Implementing innovation through education-practice partnerships

Joan M. Stanley, PhD, RN, CRNP, FAAN
Traci Hoiting, MS, RN, ACNP-C
Deborah Burton, PhD, RN, CNAA
James Harris, DSN, RN, APRN-BC, MBA
Linda Norman, DSN, RN, FAAN

Calls to transform the healthcare system and evolve the preparation of healthcare professionals have increased in recent years. In response to the concerns and recommendations voiced in the series of national reports, the American Association of Colleges of Nursing (AACN) Board of Directors initiated a series of task forces from 1999–present. The pilot Clinical Nurse Leader (CNL™) initiative which grew out of the work of the task forces represents an exemplary national partnership between nursing education and practice. The CNL is a new nursing role being developed and piloted by the AACN in collaboration with education and practice leaders.

An AACN task force, comprised of equal representation from education and practice, is currently working with 86 partnerships, including 92 schools of nursing and 191 health care institutions, to implement the CNL initiative. All of the partnerships have committed to collaboratively develop a master's CNL degree program and to transform one or more units within the healthcare institution utilizing the new CNL role. Early patient care outcomes from the initiative are positive. However, one additional outcome realized from the initiative has been the coming together of nursing education and practice to achieve a common goal—improved patient care outcomes.

Joan M. Stanley is Senior Director of Education Policy at the American Association of Colleges of Nursing, Washington, DC.
Traci Hoiting is Vice President for Nursing Practice & Operations at Swedish Medical Center, Seattle,WA.
Deborah Burton is Regional Director, Nursing Education and Performance at Providence Health System, Portland, OR.
James Harris is Chief Nursing Officer at VA Tennessee Valley Healthcare System, Nashville, TN.
Linda Norman is Senior Associate Dean for Academics at Vanderbilt University School of Nursing, Nashville, TN.
Reprint requests: Joan Stanley, PhD, RN, CRNP, FAAN, Senior Director of Education Policy, American Association of Colleges of Nursing, One Dupont Circle NW, Suite 530, Washington, DC 20036.
E-mail: *jstanley@aacn.nche.edu*

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> A partnership—two or more persons in the same enterprise, sharing the profits and risks.
> — Webster's Dictionary

Calls to transform the healthcare system and evolve the preparation of healthcare professionals are growing louder in recent years. In 1999, the Institute of Medicine (IOM) released its landmark report, *To Err is Human: Building a Safer Health System*, which called on health care systems to re-orient their efforts to reduce medical errors and improve patient safety.[1] The American Hospital Association[2] and the Joint Commission on Accreditation of Healthcare Organizations[3] released similar reports in 2002. In 1998, the Pew Health Professions Commission called for new ways of educating future health professions.[4] In 2002, the Robert Wood Johnson Foundation called for developing new practice models and enhancing collaboration between education and practice.[5] And in 2003, the IOM released its set of 5 core competencies that all clinicians should possess to meet the needs of the 21st century health system, regardless of their discipline.[6] In addition to these universal calls from outside nursing to change the way health professions practice and are educated, several studies demonstrated that more nurses educated at baccalaureate or higher levels produced better patient outcomes—specifically, reduced mortality and failure-to-rescue rates.[7,8]

In this climate, the American Association of Colleges of Nursing (AACN) Board of Directors identified some primary concerns related to care delivery and nursing education. In general, nursing had not succeeded in differentiating practice of RNs with different educational preparation; numerous reports had shown that care provided to patients was not high quality; the care delivery system was growing much more complex; and the knowledge base for nurses had increased dramatically (eg, genetics, environmental health, and informatics). In response to these complex issues, the AACN Board of Directors initiated a series of task forces to focus on these key concerns, including the Task Force on Education and Regulation for Profes-

sional Nursing Practice I (TFER I) (1999–2002); Task Force on Education and Regulation for Professional Nursing Practice II (TFER II) (2002–2003); the Clinical Nurse Leader (CNL™) Task Force; and the CNL Implementation Task Force (2003–present). (For additional information on and reports of these task forces, go to http://www.aacn.nche.edu/CNL/index.htm).

The TFER I developed models for future nursing education and regulation. The TFER II focused on nurse competencies needed in the current and future health care system to improve patient care. This second task force examined what the "New Nurse" role might look like, which resulted in the publication of the draft working paper on *The Role of the Clinical Nurse Leader*.[9] Throughout each stage of this work, external stakeholder panels, comprised of representatives of education and practice within and outside nursing, were invited to respond to the draft reports. In addition, representatives from education and practice were invited to participate in a series of meetings and discussions looking at this new nursing role. In October 2003, 283 representatives of education (165) and practice (118) met in Washington, DC to explore the feasibility of implementing the CNL both within nursing education and in the practice environment.

THE CLINICAL NURSE LEADER INITIATIVE: BRINGING EDUCATION AND PRACTICE TOGETHER

The Clinical Nurse Leader™ or CNL™ is the new nursing role being developed and piloted by the AACN in collaboration with education and practice nursing leaders. In partnership with multiple stakeholders, AACN has developed the CNL to improve patient care outcomes and better meet the changing needs of the health care system. The CNL role emerged following research and discussion with stakeholder groups, within and outside of nursing, as a way to engage highly skilled clinicians in outcomes-based practice and quality improvement.

In practice, the CNL understands the "big picture" about the patient and the care environment. At the point of care, the CNL provides lateral integration of care for a distinct group of patients and implements evidence-based practice to ensure that patients benefit from the latest innovations in care delivery. The CNL also is expected to evaluate patient outcomes, assess cohort risk, and to have the decision-making authority to change care plans when necessary. The CNL role is not specific to the acute care setting but delivers health care in all settings; however, the implementation of this role may vary across settings. Similarities or overlap in knowledge and skills between this new CNL role and other nursing roles, including the clinical nurse specialist (CNS), nurse manager (NM), and case manager are recognized. However, the CNL role represents a unique set of knowledge and skills which are implemented within a microsystem of care, at the point of care to improve patient outcomes. The CNL practices as an advanced generalist as opposed to specialty practice of CNSs, NMs, and other distinct nursing roles. Comparisons of the CNL and CNS and NM roles can be accessed in the CNL online toolkit at http://www.aacn.nche.edu/CNL/tkstage5.htm.

Table 1. CNL Partnerships by Region of the Country

CNL™ Partner Schools by Region	(n = 92)
North Atlantic	17
Midwestern	30
Southern	30
Western	15

Table 2. CNL Partnerships by Carnegie Classification

CNL™ Partner Schools by Carnegie	(n = 92)
Baccalaureate Colleges—General	3
Baccalaureate Colleges—Liberal Arts	1
Doctoral/Research Universities—Extensive	23
Doctoral/Research Universities—Intensive	17
Master's Colleges and Universities I	29
Master's Colleges and Universities II	1
Medical Schools or Centers	10
Other Separate Health Profession School	1
Other Specialized Institution	1
Unknown (No Carnegie Code)	6

To pilot this innovation, AACN currently is working with 86 education-practice partnerships in 35 states and one US territory to develop master's degree programs to prepare CNLs and to integrate this new role into a transformed care delivery model. These partnerships between 92 schools of nursing and 190 health care institutions have assumed various models. However, all of the partnerships have in common the commitment to collaboratively:

- develop a Clinical Nurse Leader master's degree program based on a common curriculum framework and set of outcome competencies; and
- transform one or more units within the healthcare institution utilizing the new CNL role.

A majority of the practice partners do represent acute care health care facilities; however, long term care, school health, community health, and visiting nurse associations are also represented. The education partners also represent a cross-section of graduate schools of nursing (Tables 1&2).

The 86 partnerships are at varying stages along the implementation continuum. The first CNL graduates

Table 3. Summary of CNL™ Three-Month Pre- and Post-Assignment Evaluation Outcomes at VA Tennessee Valley Healthcare System

Indicator	Measure	Pre- and Post-CNL Assignment Findings in Specific Patient Units
Financial	Readmission Rates	Reduction in patients diagnosed with heart failure readmissions to Medical Intensive Care Unit (MICU) and Telemetry.
	Nursing Hrs Per Patient Day	Increase in staff RN productive hours.
	Average Length of Stay (LOS)	Decreased LOS by 1 day in MICU.
Satisfaction	Discharge Instructions	Increase in completion of discharge instructions for patients diagnosed with heart failure, thus reducing readmissions to MICU and telemetry.
Quality	Falls	Reduction on general surgical unit post-operatively.
	Surgical Infection Rate	Reduction in post-operative infections on general surgical and surgical intensive care units.

completed the program in August 2005. By January 2007, a total of 12 schools had CNL graduates and were administering the new CNL Certification Examination™. The CNL Certification™ will create a unique credential for graduates of a master's or post-master's CNL program. Additional programs are slated to graduate their first class of CNLs in Spring 2007, with > 250 graduates by that date.

CREATING A SUCCESSFUL EDUCATION-PRACTICE PARTNERSHIP TO SUSTAIN INNOVATION

A true education-practice partnership requires an ongoing dialogue between the members of the academic institution and the healthcare delivery institution. Another critical characteristic of a partnership is that both partners are teachers and learners within the context of the collaborative relationship. Factors that must be taken into account when considering any potential partnership include such things as the location, availability, public or private status of potential partners, competition from other sources for resources, funding, and decision-making processes and philosophy of both parties. Opportunities to form multiple partnerships or include multiple institutions (both education and practice) in a partnership may be beneficial to create diversity of resources and clinical opportunities.[10] Five of the 86 education-practice partnerships participating in the CNL pilot initiative comprise 2 or 3 schools of nursing and 1 or more healthcare institutions. The remaining partnerships include one school of nursing and up to 9 health care institutions. If partners have similar philosophies, the obstacles that manifest themselves while forming and expanding an education-practice partnership will not be insurmountable.

For sustainable partnerships to flourish, it is imperative that a common vision be identified. Vision refers to a picture of the future with some implicit or explicit commentary on why people should strive to create that future. Clarifying the direction and need for the change is important because, frequently, people impacted by the change disagree on direction, or question whether significant change is really necessary. Creating a common vision and involving all CNL stakeholders in the planning and transition is critical. Effecting successful change requires creating a sufficiently powerful guiding coalition and anchoring changes firmly in the organizational culture. The consequences of not doing this are that the targeted innovation or change is not implemented or the quality programs do not achieve the envisioned results.[11]

Creating an effective partnership between organizations should create a new or different way of working together. The partnership may create a radical change in the culture of each organization, while introducing new ideas and different ways of doing things or viewing situations. Schools of nursing and healthcare institutions have a common goal of quality patient outcomes; however, these 2 entities frequently have approached the methods of achieving this goal very differently.

The CNL education-practice partnerships have committed to work together to implement the CNL initiative within the academic and practice settings; have committed significant resources (human and fiscal) to this endeavor; and expect to reap the benefits generated, including improved patient outcomes, new and increased enrollments, and cost benefits in health care delivery. In collaboration with AACN, the Veterans Affairs (VA) Tennessee Valley Healthcare System (TVHS) developed a CNL evaluation framework to measure financial, satisfaction, and quality outcomes. Early outcomes of this evaluation and similar projects have demonstrated positive outcomes, including reduced re-admission rates, decreased length of stay, decreased patient falls, and increased patient and RN satisfaction.[12–15] The preliminary data at TVHS indicate the potential for experiencing very positive quality and cost-benefit outcomes from this partnership CNL model of care delivery (Table 3).

MODELING AN EDUCATION-PRACTICE PARTNERSHIP AT THE NATIONAL LEVEL

The AACN CNL Implementation Task Force (ITF), established in 2004 to oversee the implementation of the CNL pilot initiative, represents a true education-practice partnership model. Membership on this task force is comprised of 50% representation from practice and 50% from academia. The ITF has produced numerous documents and materials that inform the implementation of the CNL initiative, including the CNL Curriculum Framework, End-of Program Competencies, Preceptor Guidelines, CNL Performance Assessment Tool, and now a CNL Tool Kit. (All of these materials can be found on the AACN Website at http://www.aacn.nche.edu/CNL). Each of these documents has been developed with equal input from education and practice.

In addition to seeking individual representatives from education and practice, AACN invited the American Organization of Nurse Executives (AONE) to join the CNL initiative. The AONE immediate past-president, Karen Haase-Herrick, was appointed to the CNL ITF. In addition, two AONE representatives were asked to serve on the CNL Evaluation Committee. One of AONE's major organizational initiatives is the redesign of patient care delivery models for the future. The partnering of AONE and AACN provided synergy for both initiatives. The AONE *Guiding Principles for Future Patient Care Delivery Models*[16] are congruent with the AACN Clinical Nurse Leader project goals and serve as the basis for AONE's support of this work. The AONE Board believes that innovative pilots such as AACN's Clinical Nurse Leader are critical to informing the field for the future. A new document provides a comparison of the AONE "Guiding Principles" and the AACN CNL Core Competencies and End-of-Program Competencies.[17]

IMPLEMENTING THE CNL INITIATIVE IN PARTNERSHIP: EXAMPLES IN ACTION

Providence Health System and University of Portland School of Nursing CNL Partnership

The organizational partnership between Providence Health System and University of Portland has evolved steadily over nearly a century. The shared commitment to joint CNL education reflects, first, organizationally aligned Catholic missions and values—most notably, dedication to service, compassion, and excellence. Founded by the Sisters of Providence, Providence Health System (PHS) is the oldest and largest health system in Oregon. Providence Oregon includes the only 2 hospitals in Oregon to receive American Nurses Credentialing Center (ANCC) Magnet Designation—St. Vincent and Providence Portland Medical Centers. University of Portland is the first and only Catholic university in Oregon and is run by the Holy Cross Fathers. In nursing, the close collaborative relationship was forged as the Providence St. Vincent hospital-based diploma nursing program merged with the University of Portland (U of P) School of Nursing baccalaureate nursing program in 1932. Over the years, Providence has partnered closely with U of P to provide clinical education for undergraduate and graduate nursing students, and has shared faculty and other direct clinical educational supports.

As the CNL role began to evolve nationally, Dr. Terry Misener, Dean of the U of P School of Nursing, and Ms. Kathy Johnson, Chief Nurse Executive for Providence Oregon, collaborated once again. Jointly advancing the CNL role and program seemed like a natural extension of the Providence Scholar program, which provides support for BSN students at U of P in exchange for a 3-year work commitment at Providence. While the Providence Scholar program provides a continuous stream of Catholic-educated BSNs into the workforce, it does not directly address some pervasive and complex patient care challenges. These include fragmented and uncoordinated care, communication breakdowns, and the need for expert leadership and mentorship at the bedside. The CNL role appeared to be a natural strategy for addressing many of these challenges throughout Providence. The CNL partnership was the first time Providence (practice) and U of P (academia) worked jointly on curriculum design and, subsequently, on redesigning care at the bedside. The partnership provided multi-dimensional perspectives which enhance curricular design and practice redesign. Frequent and clear communication is essential for success.

To date, Providence Health System Oregon has provided 7 scholarships to current employees who have returned to school at U of P to attain their masters' degree in the CNL program. Four more will be supported in the program in 2006. Additional resources committed by Providence include clinical practice experiences, steering team time, and clinical redesign retreats.

Close collaboration and strategic program development is managed by a joint CNL steering committee. It is comprised of nurse executives from Oregon Providence facilities, the state Director for Nursing Education and Performance, representatives from the Portland Veterans Affairs (VA) Medical Center (another U of P clinical partner), graduate U of P faculty, facility-level clinical and education directors, and the Providence Scholarship program coordinator. The current CNL students are actively contributing to refining the vision and implementation of the CNL role throughout Providence. The first CNL clinical rotations began June 2006. Collaboratively, clinical sites were selected and preceptors and mentors were identified and oriented to the preceptor and mentor roles. To date, the CNL

students have been precepted by both nurse practitioners and clinical nurse specialists. In addition, CNL clinical practica have included opportunities to observe how systems and processes (eg, medication reconciliation, quality improvement, infection control, and others) impact patient care outcomes. These experiences will enhance the CNL's ability to ensure safe and high quality patient care. The CNL Steering Committee is actively engaged in developing a CNL role description that will eventually lead to an actual broad position description. Also, the Steering Committee will tackle marketing the CNL role to internal and external audiences in the very near future.

Potential barriers to the implementation of the CNL role include insufficient numbers of CNLs across the organization (particularly as the benefit and impact of the role are realized), lack of involvement by staff nurses and others in role development and implementation, resistance to alter already-established unit processes, and competing regulatory and organizational priorities. The chief nursing officer (CNO) plays a significant role in championing and supporting implementation of the CNL role. The CNO needs to set the stage for the organization and involve multiple stakeholders so they understand the CNL role and its potential benefits. The CNO is also crucial in leading care redesign processes and advocating for financial resources. Staff nurses must be engaged early in the role development and implementation so they see the benefits of the care redesign and view the CNL as an available resource. When staff are engaged in the process, they better understand the CNL and can help champion the role.

VA Tennessee Valley Healthcare System and Vanderbilt University School of Nursing CNL Partnership

While common goals have existed between schools of nursing and healthcare affiliates for decades, formalized partnerships that clearly delineate role and functions are often absent. Formalized partnerships create opportunities for success as educators, clinicians, and administrators mutually establish goals and expected outcomes. The VA Tennessee Valley Healthcare System-Vanderbilt University School of Nursing CNL partnership is one example of a successful partnership.

With the introduction of the CNL role by the AACN, Vanderbilt University School of Nursing (VUSN) and Veterans Affairs (VA) Tennessee Valley Healthcare System (TVHS) were in a unique position to partner in the education and clinical preparation of master's-prepared nurse generalists. Vanderbilt University School of Nursing had serendipitously begun the CNL journey in spring 2003. A national focus group comprised of chief nursing officers, nurse leaders and educators was invited by AACN to discuss how a masters'-level nursing curriculum could be developed that prepared generalist nurses interested in remaining at the bedside to eliminate fragmentation of care. The chief nursing officer in the Department of Veterans Affairs, Cathy Rick, participated in this national discussion. Simultaneously, nursing administration at VA TVHS was engaged in similar discussions while redesigning the nurse case manager role. Both activities, by education and practice, culminated in a successful partnership. The CNL partnership was formalized by the completion of a Request for CNL Proposal to AACN in April 2004. Collaboratively, a CNL position description and core competencies were developed and a national VA CNL competency validation workshop was offered as case manager roles were redesigned and staff members were prepared as pioneer preceptors for the CNL student. The partnership continues as graduates now are functioning in the CNL role. A post-master's CNL option also has been initiated with the first graduates successfully functioning in the role.

Some of the activities that facilitated the development of the partnership between TVHS and VUSN include: joint appointments, funded tuition options for students, joint development options for media, joint participation in interprofessional committees and learning activities, and an ongoing dialogue between staff and faculty regarding collaborative opportunities. Benefits of the partnership that have been realized to date, in addition to the actual development of the CNL initiative, include: presentations on the CNL at joint hospital-university conferences, joint submission of several grants, more hospital staff returning for higher nursing education, increased joint and individual publications, and sharing of resources in the development of continuing education classes.

One potential barrier to introducing a new nursing role within a care delivery model is the perceived threat to other roles. In anticipation of this potential threat, partnerships or collaborations among interdisciplinary team members were created or reinforced. This resulted in the development of a marketing plan that defined the role of the CNL and highlighted the significant contributions of both the CNL and interdisciplinary team members. Tracer methodology was a tool which was familiar to clinical staff and became a key driver to spotlight the various roles and functions carried out daily by interdisciplinary team members. Clinical case examples were randomly identified and focus groups delineated the various team functions as care was delivered. Using a group facilitator, focus group members identified how the CNL could be utilized, and identified potential for reducing—if not eliminating—duplicative functions. Initial concerns were voiced by staff nurses that the CNL role was another nursing trend and may be short-lived. Others voiced concerns that the role would replace staff nurse positions. Such information allowed opportunities for nursing management to frame discussions and actions that captured each team member's value in reducing the repetitive spiral of fragmented care delivery and, ultimately, improving patient outcomes.

While all team members played a role in preparing units for the introduction of a new clinical nursing role, staff nurses played the most significant part in its success. Involving staff nurses in the role design and identification of how the CNL would reduce care fragmentation and elevate nursing practice early-on were pivotal to success. Through the CNL role, staff nurses saw new opportunities to expand their practice while remaining at the bedside. Historically, nurses who desired to remain in direct patient care and progress up the clinical ladder found it difficult, frequently electing to enter management tracks. The CNL role offers opportunities for clinical progression and increased accountability for care delivery at the unit level. In addition, staff nurses, with support from the CNL, are venturing into other innovative projects which spotlight the practice unit for "best practices" and improved evidence-based outcomes.

SUMMARY

A partnership is long-term, convergent, strength-oriented, and pulled by vision. It moves with an optimistic uncertainty. In each new partnership, you are creating a unique educational program. Each partnership is multidimensional and dependent on the interactions of a variety of participants. All participants must be empowered to have a voice for a true partnership to exist. Forming a true partnership is a learning process for all concerned and when you know better, you will do better.[18]

The CNL initiative grew out of a mutually identified need for improved patient care outcomes. Ninety-two schools and 190 health care institutions have entered partnerships committed to implement a master's CNL education program and to transition the care delivery model on one or more units within the healthcare institution. Early outcomes have demonstrated positive patient outcomes.

In the 1960's when nursing education moved into institutions of higher education, the relationship between education and practice changed significantly. Contracts were signed between schools of nursing and healthcare institutions to provide clinical sites for student practica. And, over the past decade, an increasing number of nursing clinicians have been given adjunct faculty appointments to ensure sufficient clinical faculty. However, true partnerships between education and practice have been limited. Partnership requires bilateral commitment of resources to achieve mutual goals and a shared vision. An ongoing dialogue between partners is critical to successful implementation of the partnership. To be successful, practice must have a significant role in the design and implementation of the educational experience, in this instance the CNL curriculum. Likewise, education must have input into the design and transition of models of care delivery.

The AACN CNL initiative has modeled a true partnership between education and practice not only at the individual institutions but at the national level as well. This strong partnership between education and practice has not been experienced in recent nursing history. Many successful outcomes from the CNL initiative are anticipated; however, one of the earliest and most significant outcomes to date has been the successful partnership formed between practice and education to address a common goal—quality patient care outcomes.

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