research/project design, they will be made by the PI/Co-PIs, [Name], with the consent of one member of each institution: [Organization] and [Organization]. Method and

budget changes will be reported to all members of the research team.

10. The person(s) responsible for drafting publications are the PI/C0-PIs and collaborators named in the approved IRB application. Researchers with experience in other areas may be invited to collaborate in writing scientific articles.
11. The following process will be used to identify and rank contributing authors in all presentations and publications: The first author should be the person who contributed most to the work, including the writing of the manuscript. The relative overall contributions to the manuscript should determine the sequence of authors (Kuper et al., December 2023.).
12. The person(s) responsible for choosing the venue or publication to disseminate findings, submitting reports, meeting compliance requirements, and having the authority to speak publicly for the collaboration are through a discussion and agreement of the PI/Co-PIs and collaborators.
13. Expenses related to the payment of manuscript submission fees or payment for publication in scientific journals will be the responsibility of the research team and discussed.
14. Payment for statistician advice will be the responsibility of the funded research budget.
15. Intellectual property rights and ownership issues will be identified after discussing and agreeing with the PIs/Co-PIs and collaborators.
16. The collaboration can be changed through discussion and agreement between the PI's and the collaborators.
17. All communication (including emails/phone calls) must include the PI/Co-PIs.
18. At least one member from each collaboration site will discuss and agree upon deviations from the plan.
19. The collaboration will end when the project is completed and disseminated.

Expectations of Collaborators

All members of the collaboration are expected to:

- Share findings with members in the collaboration,
- Be knowledgeable about the activities of other members,
- Support the activities of other members,
- Report and discuss problem findings,
- Attend regularly scheduled meetings,
- Notify the principal investigator in case of inability to attend a meeting and seek additional ways to contribute,
- Points to be discussed at meetings must be sent at least 24 hours in advance, even if it is for information on the progress of data collection,
- Make other members aware of any essential changes, such as changes in key personnel, equipment, or facilities,
- Share developments within the research/scholarly project so that everyone in the collaboration is knowledgeable about important information.

[Signature Page Follows]

Members of the collaboration from the [Organization] are the following:

1. [Name] (PI): Sign: _____ Date: _____
2. [Name] (Co-PI): Sign: _____ Date:_____

Members of the collaboration from the [Organization] are the following:

1. [Name] ([Role]): Sign: _____ Date: _____

Appendix T: Sample MOU for Associate Dean of Research

SERVICES AGREEMENT

([Insert Title] of Research)

This SERVICES AGREEMENT (this "Agreement") is entered into effective as of [Insert Date] ("Effective Date") by and between The [Insert School of Medicine], a [Insert State] benevolent corporation created by special act of the [Insert State] general assembly, on behalf of its [Insert School of Medicine],, Department of [Insert Department] ("[Insert School of Medicine]") and [Insert School of Nursing].

RECITALS:

WHEREAS, [Insert School of Medicine] employs on a full-time basis, [Insert Name], a faculty member in the Division of [Insert Division], Department of Internal Medicine-Nutritional Science ("Physician"), duly licensed as a physician in the State of [Insert State];

WHEREAS, COLLEGE is in need of a qualified faculty member who is knowledgeable in research administration and mentoring junior researchers to be its [Insert Title] and has determined that Physician possesses the qualities and credentials it desires for such position;

WHEREAS, PHYSICIAN has indicated his willingness to serve in such role and [Insert School of Medicine] has agreed to make [Insert Name] available to serve in such role;

WHEREAS, COLLEGE desires to lease PHYSICIAN from [Insert School of Medicine], and [Insert School of Medicine] is willing to lease PHYSICIAN to COLLEGE to serve in such capacity on the terms and conditions outlined herein.

NOW, THEREFORE, for and in consideration of the mutual promises and covenants contained in this Agreement, the adequacy and sufficiency of which are hereby acknowledged [Insert School of Medicine] and COLLEGE agree as follows:

1. [Insert School of Medicine]'S OBLIGATIONS.

Services. [Insert School of Medicine] will make PHYSICIAN available to COLLEGE for [Insert Percentage] % of his full-time working effort, provided that PHYSICIAN shall have the right to [Insert School of Medicine] holidays, sick leave, vacation and other leave, a pro rata portion of which shall be considered time during PHYSICIAN provides the services (as hereinafter defined). A more complete description of the duties and responsibilities associated with this position is set forth in Exhibit A, attached hereto and incorporated herein for reference (the "Services"). [Insert School of Medicine] or PHYSICIAN will notify COLLEGE at least [Insert Number] weeks in advance of the start of any specific work week if the PHYSICIAN will be on vacation or otherwise on leave.

Applicable Standards. [Insert School of Medicine] agrees that PHYSICIAN shall provide all services in accordance with (i) currently approved methods and practices of the [Insert State] State Board of

Healing Arts and any other appropriate board; (ii) the ethical and professional standards of the[Insert State] State Board of Healing Arts; (iii) all applicable state and federal laws and regulations; (iv) professional standards prevailing in the community at the time such services are rendered; and (v) policies, rules, regulations and/or other related competencies that may be required by COLLEGE. [Insert School of Medicine] further agrees that, at all times during the term of this Agreement, PHYSICIAN shall: hold a valid and unlimited license to practice medicine in the State of [Insert State] and have never had such license in any state suspended or revoked; have never been reprimanded, sanctioned or disciplined by any licensing board or state or local medical board; are certified by the [Insert State] State Board of Healing Arts.

2. COMPENSATION.

In sole and complete consideration of the Services, COLLEGE shall pay to [Insert School of Medicine] compensation as described below, which shall be prorated for any partial year in which this Agreement is in effect.

COLLEGE shall reimburse [Insert School of Medicine] for [Insert Percentage] % of the salary and benefit costs (based on benefits actually allocated to PHYSICIAN) of PHYSICIAN ("Compensation"), which for the Initial Term (as hereinafter defined) of this Agreement shall be [Insert Dollar amount] ("Compensation"), plus [Insert School of Medicine]'s [Insert Percentage] % administrative fee.

Following the Initial Term of this Agreement, Compensation shall increase no more than once per [Insert Number] month period and shall be limited to a percentage equal to the average of the budgeted merit increase/salary adjustment of [Insert School of Medicine] and COLLEGE for the most recent fiscal and calendar years respectively.

PHYSICIAN shall remain an employee of [Insert School of Medicine], and [Insert School of Medicine] shall be responsible to PHYSICIAN for the payment of wages and salaries, additional compensation, withholding of federal, state and local taxes, payroll taxes, and unemployment insurance.

3. TERM AND TERMINATION.

Term. This Agreement shall commence on the Effective Date and shall continue until [Insert Date] (the "Initial Term"). Thereafter, this Agreement shall automatically renew for additional [Insert Number]-year terms under the same terms and conditions then in effect unless the Agreement is terminated as provided herein.

Termination.

Termination without cause. Either party may, in its sole discretion, terminate this Agreement without cause by giving the other party at least [Insert Number] days prior written notice.

Termination with cause. Either party may immediately terminate this agreement for Cause (as hereinafter defined) upon written notice to the other party. "Cause" means (i) the suspension, revocation, condition, I imitation, qualification or other material restriction on PHYSICIAN's license, certification; (ii) an indictment, arrest or convention for a felony, or for any criminal charge of PHYSICIAN; (iii) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or (iv) either party's material breach of the terms of this Agreement which is not cured to the reasonable satisfaction of the non-breaching party within [Insert Number] days following written notice describing such breach.

Automatic Termination. This Agreement shall automatically terminate upon: (i) PHYSICIAN's death; or (ii) the termination or expiration of PHYSICIAN's employment relationship with [Insert School of Medicine] for any reason.

Effect of termination. As of the effective date of termination of this Agreement, neither party shall have any further rights or obligations hereunder except: (a) as otherwise provided herein; (b) for rights and obligations accruing prior to such effective date of termination; or (c) arising as a result of any breach of this Agreement.

4. INDEPENDENT CONTRACTORS.

For purposes of this Agreement, COLLEGE and [Insert School of Medicine] are independent contractors and this Agreement shall not constitute the formation
of a partnership, joint venture, employment, principal/agent or master/servant relationship between COLLEGE and [Insert School of Medicine]. The parties further agree that PHYSICIAN and any other employees or agents of [Insert School of Medicine] shall not be entitled to any sick leave, vacation pay, retirement, social security, disability, health and unemployment benefits, or any other benefits of an employee of COLLEGE.

5. INSURANCE AND INDEMNIFICATION

Each party shall purchase and maintain the insurance coverages set forth below, through a company or companies lawfully authorized to do business in the State of [Insert State] or through a funded self-insurance program, for claims arising out of or resulting from a party's performance under this Agreement and for which such party may be legally liable, whether performed by the party or by anyone employed by the party. It is expressly agreed and understood each party shall purchase and maintain the insurances coverages set forth below. If such insurance is on a claims-made basis and if such insurance is canceled or terminated for any reason, an extended reporting endorsement shall be purchased applicable to all claims arising during the term of this Agreement. Insurance protecting each party shall be evidenced by issuance of a certificate of insurance, or if a self-funded insurance program, by a letter in form acceptable to the parties:

- Workers' Compensation insurance to cover employees, in the amount prescribed by law;

- Comprehensive General Liability and Professional Liability coverages (including coverage of employees), each in the minimum amount of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate; and
- Employer Liability insurance in the minimum amount of One Million Dollars ($1,000,000) each accident, One Million Dollars ($1,000,000) disease policy limit, and One Million Dollars ($1,000,000) disease for each employee.

COLLEGE shall indemnify, defend, and hold harmless [Insert School of Medicine] and its employees, agents servants, officers, and trustees from and against any and all claims, demands, damages (including reasonable attorney fees and legal expenses), and causes of action to the extent the same arises from any act or failure to act by COLLEGE or any of its employees arising out of this Agreement. [Insert School of Medicine] shall indemnify, defend, and hold harmless COLLEGE, its employees, agents, servants, officers and directors from and against any and all claims, demands, damages. (including reasonable attorney fees and expenses), and causes of action to the extent the same arises from any act or failure to act by [Insert School of Medicine] or any of its employees, including PHYSICIAN, arising out of this Agreement.

6. CONFIDENTIALITY.

The parties recognize and acknowledge that, by virtue of entering into this Agreement and providing Services hereunder, the patties may have access to certain information that is confidential and constitutes valuable, special and unique property. The parties agree that neither will, at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other party's express prior written consent, except pursuant to either party's duties hereunder, any confidential or proprietary information of the other patty, including, but not limited to, information that concerns patients, costs, fee schedules, clinical pathways, equipment staging or treatment methods developed by either party, that is not otherwise available to the public. The provisions of this **Section 6** shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

7. ACCESS TO BOOKS AND RECORDS.

If the value or costs of Services rendered pursuant to this Agreement is Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, the parties agree that until the expiration of four years (4) after the furnishing of such Services, the parties shall, upon written request, make available to the Secretary of the Department of Health and Human Services (the "Secretary"), the Secretary's duly-authorized representative, the Comptroller General, or the Comptroller General's duly-authorized representatives, such books, documents, and records as may be necessary to certify the nature and extent of the cost of such Services; and if any such Services are performed by way of subcontract with another organization and the value or cost of such subcontracted Services is Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain, and the relevant patty shall enforce, a clause to the same effect.

8. MISCELLANEOUS.

Entire Agreement. This Agreement reflects the entire Agreement among the parties with respect to the subject matter hereof and supersedes all prior Agreements, memoranda, understandings and negotiations.

Amendment. This Agreement may only be amended by written Agreement signed by both patties specifically describing the provision to be amended.

Nondiscrimination in Employment. If any service under this Agreement is in furtherance of a U.S. Government contract or subcontract or is otherwise subject to the provisions of the Equal Opportunity Clause as promulgated by Section 202 of Executive Order 1 I 246, dated September 24, 1965, or to 41 C.F.R. 60-250 (requiring affirmative action to employ certain veterans), or to 41 C.F.R. 60-741 (requiring affirmative action to employ certain handicapped individuals) or to any other federal law, rule or regulation applicable to [Insert School of Medicine] as U.S. Government contractors or subcontractors (including but not limited to any applicable Section of 48 C.F.R. Chapter 1), the contract provisions required therein are hereby incorporated by reference. PHYSICIAN shall comply with all applicable local, state and federal laws and executive orders and regulations that are applicable to [Insert School of Medicine] as U.S. Government contractors or subcontractors.

Exclusion from Government Programs. Each party to this Agreement represents that:
it is not currently excluded, or threatened with exclusion, from participating in any federal or state funded health care program, including Medicare, Medicaid, and Tricare; and (b) it has never been subject to any sanctions by any of the aforementioned programs. Each party shall notify the other of any imposed exclusions or sanctions covered by this representation and the notified patty reserves the right to terminate the Agreement upon receipt of such notice. Further, if Services will be performed by entities and/or personnel of [Insert School of Medicine] who are not employees of [Insert School of Medicine], [Insert School of Medicine] represents that such entities and/or personnel also meet the requirements of this paragraph.

Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of [Insert State] without regard to the conflict of laws principles thereof.

Change in Law. In the event that any law or regulation enacted, promulgated or amended after the date of this Agreement or any interpretation of law or regulation by a court or regulatory authority of competent jurisdiction after the date of this Agreement (collectively "Change in Law") materially affects or impacts upon the reasonable expectations of either party under this Agreement, renders any provision of this Agreement illegal or unenforceable, or materially affects the ability of either party to perform its obligations under this Agreement, then either party may request renegotiation of the applicable terms of this Agreement by written notice to the other party. Both parties shall negotiate in good faith an amendment to this Agreement that preserves the original reasonable expectations of the

parties to the extent possible in a manner consistent with the Change in Law. If no such amendment is agreed upon within [Insert Number] days of receipt of such notice, then either party may terminate this Agreement upon an additional [Insert Number] days written notice.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year first written above.

[Insert School of Medicine]	**[Insert School of Nursing]**
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT A DESCRIPTION OF DUTIES

PHYSICIAN shall perform the following duties at [Insert School of Nursing]:

- Recruitment, Development and Retention
  - Provides leadership and guidance for all [Insert School of Nursing] research-related activities consistent with the mission of the College and advice and counsel on research and scholarly matters to the Dean.
  - Recruits mid- to senior-career scientists with track records of developed funding streams that align with a research program center of excellence.
  - Continuously mentor faculty and students to develop their research and scholarship.
  - Promotes and advances the careers of scientists by creating a culture of support, inquiry, innovation, and recognition.
  - Collaborates to advance team science with interprofessional partners within the [Insert School of Medicine] system, the [Insert Healthcare] System, and across regional Colleges and Universities.
- Scholarship Development
  - Models team and collaborative behaviors in a variety of settings with the College, including, but not limited to [Insert School of Medicine], the [Insert Healthcare] System, [Insert Hospital], [Insert Hospital], [Insert School of Pharmacy], community agencies and other non-collegiate partners.
  - Capitalizes the resources and capacity of the [Insert Healthcare]/[Insert School of Medicine]system.

Appendix U: Sample MOU for Joint Faculty Appointments

Memorandum of Understanding
(Joint Appointment of [Insert Name])

This Memorandum of Understanding (this "Agreement") is entered into effective as of [Insert Date] ("Effective Date") by and between [Insert School of Medicine], a [Insert State] benevolent corporation created by special act of the [Insert State] general assembly, on behalf of its [Insert School of Medicine], Department of [Insert School of Medicine] and [Insert School of Nursing] a division of [Insert Hospital], a [Insert State] nonprofit public benefit corporation [Insert School of Nursing]

RECITALS

WHEREAS, [Insert School of Nursing] desires to enhance the research opportunities for its faculty and has requested that [Insert School of Medicine], assist it in increasing opportunities for research collaboration between them;

WHEREAS, [Insert School of Medicine], and [Insert School of Nursing] have recruited [Insert Name] ("Faculty Member") to serve as an [Insert Title] on the research track, without tenure, in the [Insert School of Medicine] Department of [Insert School of Medicine], Division of Palliative Care, and as a [Insert Title] of [Insert School of Nursing];

WHEREAS, Faculty Member has indicated [Insert Name] willingness to serve in such roles;

WHEREAS, [Insert School of Medicine] and [Insert School of Nursing] have agreed that [Insert School of Medicine] should employ Faculty Member and [Insert School of Nursing] should reimburse [Insert School of Medicine] for the costs of such employment, as described in more detail herein.

NOW, THEREFORE, for and in consideration of the mutual promises and covenants contained in this Agreement, the adequacy and sufficiency of which are hereby acknowledged [Insert School of Medicine] and [Insert School of Nursing] agree as follows:

1. General Nature of the Appointment

Faculty Member will have an appointment as an [Insert Title] on the research track in the Division of [Insert Division] at [Insert School of Medicine] without tenure and an appointment as a [Insert Title] of [Insert School of Nursing]. Faculty Member's joint appointments shall begin on or about [Insert Date]. Faculty Member will be subject to all applicable [Insert School of Medicine] policies and procedures and the policies and procedures of [Insert School of Nursing] while providing services at [Insert School of Nursing].

2. Description of Duties

For the first [Insert Number] months of [Insert Name] appointment, Faculty Member shall not be expected to provide instruction in coursework at [Insert School of Nursing]. [Insert School of Medicine] and [Insert School of Nursing] expect that Faculty Member will devote primarily all of [Insert Name] full-time working efforts during such period on research, submitting research grant applications for federal funding and, in collaboration with other [Insert School of Medicine] and [Insert School of Nursing] faculty, facilitating a sustainable research funding trajectory within palliative care. Faculty Member is expected to mentor [Insert School of Nursing] doctoral students and [Insert School of Nursing] junior research faculty? in independent research activities, disseminate scholarly works regionally, nationally and internationally and serve as a reviewer or advisory board member for palliative care or nursing collaborative as a representative of [Insert School of Nursing] and [Insert School of Medicine]. After the first [Insert Date] months of [Insert Name] appointment, Faculty Member's instruction duties at [Insert School of Nursing] will be determined as outlined in the faculty workload policy as stated in the [Insert School of Nursing] faculty handbook.

3. Financial Arrangements

[Insert School of Medicine] will employ Faculty Member at an initial rate of pay of [Insert Dollar Amount], which salary rate is expected to increase annually, and provide standard [Insert School of Medicine] employee benefits ("Faculty Member Costs"). [Insert School of Nursing] will reimburse [Insert School of Medicine] for [Insert Percentage] % of the Faculty Member Costs that are not covered by external funding sources, plus [Insert Dollar Amount] annually in overhead (except that any effort of Faculty Member that is devoted to [Insert School of Medicine] effort (e.g., palliative care research) shall be reduced from both the Faculty Member Costs and the overhead on a commensurate basis, plus [Insert School of Medicine]'s [Insert Percentage]% central fiscal unit tax. The parties acknowledge and agree that such Faculty Member Costs will decrease as Faculty Member's external funding increases. [Insert School of Medicine] will invoice [Insert School of Nursing] monthly for Faculty Member Costs. Invoices that include requests for Research Support (as described in Section 4 below) shall be accompanied by receipts evidencing such expenses to be reimbursed. [Insert School of Nursing] shall pay each invoice within [Insert Number] days following receipt of such invoice. [Insert School of Medicine] shall be responsible to Faculty Member for the payment of wages and salaries, additional compensation, withholding of federal, state and local taxes, payroll taxes, and unemployment insurance.

4. Research Support

[Insert School of Nursing] will provide up to an aggregate of [Insert Dollar Amount] in start-up funding for Faculty Member's research and travel needs over the first [Insert Number] years of this Agreement. Such Research Support will be disbursed as described in Paragraph 2.

5. Facilities and Space

The parties anticipate that Faculty Member will use [Insert School of Medicine] laboratory space, equipment including a computer, and support staff, although [Insert School of Nursing] will provide Faculty member with office space and interview rooms.

6. Faculty Member Identification/Acknowledgement

On all identification/documentation of Faculty Member, [Insert School of Nursing] will be the first institution listed. Such recognition requirement includes, without limitation, presentations, publications, email signature, business cards and research in which Faculty Member is involved.

For example, all items naming Faculty Member should read:

[Insert Name]
[Insert title], [Insert School of Nursing]
[Insert title], [Insert School of Medicine]

7. Personnel Decisions

[Insert School of Medicine] shall be solely responsible for personnel decisions with respect to Faculty Member's employment with [Insert School of Medicine] but shall consult with [Insert School of Nursing] on decisions regarding compensation, discipline, and termination of Faculty Member. While at [Insert School of Nursing], Faculty Member shall report to [Insert Name], [Insert Title] of [Insert School of Nursing] and [Insert Name], [Insert Title] of [Insert School of Nursing].

8. Term and Termination

This Agreement shall commence on the [Insert Date] and shall continue for a period of [Insert Number] years at which time [Insert Name] employment shall transition from [Insert School of Medicine] to [Insert School of Nursing]. This Agreement may be terminated at any time without cause by either party [Insert Number] months' prior written notice to the other party. This Agreement may be terminated upon [Insert Number] days written notice to the other party, if the other party is in material breach of any provision of this Agreement and fails to cure said breach after the expiration of a [Insert Number] day written notice and cure period.

9. Independent Contractors

For purposes of this Agreement, [Insert School of Nursing] and [Insert School of Medicine] are independent contractors, and this Agreement shall not constitute the formation of a partnership, joint venture, joint employment, principal/agent or master/servant relationship between [Insert School of Nursing] and [Insert School of Medicine]. The parties further agree that Faculty Member shall not be entitled to any sick leave, vacation pay, retirement, social security, disability, health and unemployment benefits, or any other benefits of an employee of [Insert School of Nursing].

10. Insurance/Indemnification

Each party at its sole cost and expense shall procure and maintain the insurance coverages set forth below, through a company or companies lawfully authorized to do business in the State of [Insert State] or through a funded self-insurance program, covering the acts and/or omissions of its employees during or arising out of the performance of this Agreement in the minimum amounts described below. If such insurance is on a claims-made basis and if such insurance is canceled or terminated for any reason, an extended reporting endorsement shall be purchased applicable to all claims arising during the term of this Agreement. Insurance protecting each party shall be evidenced by issuance of a certificate of insurance, or if a self-funded insurance program, by a letter in form acceptable to the parties:

i. Workers' Compensation insurance to cover Faculty Member, in the amount prescribed by law;
ii. Comprehensive General Liability and Professional Liability coverages (including coverage of Faculty Members), each in the minimum amount of One Million Dollars ($1,000,000.00) per occurrence, Three Million Dollars ($3,000,000.00) annual aggregate; and
iii. Employer Liability insurance in the minimum amount of One Million Dollars ($1,000,000) each accident, One Million Dollars ($1,000,000) disease policy limit and One Million Dollars ($1,000,000) disease for each Faculty Member.

[Insert School of Nursing] agrees to indemnify, defend, and hold harmless [Insert School of Medicine], and its trustees, officers and employees from and against any and all claims, demands, damages (including reasonable attorney's fees and expenses), and causes of action arising from any act or failure to act by Faculty Member, [Insert School of Nursing] or any of its employees during or arising out of the performance of this Agreement. [Insert School of Medicine] agrees to indemnify, defend and hold harmless [Insert School of Nursing] and its officers and employees from and against any and all claims, demands, damages (including reasonable attorney's fees and expenses), and causes of action arising from any act or failure to act by [Insert School of Medicine] or any of its employees other than Faculty Member during or arising out of the performance of this Agreement.

11. Confidentiality

The parties recognize and acknowledge that, by virtue of entering into this Agreement, the parties may have access to certain information that is confidential and constitutes valuable, special and unique property. The parties agree that neither will, at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other party's express prior written consent, except pursuant to either party's duties hereunder, any confidential or proprietary information of the other party, including, but not limited to, information that concerns patients, costs, fee schedules, clinical pathways, equipment staging or treatment methods developed by either party, that is not otherwise available to the public. The provisions of this **Section 11** shall survive expiration or other termination of this Agreement, regardless of the cause of such termination.

12. Intellectual Property

The parties agree and acknowledge that [Insert School of Medicine] and [Insert School of Nursing] shall jointly own all Intellectual Property conceived and/or reduced to practice, in whole or in part, by Faculty Member in connection with Faculty Member's performance under this Agreement. As used herein, "Intellectual Property" means inventions, patent rights, copyrights, materials, documentation, research results, data, and other forms of intellectual property created, in whole or in part, by Faculty Member. [Insert School of Nursing] shall assign, and does hereby assign, all rights, title, and interest in such Intellectual Property to [Insert School of Medicine]. [Insert School of Nursing] agrees on behalf of itself and Faculty Member, to execute all necessary declarations, oaths, assignment agreements, and other instruments that [Insert School of Medicine] requests to transfer ownership of and to protect such Intellectual Property for the sole benefit of [Insert School of Medicine].

13. Miscellaneous

13.1 Entire Agreement. This Agreement reflects the entire Agreement among the parties with respect to the subject matter hereof and supersedes all prior Agreements, memoranda, understandings and negotiations.

13 .2 Amendment. This Agreement may only be amended by written Agreement signed by both parties specifically describing the provision to be amended.

13.3 Exclusion from Government Programs. Each part to this Agreement represents that: (a) it is not currently excluded, or threatened with exclusion, from participating in any federal or state funded health care program, including Medicare, Medicaid, and Tricare; and (b) it has never been subject to any sanctions by any of the aforementioned programs. Each party shall notify the other of any imposed exclusions or sanctions covered by this representation and the notified party reserves the right to terminate the Agreement upon receipt of such notice.

13.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of [State] without regard to the conflict of laws principles thereof.

13.5 Change in Law. In the event that any law or regulation enacted, promulgated or amended after the date of this Agreement or any interpretation of law or regulation by a court or regulatory authority of competent jurisdiction after the date of this Agreement (collectively “Change in Law”) materially affects or impacts upon the reasonable expectations of either party under this Agreement, renders any provision of this Agreement illegal or unenforceable, or materially affects the ability of either party to perform its obligations under this Agreement, then either party may request renegotiation of the applicable terms of this Agreement by written notice to the other party. Both parties shall negotiate in good faith an amendment to this Agreement that preserves the original reasonable expectations of the

parties to the extent possible in a manner consistent with the Change in Law. If no such amendment is agreed upon within 30 days of receipt of such notice, then either party may terminate this Agreement upon an additional 30 days written notice.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year first written above.

[Insert School of Medicine]	**[Insert School of Nursing]**
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix V: Sample MOU for Joint PhD Programs

Memorandum of Understanding

This Memorandum of Understanding ("MOU") is entered into on [Insert Date] and sets forth the terms and understanding between [Insert School of Nursing] ("[Insert School of Nursing]") and [Insert School of Medicine] ("[Insert School of Medicine]").

BACKGROUND

[Insert School of Nursing] and [Insert School of Medicine] collaborated to develop a PhD in Nursing Science program to educate nurse scientists who have a career goal of becoming nurse scientists. The PhD program is a joint program between the two institutions with both institutions participating in educating the students.

PURPOSE

This MOU outlines the relationship and obligations between [Insert School of Nursing] and [Insert School of Medicine] related to the PhD program. The primary goal of the PhD program is to prepare students for research positions in academia, health institutions and hospitals. Through this relationship, students will have access to exceptional faculty and labs.

I. Academic Record

a. [Insert School of Medicine] will maintain the primary, official academic record in the Student Information System ("SIS") for all Nursing Science PhD students. All courses will be registered through [Insert School of Medicine] to calculate a cumulative GPA and to demonstrate the full curriculum required for the degree on one official document.
b. Nursing Science PhD students will be awarded a [Insert School of Medicine] degree at the completion of all program requirements.
c. Milestones will be utilized to demonstrate department requirements met, dissertation requirements, qualifying or comprehensive exam requirements, and teaching requirements.
d. The [Insert School of Medicine] academic record will include advisor information.
e. A final copy of the academic record (transcript) will be forwarded to [Insert School of Nursing] and filed at [Insert School of Nursing].
f. Students will obtain official transcripts and letters of enrollment verification through [Insert School of Medicine]

II. Accreditation

a. The Nursing Science PhD program is approved through the Higher Learning Commission. [Insert School of Medicine] is the home institution for the accreditation of the program.
b. [Insert School of Medicine] will act as the lead institution in regard to this program.
c. [Insert School of Nursing] maintains separate Higher Learning Commission accreditation as well.

III. Admissions

a. The [Insert School of Nursing] PhD program will utilize [Insert School of Medicine] admissions platform.
b. [Insert School of Nursing] faculty will make recommendations for admission.
c. [Insert School of Nursing] staff or an agreed designee at the Medical School will manage the admissions process utilizing [Insert School of Medicine] admission platform.

IV. Advising

d. Nursing Science PhD students will be advised by the [Insert School of Nursing] faculty and the [Insert School of Medicine] faculty.
e. Faculty advisors will be listed in SIS. Dissertation committee members will be listed in SIS.

V. Course Catalog

f. For all courses considered to be [Insert School of Nursing]-exclusive curriculum, [Insert School of Medicine] will maintain the course in the [Insert Database] database for the purposes of registration, transcript generation, and historical reference.
g. Courses completed through other divisions and colleges at [Insert School of Medicine] will not be duplicated under the M division [Insert Name].
h. A doctoral program administrator from [Insert School of Nursing] will serve as the Graduate Program Administrator. This role will be responsible for adding new courses to [Insert Database], preparing the schedule and sections for courses, and editing any courses in accordance with the [Insert School of Nursing] curriculum committee.

VI. Course Registration

a. Nursing Science PhD students will be assigned a [Insert School of Medicine] Key and will enroll in their courses via [Insert Name].
b. Similar to all other PhD programs, advisors will authorize students to register each semester after meeting or consulting with their students to determine satisfactory academic progress.
c. As full-time, enrolled students in a complete academic year, Nursing Science PhD students will be eligible for the U-Pass benefit afforded to all full-time graduate students.

VII. Curriculum

a. [Insert School of Nursing] will design and implement programmatic assessment.
b. New courses and substantial changes to the curriculum will require approval of the Medical School's Graduate Program Council.
c. [Insert School of Nursing] faculty will utilize [Insert Name] to enter grades for Nursing Science PhD courses in which they are assigned the primary grader.

VIII. Degree Audits, Graduation, and Commencement

a. Departmental degree requirement audits will be completed by the Graduate Program Administrator.
b. The Medical School's Registrar Office will complete the overall degree completion reviews for graduating students.
c. Nursing Science PhD students will be conferred a [Insert School of Medicine] degree and will receive a [Insert School of Medicine] diploma.
d. [Insert School of Nursing] will also be included on the official diploma and the transcript.
e. As doctoral students, Nursing Science PhD graduates will be invited to participate in the

Medical School's hooding and recognition ceremonies along with the [Insert School of Nursing] hooding and graduation ceremonies. Their names will be listed in both institutions' commencement brochures.

f. Nursing Science PhD students will comply with [Insert School of Medicine] graduating student activities including completing the post-graduation job survey and the survey of earned doctorates.

IX. Financial Aid

a. As the home institution, [Insert School of Medicine] will process FAFSAs, awards, and aid disbursements.
b. [Insert School of Medicine] assumes the responsibility for meeting state and federal government standards, reporting, and auditing financial aid transactions for Nursing Science PhD students.

X. Grants Management

a. Nursing Science PhD students will be expected to apply for and receive external funding in the form of grants. The Office of Sponsored Research Services at [Insert School of Medicine] will process and manage grant applications from: 1) Nursing Science PhD students where the student is the grant applicant; and 2) [Insert School of Medicine] faculty mentoring a Nursing Science PhD student where the [Insert School of Medicine] faculty member is the grant applicant, following [Insert School of Medicine] standard operating procedures.
b. [Insert School of Nursing] Grants Management Office will process and manage grant applications from [Insert School of Nursing] faculty mentors of Nursing Science PhD students where the [Insert School of Nursing] faculty member is the grant applicant. [Insert School of Nursing] and [Insert School of Medicine] agree that each grant may have different terms and requirements. Both parties will manage the grants that they receive according to the terms of the particular grant.

XI. Identification Badges

a. Students will be granted a Medical School ID badge.
b. [Insert School of Nursing] ID badges, parking passes, and [Insert Company] emails will be given to the Nursing Science PhD students.

XII. Institutional Reporting

a. [Insert School of Medicine] will include Nursing Science PhD students in all mandatory reporting to DOE (IPEDS), National Student Clearinghouse, Higher Learning Commission, and other accrediting bodies as needed.

XIII. Insurance

a. Students will be enrolled in the [Insert School of Medicine] Medical School student health insurance plan and dental plan.
b. A [Insert Percentage]% subsidy will be applied to their account. [Insert School of Nursing] will be billed for the subsidy.
c. All graduate students are required to show proof of the MMR vaccine. Additional vaccinations may be required by the School of Medicine to conduct research.

XIV. Milestones & Dissertations

a. Nursing Science PhD students will complete a qualifying and comprehensive exam. These exams will be recorded in SIS as milestones.

b. Nursing Science PhD students will complete the Title, Scope, and Procedure form.
c. Nursing Science PhD students will follow the same guidelines and templates for submitting a dissertation to ProQuest. Dissertations of graduates will be housed and maintained in ProQuest. They will also be housed in [Insert School of Nursing] dissertation repository.

XV. Policies

a. Nursing Science PhD students will follow all [Insert School of Medicine] & Medical School policies including but not limited to:
    i. Nondiscrimination;
    ii. Student Conduct Code;
    iii. Academic and Professional Integrity Policy;
    iv. Leaves;
    v. Probation and Dismissal for Academic Reasons; and,
    vi. Registration and Enrollment.

XVI. Tuition/ Accounting/ Billing

a. [Insert School of Medicine] will calculate tuition, fees and insurance premiums and post remission, scholarships, and waivers.
b. The tuition rate for the required [Insert School of Medicine] courses is set at [Insert Dollar amount] per credit hour for the [Insert Number] year. The tuition rate is expected to increase each year and will be set by [Insert School of Medicine].
c. Course enrollments in Arts & Sciences and other programs that are considered "free trade" will be charged the standard [Insert School of Nursing] tuition rate, which is [Insert Dollar amount] per credit hour (unit) for the [Insert Number] year. The tuition rates will be updated each academic year.
d. Students will be charged the [Insert School of Medicine] Student Health Fee each Fall and Spring semester.
e. [Insert School of Nursing] will be billed for Nursing Science PhD students' tuition each semester.
f. [Insert School of Nursing] will be assessed an administrative fee per academic year at the rate of [Insert Dollar amount] per student to offset the Medical School effort toward disbursing stipends, processing billing for this special population of students, and maintaining the academic record.
g. The Medical School will pay prorations to the [Insert School of Medicine] central fiscal unit for each Nursing Science PhD student. [Insert School of Nursing] will be responsible for reimbursing the Medical School for such charges.
h. [Insert School of Medicine] will attempt to collect outstanding student account balances after a student's major program is closed. [Insert School of Nursing] will be billed and responsible for paying outstanding balances.

1. **IN WITNESS WHEREOF**, the parties hereto have executed the Agreement as of the Effective Date.

[Insert School of Medicine]	**[Insert School of Nursing]**
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix W: Magnet Nursing Research and EBP Readiness Checklist

Nurse Involvement in Research

- ☐ Nurses participate in Human Subjects Protections Training
- ☐ Nurses are actively involved in the research process, from proposal development to implementation, upholding ethical guidelines at every step
- ☐ Nurses play a crucial role in shaping the research design
- ☐ Nurses contribute to data collection and analysis
- ☐ Nurses involved in interpreting or disseminating results internally or externally
- ☐ Research topics address clinical practice, nursing care, or systems/organizational issues

Institutional Support & Infrastructure

- ☐ Nursing Research Council or equivalent structure is established as part of the nursing shared governance structure
- ☐ Nurses contribute to ethical research review, often by participating in institutional research committees, peer review, or quality improvement/evidence-based practice councils that review proposals for adherence to ethical principles
- ☐ IRB processes are in place and accessible to nursing staff
- ☐ Partnerships exist with academic/research institutions or RN team conducting active research
- ☐ Leadership visibly supports research efforts
- ☐ Resources provided (e.g., time, funding, mentorship)

Ethical Compliance

- ☐ IRB approval or exemption obtained for each study
- ☐ Research complies with federal/international ethical standards
- ☐ Human subjects protections are documented and followed
- ☐ A clear plan for the security, privacy, and retention of research data is established and adhered to
- ☐ All research team members complete required disclosure of conflicts of interest relevant to the study

Alignment with Magnet Goals

- ☐ Research supports one or more Magnet Model Components:
- ☐ Structural Empowerment
- ☐ Transformational Leadership
- ☐ Exemplary Professional Practice
- ☐ Empirical Outcomes
- ☐ Clear connection between research/EBP and improved nursing practice, outcomes, or work environment **Source examples must showcase that an RN was the PI, co-PI, or site PI for the study*

Evidence of Impact

- ☐ Research outcomes are measurable and documented
- ☐ Findings are implemented or inform clinical/organizational practice
- ☐ Examples of practice changes resulting from research are available

Dissemination

- ☐ Research shared internally through presentations, forums, or reports
- ☐ Posters or abstracts submitted to regional, national, and international conferences
- ☐ Peer-reviewed publications produced and widely disseminated externally
- ☐ Official hospital/system documentation (e.g., policy or procedure manual updates) reflects the change in practice resulting from the research
- ☐ Formal peer review of EBP initiatives (even those not published externally) is conducted by internal or external nursing experts

Structural Empowerment & Nurse Autonomy

- ☐ Designated bedside nurse champions are identified and actively lead the research/EBP implementation on their units
- ☐ Nurses (via Shared Governance/Councils) have the formal authority to approve, implement, and audit research-based practice changes
- ☐ Participation in the research process or use of EBP is integrated into nurse performance reviews or professional advancement (e.g., career/clinical ladder)

Evidence-Based Practice (EBP) & Quality Improvement (QI) Processes

- ☐ A recognized EBP model (e.g., Iowa or Johns Hopkins) is consistently used to guide practice changes resulting from research
- ☐ Baseline data for the targeted outcome (e.g., mortality, time-to-intervention) is collected before implementing the new practice/tool
- ☐ A formal process exists to monitor fidelity and outcomes of EBP changes (e.g., 3-, 6-, 12-, and 18-months post-implementation)
- ☐ QI/Process measures (e.g., documentation compliance rate, adherence to the new protocol) are consistently tracked and reported back to staff

Appendix X: Data-Sharing Agreement Example

This template outlines requirements and procedures for managing, sharing, and preserving scientific data to ensure transparency and accessibility for research projects. The template can be downloaded at aacnnursing.org/APP-Resources.

Contributors

The following individuals served as facilitators, lead writers, and contributors to this playbook. Names are listed alphabetically within each chapter section. Chapter facilitators and lead writers are identified where applicable.

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