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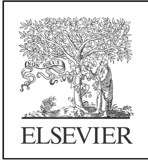

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Academic/clinical nursing integration in academic health systems

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ABSTRACT

Background: Sustained partnerships that strengthen and expand nursing's contribution to the integration of academic nursing into clinical practice holds the promise of improving Academic Health Systems (AHS).
Purpose: The purpose of this paper is to propose a framework whereby academic/clinical integration can be achieved within the AHS to enhance relationships between academe and clinical nursing entities.
Methods: Nursing deans and chief nurse officers/vice presidents from top ranked AHS offer perspectives to advance the integration of nursing leadership into the governance of high functioning AHS.
Findings: Academic and clinical nursing entities within the AHS governance calls for a shared framework to promote an integrated approach to full engagement of academic and clinical nursing.
Discussion: The collaborative benefits of aligning nursing's academic/clinical missions within AHS are described. The challenges and opportunities inherent in the way forward must build on intentionality and commitment for academic and clinical nursing entities to transform the AHS and improve outcomes.

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Introduction

Discourse on the state of partnerships between academic nursing and care delivery institutions has been a topic of recurring interest. The most recent literature has centered on the roles of academic nursing deans in assuming a leadership role to advance academic/service partnerships (AACN, 2016; Sebastian et al., 2018). The professional literature rarely includes reports of sustained academic/service nursing partnerships based on the commitment and engagement of chief academic officers (deans or chairs) and chief nurse officers. Rather, the literature includes recommendations for successful partnerships from academic and executive nurse leaders (Beal et al., 2012); Beal, 2011; Everett, Bowers, & Beal, 2012; Gilliss & Fuchs, 2007). In response, as promising as these recommendations could be, existing reports continue to focus on the nursing partnership and its value in developing workforce capacity (Beal, 2012; Clark &

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Allison-Jones, 2011). Although recognized as vital to the future of nursing education and nursing service (2011), relationships between the educational and service delivery leaders remain misaligned (Houston et al., 2018) with few exceptions (Bay & Tschannen, 2017). As noted in the New Era Report (AACN, 2016), nursing schools in academic health centers (AHCs) are ideally positioned to forge these relationships, although these premises can also be applied to nursing schools that are not AHC affiliated.

Partnerships seem to die out after bursts of episodic interest that feature new start-up initiatives, in contrast to building on previous successful experiences that advance the academic/service partnership agenda to build workforce capacity and improve quality care. Importantly, the inclusion of nursing leaders into the Academic Health System (AHS) governance structure that is not dependent on personal relationships has not been widely adopted.

Successful collaborations between schools of nursing and health care service-delivery organizations are often described as dependent upon the leadership and relationship of deans with chief nurse officers. Failure to optimize these partnerships has been identified as limiting opportunities for collaboration and innovation in nursing education and patient care delivery. The partnership approach frames the solution advanced by the New Era Report (AACN, 2016). Specifically, the Report recommends adding the dean to the clinical decision-making forum as the solution. We believe that the development of sustained and committed partnerships must move beyond personal relationships and novel strategies enacted by nurse leaders. In fact, rather than focus on nurses partnering with nurses, we believe that nursing leadership needs to be incorporated into the governance structure of the AHS. Only when both academic and clinical nurse leaders participate in the governance structure will the full promise of their value be realized. Although these nurse leaders may enact roles within each other's organizations (i.e., Associate Dean for Clinical Affairs or Vice-President for Academic Nursing), we believe that the required changes go beyond the nurse executive and the dean. Fundamental change through the integration of nursing education and nursing service leaders into the governance structure of the academic health system (AHS) is required to transform care delivery systems into high-value, patient-centric organizations.

Purpose

This paper builds on current literature reviews and The New Era Report (AACN, 2016) and proposes a framework in which academic/clinical integration can be further achieved within AHS through an enhanced relationship between academe and clinical nursing entities. We propose that the nursing education and nursing service can be organized within the governance structure of the AHS to promote an integrated and sustained approach to full engagement of nursing education, clinical preparation, and care delivery, enabling the AHS to more effectively accomplish its mission.

Background

The original AACN-AONE Task Force on Academic-Practice Partnerships concluded its work several years ago (Beal et al., 2012) Charged to initiate a national dialogue on current/future best practices in academic-practice partnerships, the Task Force completed a detailed history, reviewed and defined characteristics of successful partnerships, and proceeded to identify the impact and propose strategies for success.

The Task Force concluded there was little replicable evidence to support nursing partnership development and sustainability. They observed that academic/service partnerships take many forms. Among these are models for Faculty Practices/Joint Appointments; Research Centers – knowledge development/use; Workforce Development/scholarships; Educational Redesign/Internships; Dedicated Education Units; and Innovation Centers.

In 2012, Beal conducted an integrative review of 110 manuscripts examining academic service partnerships in nursing and described how the majority were anecdotal and often lacked replicable evidence. The themes included: prerequisites for success, benefits; partnership types; and variations on workforce development (including academic/practice progression and educational redesign). In 2016, the American Association of Colleges of Nursing (AACN) contracted with Manatt Health to advance the agenda of academic nursing partnerships. Initiated by nursing deans in Academic Health Centers (AHC),* the final AACN report was entitled, *Advancing Healthcare Transformation: A New Era for Academic Nursing*. The New Era Report called for a paradigm shift to align nursing education, research, and practice across all types of academic institutions with practice partners. Its stated purpose was to provide a "deeper examination of the potential for enhanced partnerships between academic nursing and AHCs around the imperative to advance integrated systems of care, achieve improved health outcomes for patients and populations, and foster new models of innovation."

Historical Context

The separation of academic nursing from the clinical system accelerated following the 1965 paper published

* Academic Health Centers, are defined as one or more health professions schools (i.e., the medical school plus one other and a hospital) (AAMC, 2014) with varying combinations of health professions schools in addition to medicine with a teaching affiliated hospital and/or health system.

by the American Nurses Association (ANA), which advanced the position that minimum preparation for entry into professional nursing practice should require a baccalaureate degree in nursing (BSN; ANA, 1965). The BSN, awarded by accredited institutions of higher education, is grounded in liberal arts and sciences coupled with evidence-based practice, nursing science, leadership, quality improvement processes, and professional role development. To meet this demand for a more highly educated nursing workforce, nursing education programs migrated toward universities for academic and clinical coursework, a shift that weakened its previously strong ties with clinical service, characteristic of the hospital training model (Donley & Flaherty, 2002). Changes in health care and educational financing, along with evolving AHS ownership and organizational structures may have further distanced academic from clinical nursing and, thus, their level of integration within hospitals (Hudspeth, 2016).

The development of nursing as a theory-based discipline with a scientific basis for practice became the focus of academic nursing, expanding nursing's contributions to practice, research and education outside of hospital and health system settings and further accelerating the separation from the practice of care delivery. The ability of academic nurses to participate in care delivery was compromised by significant teaching demands and expectations for scholarship required for university career advancement. Despite the claim that combining research, education and practice improves care delivery, academic leadership that supports such integration and enables the integration of these combined roles is rare. Mainstream career pathways for faculty members who desire to integrate academic and clinical nursing are limited (Van Ostreen et al., 2017). The New Era Report (AACN, 2016) brings a renewed focus on the importance of the integration and proposes an approach that is promising, but, in our view, does not go far enough.

Organizational Context

The New Era Report (2016) was commissioned by AACN to assess the alignment between major stakeholders in academic nursing and AHCs. The report was based on interviews and surveys with deans of nursing and chief nursing officers, as well as deans of medicine, chancellors and vice-chancellors, and health system chief executive officers. Findings highlighted differences in perspective *(read: culture)* among academic nursing leaders and service delivery leaders in AHC clinical environments. Key differences were identified in how operations are managed, and how and whether the academic and health center organizations were aligned in relation to priorities, costs of care, transitional care and patient-centered models (Sebastian et al., 2018). The New Era Report reinforced the following findings: (a) academic nursing is not positioned as a partner in healthcare transformation; (b) institutional leaders see the missed opportunity for alignment with academic nursing and seek new approaches; and (c) fundamental to this alignment is resource allocation, given that insufficient resources are a barrier to supporting an enhanced role for academic nursing without extramural, entitlement or institutional funding (AACN, 2016, pp. 6–7). The Report (2016) further stated: "Overcoming these challenges will require a paradigm shift in how academic and clinical programs across health science schools and the clinical enterprise organize and align themselves" (p. 19).

The New Era Report recommended six major areas for action (pp.7–8) to be adopted by academic leaders. These include:

1) Embrace a new vision for academic nursing;
2) Enhance the clinical practice of academic nursing;
3) Partner in preparing nurses of the future;
4) Partner in the implementation of accountable care;
5) Invest in nursing research programs and better integrate research into clinical practice; and
6) Implement an advocacy agenda to support the new era for academic nursing.

Of note, the Report advanced recommendations to be enacted by the dean, while calling for a change in culture that could only be accomplished by the cooperative leadership of nursing and health system executives, university presidents and the deans of nursing and medicine. Although the proposed actions appear to advance integration, the report falls short of calling for change of the participatory governance structures and related processes. The proposed changes require organizational leaders to accept equal responsibility and accountability for changes in the system, including the governance structure.

The collaborative imperative for deans of nursing schools to lead this transformation with service partners was broadened in a more recent publication (Sebastian et al., 2018) outlining future collaboration opportunities for deans and their service partners. Yet again, the discernable focus of this strategy relies on the fundamental relationship between the dean and the Chief Nursing Officer (CNO) without the inclusion of the university or other academic health system leaders. Similarly, the AACN recently (2018) reconstituted a joint AACN-AONE Advisory Committee as a step toward bringing these education and service partners together to work on a new vision for academic nursing (Beal and Zimmermann, 2019). This first step can build the vision for ultimate integration, but we suggest that the work extend its reach into the overall governance structure.

Given the uniqueness of each environment, a prescription for exactly how deans and CNOs would advance a proposal for integration requires an institutionally tailored approach. Each entity must address

its structure, processes and desired outcomes both individually and together. Linda Everett, a former CNO who served as co-chair of the 2012 AACN-AONE Task Force, offered her own insights in follow-up to the Task Force's work (Everett, 2016). She addresses the interdependence between leadership, followership and suggests that academic/practice partnerships can be strengthened by intentional decision-making on who leads/who follows and in which area. We agree with (Everett 2016) but would expand her observation to include all participants in the AHS and not exclusively nursing. In other words, there would be projects or portfolio elements led by nursing education and others led by medical education. Still, other areas would be led by quality experts, infection experts, or those who plan innovations in population health care. For the development of sustainability that brings value to the AHS, the relationships must be recognized as having value to the organization, be included in the governance structure, and not be at risk of change with changing leadership. Specifically, the engagement must be institutionalized and interprofessional. In doing so, the combined portfolios of nursing, medicine, administration and allied participants would each take on specific and coordinated responsibilities required to operate a highly functional AHS.

Institutionalizing Priority Relationships

Long-standing relationships between colleges of medicine and health care systems have renewed their focus on collaboration in light of changing contexts. In 2013, the American Association of Medical Colleges (AAMC; 2014) commissioned Manatt Health Solutions to conduct a parallel study to The New Era Report. Under the guidance of the Advisory Panel for Health Care, AAMC and Manatt developed a framework for leadership that guided AMCs to move toward a sustainable model in the future. Perhaps the most notable aspect of this Report is the title: Advancing the Academic Health System for the future. As AMCs shifted their approach to the addressing the triple mission and moved toward the operating model in which the academic medical center was recast as the academic health system, acknowledging the importance of the larger system to address the full set of aims. The challenges for AMCs to grow and develop as AHSs requires leadership and structures to support clinical expansion, community engagement, the evolution of interprofessional leadership and practice structures to lead clinicians toward greater accountability, a movement toward population health, and transparency in quality outcomes and financial performance apparent to patients and payers.

Academic nursing, defined as the integration of the tripartite missions of education, practice and research across both the educational and clinical enterprise, must similarly consider operation within the AHS, rather than the more narrowly organized AHC when developing structures, relationships, and research to improve patient care delivery, population health, outcomes, and workforce development. Indeed the functions of academic and clinical nursing in AHS overlap, just as the functions of academic and clinical medicine overlap in many of the same activities. Hence the need for integration. All the major contributors, academic and clinical nursing, academic and clinical medicine and health system executives, are needed to effectively plan for and prepare the health workforce, design and implement innovations in care delivery and research to improve health care delivery and improve health outcomes.

Notably, both reports call out the importance of the baccalaureate and advanced practice nursing workforces as the groups predominantly responsible for the delivery of patient care. This underscores the need for the AHS to integrate those leading the preparation and deployment of the healthcare workforce of the future, in both medicine and nursing. As the "end-user" of the graduates of health professions preparation programs, AHS leaders, including CNOs, CEOs and others, must have input into programs that would result in graduates prepared to work in today's health care environments. Perhaps the most striking difference between these two reports is that academic and clinical medicine are already generally unified through governance and practice plans. In contrast, academic nursing and clinical nursing often have separate governance, structure, finance, and practice plans. The conclusions and implications of these reports highlight the interdependence and differences across these two professions while pointing to the collaborative opportunities that would advance the practice of nursing and add value for each respective discipline within health systems.

Frameworks for Alignment

We propose the Academic/Clinical Integration framework, which depicts how the enhanced integration between academe and clinical in which the AHS can better achieve the Quadruple Aim Building from two familiar models, the Quadruple Aim and the Learning Health System (LHS), the Academic/Clinical Integration Framework is illustrated in **Figure 1**.

The Quadruple Aim drives patient and population care experiences and outcomes, workforce preparation, and well-being, and cost of care (Shirey et al., 2020) while the LHS drives innovation, continual improvement, and value-based care (Quatman-Yates, et al., 2019). The combination of the Quadruple Aim and the LHS provides the basis for the integration of academe and practice relationships conceptualized into the "Academic/Clinical Integration Framework." The framework identifies how the academe and practice integration are able to strengthen the components of the LHS, which then amplify the progress of the AHS toward improving outcomes in the areas of

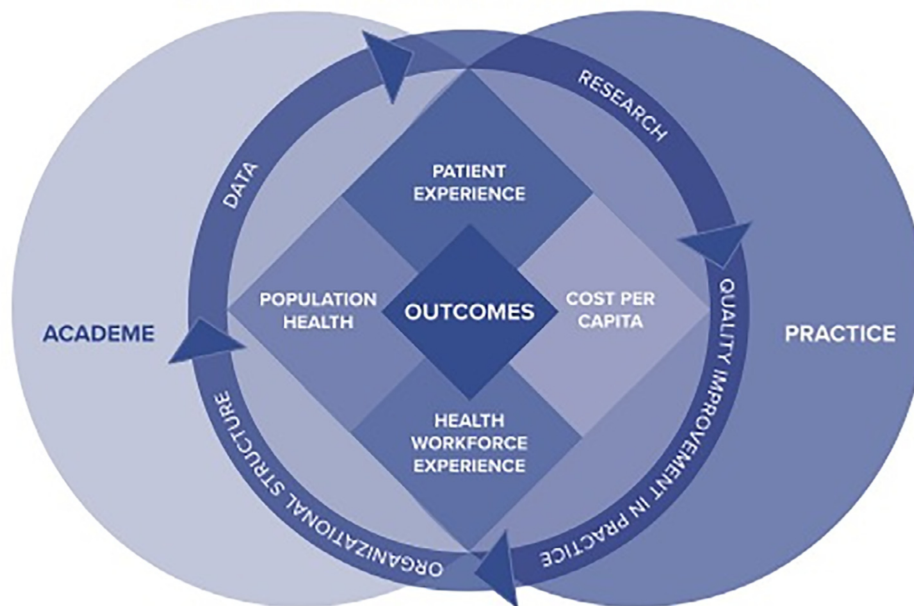

Figure 1 – The academic/practice clinical integration framework

patient experience, cost per capita, health workforce experience and population health (Quadruple AIM).

In Figure 1, the inner circle of the Venn diagram depicts the relationship of the Quadruple Aim and the LHS in academia and practice. The larger the overlap between the academic and clinical circles, the more augmented the LHS and achievement of the quadruple aim becomes within the LHS. The space in the overlapping area of the academic and practice circles expands over time as academic and practice activities become more integrated. These two well-known models are joined to create an integrated framework that serves to guide the outcome and benefits of the academic and practice in joint work.

The Quadruple Aim, depicted inside the Venn diagram, aligns with the recommendations of the New Era Report (2016) and serves as a logical model for improving health care quality and the overall goals of the AHS. Initially, conceived as the Triple Aim (Stiefel & Nolan, 2012), and then expanded to the Quadruple Aim, these four aims include outcomes that: improve the patient experience of care, improve the health of populations, reduce the per capita cost of healthcare and improve the work-life (or well-being) of the health workforce who deliver care (Bodenheimer & Sinsky, 2014). Each of these aims serves as the basis for preparing the health care workforce to improve access to high quality, safe, cost-effective patient, and population-based care are paramount to the adequate preparation of today's nursing and health care workforce.

Likewise, the Academic/Clinical Integrated Framework also offers a unique opportunity for AHSs to achieve and strengthen their capabilities as a LHS, which also facilitates improvement in patient outcomes (McLachlan et al., 2018). The LHS model, which encompasses circular arrows surrounding the Venn diagram framework, positions AHSs to capitalize on major technological advances, generate knowledge, apply evidence, enable rapid learning and improvement based on patient care data. These processes ensure greater quality, safety and innovation in health care. Learning health systems are characterized by four main characteristics: (a) an organizational structure, which supports patients, health care professionals and researchers collaborating to utilize and develop big data; (b) "big data," large electronic health data; (c) quality improvement using new knowledge generated through research; and (d) research occurring as a part of routine health care settings (Forrest, Margolis, Seid, & Colletti, 2014). When combined with the dimensions of the Quadruple Aim, the LHS optimizes value in the AHS providing better care at lower costs.

The coordinated approach articulated through the *Academic /Practice Clinical Integration Framework* positions the AHS to accomplish better outcomes in the areas of the patient experience, population health, safety, health workforce, student, and faculty development. The Academic/Clinical Integrated Framework connects the development of knowledge, translation and execution for better patient- and family-centered care, population care, quality improvement, cost-effectiveness and workforce development. Given the differences in each entity's respective mission in the AHS, academic priorities often address the education of interprofessional students, advancements in science and research, knowledge development, and models of care delivery. Practice priorities, on the other hand, focus on delivering outstanding patient care, including quaternary care and significant charity care, clinical research and developing the future health workforce.

The Academic/Clinical Integrated framework provides the underpinning for the two organizations to outline

the component parts, the benefits to their respective AHS, while establishing activities that can be jointly undertaken, thereby bringing each party's respective work into closer alignment. The components of this integrated framework include the AHS, academe and practice, while the outcomes of the Quadruple Aim are to improve the patient experience of care, improve the health of populations, reduce the per capita cost of health care, and improve the work life (or well-being) of the health workforce who deliver care. Within the AHS, the following factors drive its overall goals: executive leadership, mission, health professions education, value-based care, the LHS, accreditation, research, and innovation (Clancy & Garson, 2015).

Through the Integrated Framework, academic and clinical nursing may be able to more effectively utilize the talents of each and join with academic and clinical medicine, other health professionals and administration to ensure the AHS are most effectively achieving each element of the LHS in a way that puts nursing at the forefront of patient quality improvement. An example of the overlap to promote quality improvement in academe and practice using the Academic Clinical Integration Framework follows. In a large urban AHS School of Nursing, the Dean and faculty members collaborated with the CNO, nursing and medicine to design a dissemination, implementation and improvement study using a retrospective analysis of Hospital Acquired Pressure Ulcers (HAPI). The Dean and CNO sustained leadership commitment and allocated resources to this collaborative study that supported the involvement of students, faculty, hospital nursing, and medical staff. Together clinical nurses, graduate nursing students, and faculty members implemented an intervention in consultation with the wound care team that included improved reliability for measuring pressure ulcers. Daily data were collected by students and nurses and analyzed from electronic health records by faculty to inform just-in-time interventions at the unit level; overall data was analyzed by faculty each month and monitored over 2 years by academic and clinical nursing. Data analysis showed a steady 40% decrease in HAPIs over 2 years. The collaboration led to evidenced-based Pressure Injury Rate improvement in the AHS, related increases in health system reimbursement, and has been acknowledged by the Health System Board's Patient Care and Quality Assurance Committee (Polancich, Poe, Miltner, Shirey, & Harper, 2020). This highly engaged collaboration and learning among faculty in nursing and medicine, their respective students, and the involved clinicians, resulted in cost-effective interventions that improved the patient experience, quality outcomes for the patient/patient population, and improved the satisfaction of the involved members of the workforce. Importantly, this joint study enhanced quality patient care, student education, professional development and increased research capacity for academic and clinical nursing. The improvement in the pressure injury rate over time is reflective of the process and outcomes of nursing care, demonstrating the success of this academic and clinical integrated initiative.

Collaborative Benefits

While carrying out the different components of the AHS mission, AHSs compete in highly competitive health care markets, resulting in dynamic nurse labor markets. Job markets constitute a significant factor in nurse turnover, and employers often consider this element of turnover, both costly and challenging to manage. Academic health systems can minimize turnover through the strategic alignment of education and training opportunities between nursing academe and practice offering cost-effective, distinctive, and efficient management of nursing resources. The coordinated and integrated approach between academe and the AHS would enable the AHS to more effectively develop and manage the nurse labor training and development opportunities, thus ensuring a competitive advantage in the recruitment and retention of nurses in their labor market. Nursing schools based at AHSs offer highly specialized education and training opportunities for quaternary care delivery. These approaches coordinated between academe and practice enable the AHS to provide access to these highly specialized nursing programs and training opportunities, which in turn, can be developed in real-time to meet the specific needs established by the clinical leadership.

The academic institution is driven by leadership, through its governance and organizational structure, to accomplish its missions: health workforce preparation and development; research and knowledge dissemination; and the design and testing of clinical innovations. Likewise, the clinical services delivery enterprise is driven by its leadership, to accomplish its mission of clinical care delivery, as influenced by the quality of its operations, available reimbursements and the quality of care and engagement of patients and providers. The overlap in these factors across the AHS is evidenced through the ongoing integration and commitment to several distinguishing features of the mission of the AHS. Among these are: the education of tomorrow's doctors, nurses and other health professionals, pioneering of biomedical and clinical research, a significant portion of care delivered to underserved populations, a range of care services including high quality innovative quaternary care limited in its availability (e.g., comprehensive cancer centers, level one trauma centers, and pediatric intensive care units; (Advancing the academic health system for the future: A report from the AAMC Advisory Panel on Health Care, 2014). Through the application of these two integrated frameworks, the synergistic overlap for the missions in practice and academe can serve as a catalyst for innovation, research, quality improvement in the LHS as well as the dimensions of the Quadruple Aim.

What is the value of a coordinated and integrated approach? An obvious, but often elusive example, is the alignment of preparing the nursing workforce needed in the AHS, including adequate numbers of well-prepared nurses whose education has prepared them to function in the highly specialized AHS. Not only does this workforce provide sophisticated care directly to patients, but they are able to improve care through quality improvement projects, as illustrated in the previously described example. In the clinical setting, students, faculty and professional staff mentors work on longitudinal projects that enable all concurrently learn how to use evidence to improve care, but to actually improve care outcomes through collaboration with the service sector on clinical problems of high priority. These coordinated efforts provide ongoing assessment, implementation and evaluation of high priority clinical areas. Such student experiences, whether in nursing or medicine, are reality-based and the service sector benefits from the added capacity of students and faculty who can focus on these areas and accelerate outcomes. These examples highlight the possibilities for improvement when we align resources around agreed-upon priorities to produce beneficial outcomes for all entities (e.g., meaningful education, research and projects for students, value-based projects for the service sector based on identified needs, and aggregate tailored outcomes for the AHS and university program).

Assessing Challenges and Opportunities

Moving beyond rhetoric to the changes described is complex and requires strong leadership and collaboration. The essential messages of this paper are twofold: (a) the benefits of integration can and should serve the goals of the academic health system; and (b) the work of integration requires intentionality and commitment to collaboration across the AHS, beyond nursing. The movement from a focus on the partnership between the nursing entities to understanding the strategic importance of the nursing entities to the AHSs provides compelling support for bringing them into a strategic alliance with the governance structure of the AHS.

Academic health systems have strategic priorities and plans, as do the schools associated with them. These plans should have a relationship to one another and alignments should be collaboratively identified to create blueprints for success. Given a commitment to goals of the AHS, each major contributor (e.g., academic medicine, clinical medicine, academic nursing, clinical nursing and executive leadership, including health system CEOs, presidents, provosts and others) could call out the ways in which they are able to contribute to the strategic priorities. Explicit priorities would drive the plan – for workforce development and well-being, for clinical delivery design and quality, for cost-effective solutions and for knowledge development.

Therefore, the commitment would begin with a joint review of challenges and opportunities specific to that AHS. The development of a governance structure where this work is accomplished will promote ongoing dialogue, early recognition of changing needs and opportunities for celebration. The development of a structure, with a charter, would help to address the barriers posed by changing leadership within the AHS. The ability to successfully form a working alliance should not be based on whether one or two leaders enjoy a positive relationship. Governance matters and expectations include the development of explicit roles and responsibilities.

Intentionality and Commitment

The transformation to alignment across education and clinical service delivery in nursing and medicine begins with a commitment by the AHS leadership to working together. An integrated structure requires a detailed agreement that provides a foundation for direction and ongoing review and serves as a “true North” when the commitment is at risk through disagreement or competing priorities. The document, based on mutual respect and the acknowledgment of the differences and overlap in organizational mission, needs to be written, signed and periodically reviewed at the highest levels of each organization in academe and practice, including but not limited to: the

Table 1 – Proposed Organizational Commitment Assumptions
A long term commitment by the AHS leadership to working together across disciplines should be tailored to academic and clinical organizational characteristics and respective needs.
Detailed agreement or charter is essential for sustainability.
The charter provides a foundation for direction and ongoing review, is written, signed and periodically reviewed by leaders at the highest levels of both organizations.
The governance structure of the AHS should include both nursing education and practice together with medicine and other health related disciplines.
An evaluation blueprint is a prerequisite for shared planning for joint academic and clinical work, with expected outcomes and continuous monitoring for progress.
Integrating academe and practice builds on a shared framework centered on patients, populations, learners, and each other.
Funding shared work is a priority and reinforces value-based joint activities.
Shared frameworks that integrate learners, learning, patients, populations, populations, and quality validates the overlap of academic and practice activities.

President, Provost or those in representative titles, and the CEO of the Health System and others as appropriate. This charter, endorsed by all participants, serves as the organizational commitment that goes beyond nursing education and service and provides the basis for our organizational assumptions. The charter is based on a set of organizational commitment assumptions that are expanded from the AACN Academic Partnership Resources and Guidelines (2020) and compiled from existing literature (see Table 1) as a way forward in the shared work of academic/clinical integration.

Conclusion

The value of working together in an integrated AHS leadership model has never been so urgently needed. Care is more complex and new models are needed to care for people in remote areas and those with chronic illnesses. This is particularly true for those entities that have annexed other care partners to create the academic health systems that have replaced the academic health centers. Care will be improved through population approaches that employ evidence in care design, delivery and monitoring. As we write, the COVID-19 pandemic is moving across the U.S. and the importance of working together to stand up new services and prepare the healthcare workforce has come into high relief. Let us learn from this remarkable experience in which we were required to abandon “business as usual” and consider how we can put these lessons to good use to transform the governance of the AHS. Nursing’s leadership from education and clinical care delivery belong at the decision-making table, permanently included by revisions in the governance structure of the AHS.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.outlook.2020.09.002.

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