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Conceptual models to guide best practices in organization and development of state Action Coalitions

Mary E. Cramer, RN, PhD, APHN-BC, FAAN[a,*], Linda Lazure, RN, PhD[b], Kathy J. Morris, APRN, DNP[a], Marilyn Valerio, RN, PhD[c], Rosanna Morris, BSN, RN, MBA, NE-BC[d]

[a] University of Nebraska Medical Center College of Nursing, Omaha, NE
[b] Creighton University School of Nursing, Omaha, NE
[c] Dean Emeriti, Nebraska Methodist College School of Nursing, Omaha, NE
[d] Chief Nursing Officer and Senior Vice President, The Nebraska Medical Center, Omaha, NE

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ABSTRACT

The RWJF/AARP *National Campaign for Action* established a goal of establishing Action Coalitions in every state by 2012. Last year, a small Steering Committee formed in Nebraska and used two conceptual models to guide the organization and development of its Action Coalition. The purpose of this article is to present the *Internal Coalition Outcome Hierarchy (ICOH)* model that guided development of partnership and coalition building. The second model, *Determining Program Feasibility*, provided a framework for data collection and analysis to identify the opportunities and challenges for strategic program planning to accomplish identified key priorities for Nebraska. A discussion of the models' applications is included and offered as best practices for others seeking to form partnership/coalitions and establish action plans and priorities.

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In January 2011, a small group of nurse leaders formed a Steering Committee to begin the organizational work of forming a state Action Coalition in Nebraska focused on implementing the Key Recommendations outlined in the Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (2010). The Committee worked for six months with expert consultation from Dr. Susan Hassmiller, Senior Nurse Advisor, Robert Wood Johnson Foundation (RWFJ) and Dr. Winifred Quinn, AARP Legislative Director, and using two conceptual models to guide their work on accomplishing the following goals: a) recruit partners, including lead nursing and non-nursing partners for the Action Coalition; b) establish an organizational infrastructure for the Action Coalition that included the appointment of statewide nurses and non-nurses for key leadership roles; c) identify two to three priority Key Recommendations (IOM, 2010) for Nebraska based on statewide input; and d) raise funds to support operations of the Action Coalition.

In six months, the committee accomplished its goals and submitted its application to the *Robert Wood Johnson Foundation (RWJF)/AARP National Campaign Action*. In September 2011, the Nebraska Action Coalition (NAC) officially was recognized as part of the national effort. The purpose of this article is to describe the successful process used by the Steering Committee to form its Action Coalition and to discuss the conceptual models

* *Corresponding author:* Dr. Mary E. Cramer, 985330 Nebraska Medical Center, Omaha, NE 68198-5330.
E-mail address: mecramer@unmc.edu (M.E. Cramer).
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used to organize and develop goals and action plans to advance priority Key Recommendations in Nebraska.

Methods

Conceptual Model for Coalition Organization

The venue for implementing the *IOM Blueprint for Action (2010)*, as part of the *RWJF/AARP National Campaign*, is based on the formation of community coalitions (i.e., Action Coalitions), defined in the literature as "…voluntary collaborations between public and private agencies and community stakeholders who are focused on a shared interest involving community health promotion" (Cramer, Atwood, & Stoner, 2006a; Mitchell & Shortell, 2000). Coalitions work to develop and nurture their community partnerships around a shared vision, which for Action Coalitions is the vision of improved healthcare through more effective utilization of the nursing profession. This message of *improved healthcare*, and not *nursing's self-interests*, was to be seminal in building partnerships with nurses and non-nurses and in maintaining partner focus on a mutually agreed-upon end goal.

Principles from the *Internal Coalition Outcome Hierarchy* (ICOH) model (Cramer, Atwood, & Stoner, 2006a) (Figure 1) guided development of the NAC organizational structure. The ICOH model asserts that effective community coalitions function as learning organizations. They are voluntary and temporal networks of associations, and their most significant challenge is consistently assuring that benefits of coalition membership outweigh costs in terms of partners' time, commitment, level of involvement and relationships with other partners (Armbruster, Gale, Brady, & Thompson, 1999; Provan, Veazie, Teufel-Shone, & Huddleston, 2004). Thus, coalitions must have an internal organizational structure that is effective in helping them achieve their desired goals and community impacts based on the voluntary nature of their partnerships.

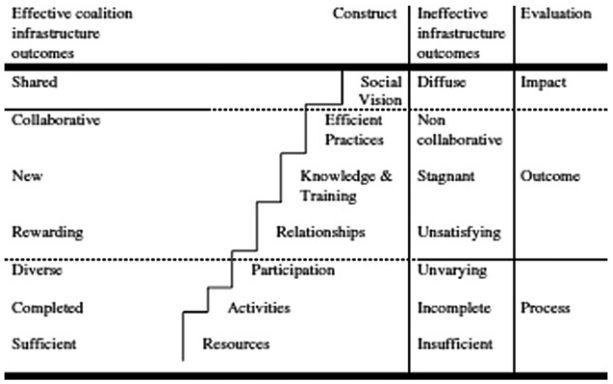

Figure 1 – Internal Coalition Outcome Hierarchy (ICOH) Model.

Well-organized community coalitions achieve a shared sense of *Social Vision* among partners by establishing targeted goals at each level of the ICOH hierarchy. For example, effective coalitions target goals to build *Resources* (e.g., money, training, consultation, information, educational and marketing materials, workforce) to support a sound infrastructure, and these resources are readily available to partners to accomplish coalition goals. Well-organized coalitions have defined implementation and action plans, including goals and objectives (*Activities*) that are developed through collaboration with a broad range of their partners (*Participants*). Effective coalitions have governance that is continually focused on recruitment of new partners and an ever-increasing involvement of their partners' representative members. The infrastructure and governance of effective community coalitions facilitate positive and productive *Relationships* among the partners to ensure satisfaction. Meetings are productive and focused so that partners feel their investment of time has been useful and meaningful, and their contributions have been important. Effective coalitions conduct themselves like learning organizations by recognizing the importance of improving partners' *Knowledge and Training* in the designated areas of the coalition's focus and through a variety of venues (e.g., workshops, websites, and community forums). Partners bring a wealth of expertise and experience that should be recognized and utilized as contributions to the learning environment. According to the ICOH model, when partners have improved *Knowledge and Training*, then it follows that they develop more *Efficient Practices* in key areas as political advocacy, media communications, and leadership—all essential for the development of *new* leaders who can invigorate and sustain the coalition into the future (Cramer, Atwood, & Stoner, 2006a; Weiner & Alexander, 1998). Periodic evaluation of the community coalition's internal organizational effectiveness can be performed using the *Internal Coalition Effectiveness*© ICE© instrument (Cramer, Atwood, & Stoner, 2006b) for quality improvement and to determine if coalition members and leaders perceive the governance and infrastructure in similarly constructive ways such that adjustments can be made when needed.

Model Application

Using the ICOH model, the Steering Committee focused on building *Resources* and recruiting a diverse and committed group of *Participants* into the NAC. All partners—nursing and non-nursing—were asked to sign a NAC Letter of Support and make a financial pledge. This created a vested interest among partners and an incentive for active participation in the work to be done. All 15 NAC partners made financial pledges that varied from $100 to $20,000 in addition to in-kind contributions for copying, printing, supplies, and office space.

The Steering Committee focused early recruitment efforts on educating and aligning nursing behind the

IOM Key Recommendations (2010). The partner recruitment process involved personal meetings, phone calls, and emails. A "Recruiting Toolkit" was assembled of materials from *RWJF/AARP* and those developed and "branded" (i.e., logo and letterhead) by the Steering Committee. An NAC organizational chart was structured (Figure 2) based on consultation with other state Action Coalitions and in consideration of the state's largely rural geography. The resulting NAC infrastructure allowed for broad leadership opportunities across the state's health planning regions, and featured multiple lines of communication between working teams and the Executive Committee. A Strategic Planning Committee composed of business, political, and fundraising leaders was to serve as an ad hoc consultation venue for the NAC. An NAC Director and staff position were to be funded from partner pledges.

The Steering Committee increased *Knowledge and Training* among state nursing leaders by disseminating via various educational materials concerning the IOM report (2010). More than 300 invitations were sent to nurse leaders across the state to attend an NAC Nurses' Forum to elicit input on which of the IOM Key Recommendations (2010) were top priorities for Nebraska. Data on nursing workforce and state demographics were included to better inform dialogue and decision-making. The NAC Nurses' Forum proved an excellent opportunity to discuss nursing's common interests and to clarify the IOM Key Recommendations (2010). For example, some nurses were concerned the goal for 80% BSN education was a call for "entry-level practice" and not the intent for a seamless transition in education. The NAC Nurses Forum featured spirited debates and in the end, those in attendance were able to identify two priority goals for advancing nursing practice and education.

The Steering Committee worked to promote *Relations* among the newly forming partnership by conducting a statewide NAC Workshop and Public Reception. The afternoon Workshop convened 75 individuals from our NAC organizational partners to participate in the development of action plans for education and practice. The Workshop featured concurrent sessions in six statewide locations—all connected by IPV technology. During the Workshop session, Dr. Susan Hassmiller met privately with a small group of corporate donors to elicit their support and afterwards, a Public Reception was held, featuring Dr. Susan Hassmiller as the keynote speaker. The Reception was well attended and increased public awareness about the NAC and its *Social Vision* to improve the quality of healthcare in Nebraska through nursing.

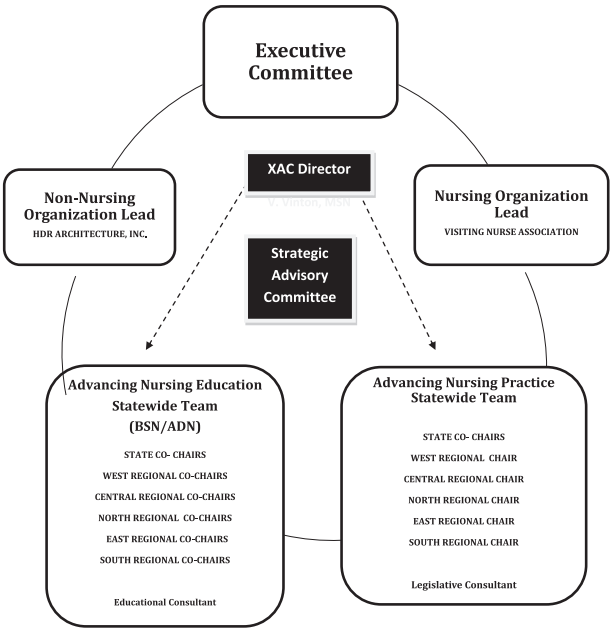

Figure 2 — [Blinded] Action Coalition Organizational Chart.

Conceptual Model for Action Plan Feasibility

The 2011–2012 NAC strategic action plan focused on two goals a) removing barriers to scope of practice, and b) increasing the nursing workforce to 80% BSN by 2020. The NAC Executive Committee (formerly the Steering Committee) used principles from the model, *Determining Program Feasibility (DPF)* (Cramer & Roberts, 2009) (Figure 3) as an analytical guide to determine the feasibility of implementing the two goals. The process for planning is discussed as a best practices model for other Action Coalitions needing to develop strategic plans, build consensus around priority goals, and develop options for implementation according to the hierarchical steps of the model. The following discussion explains the DPF model and its application to the NAC priority goals:

Goal 1: Removing Barriers to Scope of Practice

Nebraska statute requires an integrated practice agreement (IPA) between advanced practice registered nurses (APRNs) and a collaborating physician. The IPA stipulates that the collaborating physician practice in the same geographic area (distance not defined) and practice specialty (http://dhhs.ne.gov/publichealth/Documents/aprn_practice_agreement.pdf). There is a waiver process for APRNs who are unable to secure the IPA; however, few have applied because it is reportedly time-consuming and burdensome. The APRN waiver-applicant must validate attempts to find a collaborating physician and to practice in an underserved (often rural) area where there is limited availability of collaborators. If approved, the waiver required annual review by the APRN and Board of Nursing and may or may not be revoked. An IPA is required for each APRN practice site; thus, some APRNs have had to secure multiple IPA agreements depending on their practice. Some APRNs report having been asked to pay "fees" to the collaborating physician to cover "liability costs," despite Nebraska IPA statutes that state "…each

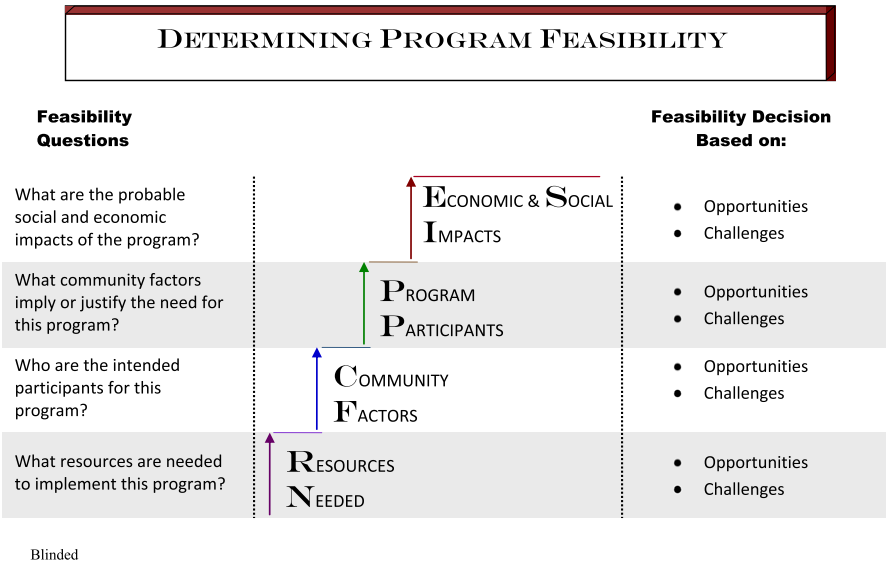

Figure 3 – Determining Program Feasibility Model Blinded

provider shall be responsible for his or her individual decisions in managing the health care of patients" (http://dhhs.ne.gov/publichealth/Documents/Nursing-Nurse%20Practitioner%20Act.pdf). Some APRNs report having been turned down for an IPA by local physicians who cite a "conflict of interest." Finally, some physician groups contend the IPA is essential for professional discipline and patient safety, despite a state Advanced Practice Registered Nurse Board that has been effective in scope of practice and disciplinary issues.

The IPA has been a significant barrier to mental health services in rural Nebraska. Ninety-four percent of Nebraska counties are designated as medically underserved areas for mental health services; yet, nearly 70% of the trained psychiatric-mental health APRNs educated at UNMC College of Nursing have moved from Nebraska after graduation (Rice, January 2012), often citing difficulty in securing an IPA.

Resource Question: "What Resources are Needed to Remove Scope of Practice Barriers in Nebraska?"

According to the DPF model, establishing program feasibility begins with ensuring adequate resources. The resources needed to remove the IPA barrier included a) communication networks, b) finances, c) workforce, d) consultation services, and e) data. Communication resources (i.e., professional print materials, social media marketing venues, and telecommunications) would be essential to communicating with statewide community stakeholders concerning the importance of APRNs for rural access and quality care. Presentations would need to be scheduled with local and influential community groups, such as the Lions Club, Rotary International, Optimist Club, critical access hospital directors of nursing and chief executives, individual healthcare providers, and rural long-term care facilities, as well as the Nebraska Rural Health Association. Financial resources would be needed to pay for statewide travel, meeting expenses, and telecommunications among rural regional APRNs and business partners. Staffing resources would be needed to operationalize NAC work in rural communities where partner support for APRN practice was deemed essential to future legislative efforts. The NAC Practice Team needed support staff to coordinate their activities and help identify key APRN leaders in rural areas who would actively engage their business partners and communities in NAC goals.

The NAC required professional consultation from corporate fundraisers, policy makers, and business leaders on legislative strategies and financial support. These consultative services were to be housed in the yet-to-be-developed Strategic Advisory Committee (Figure 2). Finally, quantitative and qualitative data were needed to document barriers to APRN practice; thus, a survey would need to be developed and deployed to all practicing APRNs in Nebraska.

Participant Question: "Who are the Participants that need to be Involved in Removing Scope of Practice Barriers in Nebraska?"

Rural community stakeholders, including APRNS in rural practice, were identified as the key participants needed to accomplish this goal. The NAC Steering Committee had been advised by a small group of leaders in state government that having a strong and diverse base of support from rural stakeholders (e.g., executives from acute-care facilities, critical access hospitals, nursing homes, community health clinics, local businesses leaders, and healthcare providers) would be crucial to any legislative efforts. Thus, APRNs would need to be strong participants in this process to help rural stakeholders understand and value the importance of having primary-care providers for accessible

healthcare, and the economic impact this has had on their community. Toward that goal, the NAC Advanced Practice Team needed to establish goals and coordinate activities of APRNs within the state. The APRNs across the state would play a crucial role in creating a grassroots level of support by developing relationships with their local community stakeholders and educating them on the need for barrier-free practice.

State senators were another key participant group. It would be essential that NAC APRN leaders across the state forge relationships with their state senators and provide accurate data and exemplars of APRN care in rural Nebraska, including the financial impact of primary care, to build a contingent of rural support in the legislature.

Physician engagement in the process was also identified as important to the effort. The NAC wanted to foster more collegial communications with the state medical associations and ensure a continuing dialogue to keep physician colleagues informed about the IOM Recommendations and NAC goals. Barring official support from the medical associations, the NAC hoped to improve relations and find physician champions for APRN practice and for the IOM.

Recommendations

Community Factors Question: "What Community Factors Justify the Need for Removing Barriers to Scope of Practice and Indicate Likelihood of Success?"

Demographic data showed a growing demand for primary care in the state based on an aging population. The number of elderly in the state over the age of 65 years was expected to comprise 20.7% of the total population by 2030 and up to 22% of the rural population (Dalla, DeFrain,& Ratcliffe, 2004). This demographic change would create a significant demand for chronic disease management most especially in the state's rural and underserved areas. Indeed, significant health disparities already existed between rural and urban elderly in the state in comparison with national indicators. For example, the national mortality rate from falls among older adults was 21 per 100,000 versus the state's rate of 53.2 (CDC, 2005). In 2006, only 85.3% of the state's rural residents (versus 88.9% of urban residents) rated their health as good to excellent and the prevalence of selected chronic conditions in rural areas of the state for 2005 exceeded that of urban areas (29.4% arthritis in rural vs. 23.4% arthritis in urban; 28% hypertension in rural vs. 21.6 % hypertension in urban) (Wang, Mueller, & Xu, 2008).

Yet, recent workforce data showed a serious state shortage of primary-care providers (PCPs) especially in rural areas where 42% of the state population resided. A comprehensive state workforce report noted (p. 84), "…rural areas [of Nebraska], especially in rural health clinics, mid-level practitioners have an important role in primary care" (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009). Still, data showed that Nebraska's state-designated primary-care shortage areas, which use a benchmark ratio of 1 PCP:2,000 population, had 22 counties with no PCPs or below the standard. In addition, 50% of the counties had been federally designated as health professions shortage areas (HPSA) for primary care (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009. Thirty-three counties (of 93 counties) had no APRN. In comparison with the average ratio of APRN to population in the U.S. (42 APRN:100,000 population), only 20 counties in the state met or exceeded this standard. Only 4.3% of RNs in the state were APRNs in comparison with 8.3% in the U.S. (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009).

Other community factors to consider in determining feasibility of the program to remove the IPA (Integrated Practice Agreement; Nebraska Statutes RelatingNurse PractitionerNurse Practice Act # 38-2322) barrier included the relationship between the state medical association and the professional nursing associations. In the mid-1990s when the scope of practice for APRNs was opened in the Nebraska Unicameral, the medical community fought vigorously against APRN independent practice. Thus, the IPA and the APRN Board were developed. In the years since then, some failed attempts to eliminate the IPA had been initiated by APRNs acting independently of their professional nursing associations and leading to further disharmony between the medical associations and nursing professions. Any renewed efforts to remove barriers to APRN practice would require first establishing collegial relations with physician groups and educating them on the IOM report (2010) and APRN practice issues.

Social and Economic Impact Question: "What would the Social and Economic Impact be if Barriers to Scope of Practice were Removed?"

The DPF model asserts that feasible programs must delineate clear social and economic impacts. In the case of removing APRN practice barriers, both opportunities were present. From a social impact perspective, rural communities needed access to primary care. Despite the fact that the number of APRNs in primary care in Nebraska had grown 9% in past 10 years and that 33% of APRNs practiced in primary care in 60 of 93 counties (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009), the state's rural areas faced serious primary-care practitioner shortages. Indeed, a recent health workforce report (Mueller, Nayar, Shaw-Sutherland, Nguyen, Xu, Vanosdel, & Hummel, 2009) had recommended expanding the pipeline educational programs to meet the growing demand. Thus, increasing the numbers of APRNs in the state and removing barriers to their practice could have a significant impact on the rural economies, most of which require primary care coverage for their local nursing homes and clinics.

Program Feasibility Decision

Based on these data organized according to the *Determining Program Feasibility* model, the NAC leadership

determined that the challenges of removing the IPA through legislation in year 1 outweighed any immediate opportunities for success. The decision was made to address the challenges and direct resources toward grassroots support of APRN practice among key community stakeholders across Nebraska and with physician colleagues. The APRN associations were also supportive of this decision.

Goal 2: Increasing Nursing Workforce to 80% BSN

Resources Question: "What Resources are Needed to Reach the Goal of 80% BSN by 2020?"
Finances and communication networks would be needed to facilitate meetings among the 14 schools of nursing. Staffing resources were needed to collect data, and professional consultation was needed to learn about other models of seamless transitions in nursing education that have been used elsewhere (e.g., Oregon). In addition, other necessary resources included the development of more sections of prerequisite courses, efficient nursing curricula, more distance education options, retiring faculty options for teaching, shared APRNs between agencies and schools, and scholarships for students to become faculty. Finally, more teaching sites, more preceptors, and better salaries for faculty would be required to reach the goal.

Participant Question: "Who are the Participants that are Needed to Reach the Goal of 80% BSN in Nebraska?"
Participants needed to reach the goal of 80% BSN by 2020 included a wide variety of stakeholders, most importantly the associate-degree program directors of nursing and presidents of community colleges, the deans and directors from each of the baccalaureate-degree granting nursing programs, and prospective nursing students themselves. Major health facilities that employed nurses (i.e., acute-care hospitals, critical access hospitals, and nursing homes) would also have a vested interest in the IOM Recommendation to offer pay differential, tuition reimbursements, and role differential responsibilities. Their engagement and participation would be paramount. Finally, state senators were needed as participants to support potential legislation to advance nurse-education goals based on their understanding of and appreciation for the economic link between an adequate supply of qualified nursing faculty and keeping their rural community colleges of nursing open for business.

Community Factors: "What Community Factors Justify the Need to Reach a Goal of 80% BSN in Nebraska?"
Nurses represented more than 40% of the state's health care workforce, but only 55% held a BSN degree or higher (Nebraska Center for Nursing, 2010). This presented a lofty challenge. The associate-degree programs, mostly located in rural communities, would need to see this as an opportunity to increase their supply of qualified faculty and not as a threat to their role in nursing education.

A significant challenge in meeting this program goal would be working with employers, especially in rural areas, about the need for the BSN vis-à-vis quality care and pay differentials as workplace incentives for advanced education. State data showed that for RNs employed in hospitals, the associate-degree RN earned the same salary on average as the baccalaureate-degree RN (Nebraska Center for Nursing, 2010) (Figure 4).

Community factors that would support this goal were the health-reform changes (i.e., creating safety nets around patients, helping them navigate transitions in care) and the incentive for hospitals to ensure high-quality nursing care. Data showed that the number of Magnet hospitals in the state had grown, and they were contributing to the state demand for BSN-prepared nurses.

Social and Economic Impacts Question: "What is the Social and Economic Impact of Reaching the Goal of 80% BSN?"
A decade and more of research has linked higher educational levels of RNs with improved patient outcomes in acute-care settings (Aiken et al., 2003; Estabrooks et al., 2005; Friese et al., 2008; Tourangeau et al., 2007; Van den Heede et al., 2009). Thus, the goal of having 80% BSN nurses is not geographic-specific. It is equally important for both urban and rural communities. Rural communities and healthcare facilities must strive for the same goals for a qualified workforce; otherwise, they run the risk of appearing to accept lower standards of care due to difficulties in hiring qualified nursing staff.

That said, rural communities depend on their local nursing homes and/or critical access hospitals for accessible healthcare, and having an adequate supply of qualified nurses at all levels of education is essential to staffing and to *business*. Without a supply of qualified nurses, rural economies would suffer. An economic analysis in Nebraska (Chen, Fraser-Maginn, Su, Mason, 2006) demonstrated a link between the economic vitality of rural communities and accessible, quality healthcare. Data on one rural county in Nebraska found that a) every

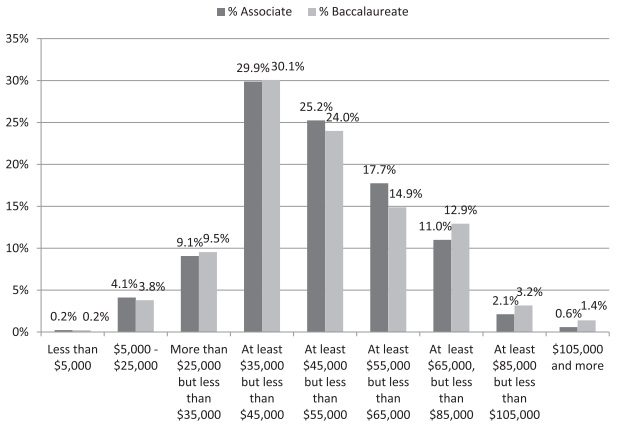

Figure 4 – RNs working in hospitals in Blinded and by salary. Source: Blinded

additional job in the healthcare sector led to another 0.33 jobs created in other sectors of their economy, b) every dollar of income earned in their healthcare sector led to another $0.23 of income earned in other sectors, and c) every dollar spent in their healthcare sector resulted in another $0.35 spent in other sectors of their economy (Chen, Fraser-Maginn, Su, Mason, 2006).

Program Feasibility Decision

Based on these data organized according to the *Determining Program Feasibility* model, the leadership directed its efforts in year 1 toward building trust and communications among the 14 schools of nursing in the state and as a group toward examining successful models for seamless education. An Education Team was formed with regional co-chairs that included one ADN co-chair and one BSN co-chair from statewide designated regions. Increasing access to BSN and graduate nursing education in the state is critical to meeting the 2020 goal; therefore, the team decided to identify competencies common to both ADN and BSN curricula as well as those that differ. This task precedes the subsequent curricular work that needs to occur to facilitate seamless academic progression, ensuring access to ongoing education for all nurses in Nebraska.

Conclusions

This article has presented the conceptual models and processes used by the Nebraska Action Coalition to organize and conduct strategic planning. Each state Action Coalition (AC) will have its own unique challenges and opportunities for enacting the IOM Key Recommendations, and these models may serve as a guide to others. In Nebraska, the opportunities to improve access and quality of care are significant, especially in rural areas of the state. However, there are also significant challenges that include the need to improve communications, build rural and grassroots networks of support, establish statewide communications with our partners, continue fundraising, and keep forward momentum on the education goal with our associate- and baccalaureate-degree programs.

The *ICOH* model and *ICE©* instrument presented in this article are intended to assist other state ACs to self-organize and maintain effective leadership structures. The *DPF* model provides guidance for ACs on how to analyze relevant data to identify and prioritize goals based on factors that are inherently unique to each state. By engaging in this process, AC leaders can better determine those opportunities and challenges that are most likely to yield the "quick wins" that are crucial to generating and sustaining coalition momentum and member motivation. Finally, the information yielded from the models can better prepare AC leaders to recruit partners from outside the nursing community – particularly those asked to make financial contributions and who require more than altruistic reasons to engage with the AC. Potential partners from outside nursing must be able to see the connection between AC goals and their own self-interests regarding community, economic, and social factors. It is the AC leadership's job to articulate a shared vision to our non-nurse partners by answering the tacit question they will have, "*What is in it for me?*"

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Nebraska Assembly of Nursing Deans and Directors
Nebraska Affiliate of the American College of Nurse Midwives
Nebraska Association of Nurse Anesthetists
Nebraska Emergency Nurses Association
Nebraska Nurses Association
Nebraska Organization of Nurse Leaders
Nebraska Methodist Hospital
Nebraska Methodist College, School of Nursing
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