Nurses & Nurse Practitioners of BC

Academic-Practice Joint Appointments in Nursing

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Background

Structural and organizational integration of research, education, and practice initiatives between academic and organizational partners has been recognized globally as a primary mechanism to advance, transform, and sustain excellence in healthcare delivery.[1–3] For decades, health service organizations and academic counterparts have acknowledged the need to better align themselves to advance tripartite mandates related to clinical care delivery, research, and teaching.[1] Despite this recognition, however, 'unlinked partner models' continue to dominate academic-practice relationships, resulting in disparate financial and performance measures and an overall lack of executive authority that can bridge and align patient care with research and education.[3]

In response to these issues, new partnership models and roles have been developed to promote integration, congruency, and alignment between academic institutions and healthcare organizations.[1–5] These innovative approaches include the development of Academic Health Science Centers, which refer to relationships between academic programs and affiliated health authorities that provide facilities necessary for delivering care, research, and education.[1] These organizations combine healthcare services with research and teaching and use collaborative mechanisms between the hospital and university, often through affiliated agreements to bridge research with practice.[1] In addition to these centers, dual or joint appointment positions between academic and service sectors have also been developed.

These positions are developed through an agreement between a school and clinical agency to appoint persons to a particular position in both organizations.[6] Although joint appointments have been found to promote collaborative practice between institutional

and organizational structures and support inter-organizational communication and cooperation, little research has been done regarding how these roles are developed and implemented.[6]

Purpose

Healthcare and the nursing profession, specifically, face myriad issues that are impacting service delivery. These challenges include the availability of clinical faculty to support practice education for nursing students, staffing constraints, and the availability of integrated evidence to support clinical practice and education initiatives.[4,5] Given the potential contributions of joint appointments to both academic institutions and the health system, the following provides a literature synthesis and summary regarding joint appointment roles within nursing and their impacts on health service delivery and education.

Methods

A search strategy was developed using the Cumulative Index for Nursing and Allied Health Literature (CINAHL) (Appendix A). The following search terms were used, "joint appointment" as a major subject heading, OR "dual appointment" OR "lecturer practitioner" AND nurs*. Expanders included applying related words and applying equivalent subjects. No date limiter was set as the intention was to identify all relevant literature on joint appointments (n=164). In addition to this, the Ministry of Health Librarian was consulted. The librarian completed two search strategies using the Health and Human Services library access through the Ministry of Health (n=29).

Inclusion criteria included research articles focused on joint appointments outside of established roles such as clinical preceptors, which were specific to nursing, included the term "joint appointment" in the title, abstract or as a keyword, were written in English language, and accessible online. Exclusion criteria included articles that were exclusively anecdotal, those focusing on established roles such as clinical sessional faculty, those not accessible online and those not accessible in English.

Titles, abstracts and keywords were reviewed for 193 articles. A total of 16 articles are included in this summary based on their relevance to the topic of interest.

Evidence summary

Joint appointments

Research into joint appointments in nursing can be found as early as the 1980s, with more specific attention increasing in the 1990s and early 2000s, particularly in Australia and the United Kingdom.[2,6–10] Interest in joint appointments emerged after nursing moved into higher education, in response to increasing tensions between nursing education and health system operations whereby nurse educators experienced less control over practice models which resulted in clinical education being highly dependent on institutional nursing staff.[9] Since their inception, joint appointments have been considered a key mechanism for addressing the often-cited theory-practice gap in nursing.[10]

Joint appointments are distinct from individuals employed separately by educational institutions and healthcare organizations in those joint appointments, as one position, aim to mutually benefit both the institution and organization within one distinct role. Furthermore, these roles differ from those with academic and practice expertise, such as clinical nurse specialists' roles or clinical nurse scientist positions. Joint appointments typically refer to positions with academic and clinical responsibilities and, therefore, involve dual reporting structures to organizational and institutional leadership as well as collaborative funding models.[6,11]

Joint appointments are considered to be inherently collaborative, often grounded in five common goals: improving the quality of nursing practice, enhancing the learning environment, promoting research capacity, fostering interprofessional collaboration and maximizing cost-effectiveness.[9] Resultingly, they have been hypothesized to be a key strategy in mitigating structural gaps related to research, education, and practice.[8]

Evidence-informed approaches: Joint appointment models of practice

Joint appointments have been implemented differently across academic and organizational settings, often with one agency assuming primary responsibility. For example, positions can be implemented as faulty-agency roles, where primary responsibilities of the position pertain to the academic institution, or agency-faculty roles, where primary responsibilities of the role are associated with the healthcare organization.[6] Most joint positions noted in the nursing literature have focused on dual roles related to nursing practice and clinical education. Examples of these models include:

1. Collaborative clinical education models: staff nurses working in a joint appointment as assistant clinical instructors who are paid by the educational institution and work collaboratively with a full-time faculty member.[12]

2. Clinical scholar models: clinical nurses continue organizational employment but are periodically released from their position to work as clinical educators. During this time, the clinical educator would be paid by the education institution and have access to a faculty member who provides intermittent support.[13]
3. Staff tutors or clinical facilitators: Clinical nurses work as staff tutors to provide a component of clinical education (e.g., 50% of clinical education), with a faculty member providing the other component. The clinical facilitator often supports students in general practice areas in psychomotor and clinical skill development.[10] Depending on the model, the staff tutor and faculty member work collaboratively to provide students with feedback on both written and practice performance.[14]

In addition to these models, joint appointments have occurred at a leadership level as 'joint clinical chairs', which focus on developing research, clinical, and professional practice initiatives.[8] These positions were widely available in Australia in the late 1990s and encompassed broader or system-level responsibilities such as health system service improvement, evidence-based practice initiatives, and developing research priorities for the organization, along with traditional academic responsibilities such as obtaining grant funding, publishing in high-impact journals, and maintaining a high profile for the university.[8,9]

Other leadership joint appointment models include joint clinical nurse specialist positions. This model was adopted in the United States by Michigan State University and McLaren Greater Lansing, an acute care teaching hospital. The position had a 20/80 split, with 20% being clinical practice and 80% focused on system and organizational priorities and evidence-based practice projects, mentorship and support of nursing students, and supporting staff in leading and implementing quality improvement projects and knowledge dissemination.[2]

Similar to joint clinical chairs, the United Kingdom developed a Clinical-Academic Partnership Model. These models often involve relationships between academic institutions, stakeholders, governments as well as professional foundations or associations and are broadly defined as programs that aim to bridge nursing education programs with practice environments as a means of advancing nursing practice and contributing to population health.[15] The model in the United Kingdom was supported by a local University and corresponding healthcare organizations, consisting of seven acute care sites, three community practice sites, an integrated acute medicine site and an ambulance service.[5]

Positions and training pathways were jointly funded by the National Health Services and the Workforce Development Directorate of the Strategic Health Authority.[5] The program aimed to establish, develop, and sustain non-medical clinical academic capacity by developing research collaborations and role development for nurses, midwifery and allied health professions. The program consisted of numerous educational initiatives grounded in research and practice, including pre-doctoral awards, which provided opportunities to engage in clinical research, to work with

academic faculty and to undertake a specific research role on research projects. Other opportunities included a clinical doctorate research scheme, structured as a 40% clinical and 60% academic to support individuals working towards a Doctor of Philosophy (PhD). The program also included a clinical academic coordinator role. This joint appointment worked to identify and establish key stakeholder partners, act as a conduit to manage funding investments, engage in recruitment, and support clinical academic fellows engaged in the clinical-academic partnership program.[5]

Role Responsibilities

Depending on the model of the joint appointment and the level of the position, for example, clinical education and nursing practice (individual level), versus tenured faculty and clinical academic coordinator (system level), role responsibilities and expected outcomes may vary. However, some common role responsibilities include:

- Policy and strategic development for clinical operations
- Promoting evidence-based practice
- Administrative duties such as audits
- Supporting clinical staff
- Supporting nursing students or nursing education
- Undertaking research initiatives[2,3,8–11]

Benefits of joint appointments

Joint position appointments hold the potential to facilitate rapid and timely delivery and dissemination of research evidence to inform clinical practices, thereby improving healthcare delivery. Agency-faculty joint appointments that employ practicing nurses as clinical educators hold the potential to increase the capacity of post-secondary institutions in that faculty assume responsibility for larger cohorts due to their reduced role expectations associated with clinical education and can also increase the quality of clinical education by ensuring nursing students are supported by clinical nurses with expertise in a particular practice area.[3,4] In addition to this, other documented benefits include:

- Enhanced institutional cooperation and communication.
- Improved collaboration between preceptors and faculty to support student evaluation, remediation, and access to alternate learning experiences.
- Increased access to qualified faculty with clinical expertise.
- Increased theory integration into nursing practice.
- Increased access to publications, conferences, and research activities for clinical staff.

- Increased implementation of evidenced-based projects and initiatives, including quality improvement projects.[2,9,15]

Implementation considerations

Facilitators of joint appointments

Several facilitators to the successful integration and implementation of joint appointments have been noted across the literature. These include:

1. Clear and mutually established goals and values by the administration of both institutions.[6,11,16]
2. Established and agreed upon cost-sharing agreements for the role.[16]
3. Identifying organizational stakeholders, such as chief nurse executive and chief nursing officers, chief financial officer and human resources as well as institutional leaders such as the dean of the college, the executive team, academic affairs, and human resources to support role development and facilitate practice-based research initiatives and implementation.[2,9,15]
4. Identifying key academic-practice roles such as a vice president, executive director, or clinical academic coordinator for program and/or joint-appointment oversight.[5,15]
5. Development of an integrated job description that is flexible to accommodate role evolution.[9]
6. Sufficient orientation and knowledge dissemination of the joint appointment role, including regular meetings with operational administrators, quality departments, physicians and nursing staff to facilitate role clarities and discernment of role-associated responsibilities.[2]
7. Appropriate facilities and accessibility to technology, including office equipment, hospital email, and access to electronic health records and internal agency documents.[2] This includes access to employee benefits including vacation time, health benefits etc.[11,16]
8. Routine evaluation of the role using collaborative metrics facilitates unrealistic or vague requirements and expectations.[16]
9. Enable flexible division of work, in contrast to rigid 50-50 structures.[11]

Barriers to joint appointments

Multiple barriers to the success of joint appointments have been identified in the literature. These include:

1. Workload demands: Individuals in joint appointments face expectations of a full-time workload demand for both roles simultaneously, resulting in unreasonable expectations of role performance.[8,10,16]
2. Term appointments: Joint positions have historically been allocated on a term basis, for example, 3-5 years. In the absence of being able to maintain a tenured position, candidates risk permanent employment when taking the joint role. Furthermore, the length of the term impacts the position's outcomes, as research funding, project development, and implementation may take longer than the appointed term.[8]
3. Conflicting key performance measures: Organizations and universities hold conflicting performance measures. For example, universities often prioritize grant funding, publications and PhD completion rates, which conflict with operational priorities such as service improvements[7,8]. Operational involvement and management also impinge on the extent to which a joint appointment at a professional level is able to challenge traditional approaches and address clinical issues.[8,16]
4. Role Clarity: Joint positions are challenged by differing philosophies of organizational institutions, as well as discerning the boundaries of the role, for example, being responsible for supporting staff versus students or both[7]. Staff within the organization are also challenged in understanding of the appointees' role and responsibilities.[9]
5. Institutional Commitment: Education institutions grapple with differentiating and ascertaining the value of joint appointments from sessional, clinically-based positions.[9]
6. Joint Executive Authority: In most jurisdictions, there is no joint executive authority that supports financial and performance reporting measures, creating complexity in developing a position that is jointly funded by and accountable to different government divisions.[3]

Joint appointments vary in scope, occurring at the individual level, such as the staff tutor or clinical facilitator, or at the program level, such as the clinical-academic partnership model in the United Kingdom. In addition to scope, joint appointments typically focus on two main areas: 1) increasing clinical skills and knowledge in academic institutions and 2) increasing research capacity in health system organizations. Although joint appointments straddle organizations, one institution typically assumes more responsibility for the position. As a result, funding for the position, role responsibilities, and intended outcomes may vary.

Joint appointments have been found to improve care coordination, organizational alignment, research implementation, and clinical education for nursing students. Despite their potential contributions, numerous barriers to their successful integration still need to be addressed. These barriers often occur at the system level due to dual reporting structures, diverging organizational priorities and expectations, and subsequent increased workload for the individual in the joint appointment.

Although the information provided here offers a summary of existing literature on the topic, it bears consideration that the majority of research integrated here is from the 1990s and early 2000s, suggesting that the role has held less interest amidst ongoing health system changes and challenges. In addition to this, much of the literature is from Australia, the United Kingdom and the United States and, therefore, lacks considerations specific to the Canadian context.

APPENDIX A

Search Strategy – CINAHL

Search	Strategy	Results
S1	MM “Joint appointment”	112
S2	“dual appointment” OR “Lecturer practitioner”	94
S3	Nurs*	938,305
S4	S1 OR S2	203
S5	S4 AND S3	164

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