An Evaluation of the Interorganizational Relationships of the Union Family Health Center: Phase One of Assessment and Evaluation of the Union Family Health Center's Context

By

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Abstract

TITLE: An Evaluation of the Interorganizational Relationships of the Union Family Health Center

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The Union Family Health Center (UFHC) is a small rural primary care clinic that is staffed by nurse practitioners. It is critical for small rural clinics to have partnerships within the community in order to survive. This study examined how those partnerships are developed, maintained, and new relationships identified with the community and the larger political, economic, social, and legal environments as well as the strengths and limitations of the UFHC as it strives to address the needs of the community. The study used a qualitative design, using a semi-structured interview and phone calls with nine consortium members. Data were analyzed using content analysis to generate themes related to the research questions. Themes generated relating to development of relationships included organizational commitment/cooperation, grant requirement, and student opportunity. Themes relating to maintenance of relationships included personal, professional/organizations, and obligatory commitment. Themes relating to identification of new relationships included residents of the communities, government agencies, political/special interest groups, and other organizations. Themes related to the strengths and limitations of UFHC included economic, social/emotional, location/physical, and political.

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Chapter I

INTRODUCTION

Background

Primary health care is defined as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Institute of Medicine, 1996, p. 31). Harris & Leininger (1993) stated that rural areas have fewer primary health care providers and that those providers see more patients on average than their urban counterparts. People who live in rural areas tend to be older, poorer, and less well insured than those living in urban areas (Bigbee, 1992; Harris & Leininger, 1993; Vrabec, 1995). It also can be more difficult for people in rural areas to physically access a primary health care provider because there is likely to be no public transportation, and often there is a long drive over poor roads to the nearest site (Harris & Leininger, 1993). When individuals do not have a source of primary health care, they turn to local emergency rooms, which is a high cost, episodic form of health care (Institute of Medicine, 199l; Thompson & McNair, 1995). The people of Union, Oregon are no different.

Union and the surrounding towns of Cove and North Powder have a combined population of approximately 4361 (1990 US Census Data). Approximately 33% of those households fall below the poverty level, and 14% of the residents are 65 years of age or older (1990 US Census Data). The population density in this area is less than 12 people per square mile and the area has been designated as a health professional shortage area. The closest metropolitan area in Oregon is 259 miles away. Many occupations in this area involve farming or timber industries. In 1990, Union's only primary care provider left the area. When this happened, community members voiced concern about the lack

of accessible primary heath care within their community. As a result, a series of public meetings were held to discuss the availability of primary health care in the community.

In 1992, a feasibility study by a group of nurse practitioner students suggested that the needs of a "sizable underserved population" could be satisfactorily met by a nurse practitioner clinic (Eytchison, Elder, & Ray, 1992, p. 16). In 1994, the City of Union's Community Response Team developed specific strategic goals for economic development of the community, including plans to establish a health care facility for the residents by 1996. In response to the need for primary health care the Oregon Health Sciences University (OHSU) School of Nursing opened a non-profit clinic in Union in May of 1994. The Union Family Health Center (UFHC) utilizes family nurse practitioners to meet the primary health care needs of this community.

A federal grant was obtained to assist in funding the clinic's first three years. As a prerequisite for the grant, a consortium was needed to supply guidance and assistance with the issues related to delivering primary health care services. A consortium was organized as part of the planning process. Those involved in the consortium consisted of agencies concerned about or committed to providing health care to the community. The groups involved in the consortium included, (1) OHSU at Eastern Oregon University, (2) Union Family Health Center, (3) Union County Center for Human Development (CHD), (4) Union School District, (5) City of Union and Union Volunteer Ambulance Service, (6) Grande Ronde Hospital (GRH), (7) Northeastern Oregon Area Health Education Center (NEOAHEC), (8) Oregon State University (OSU) Extension Service, and (9) Eastern Oregon University (EOU). These agencies would provide assistance and commit resources to assist with the provision of primary health care services.

Problem

As the Institute of Medicine definition states, a primary care clinic must be "...integrated...developing sustained partnerships...and practicing in the context of family and community"(p.31). There are many examples of small clinics, which did not develop

partnerships, that closed soon after opening due to lack of community support (Barger, 1995; Mackey & McNeil, 1997). It is critical for small rural clinics such as UFHC to have partnerships within the community in order to survive. During the time of developing these partnerships, UFHC has been operating with grant funding. The grant is now completed, and research is needed to provide an external scan of the environment that can be used for program evaluation, an assessment of needs, and strategic planning. In addition, as other nurse practitioners move into independent practices in other rural areas, this research may be helpful for setting up and maintaining a thriving practice.

Research Questions

There are two specific research questions identified for this project: 1. How are the interorganizational relationships of UFHC (a) developed, (b) maintained, and (c) new relationships identified with the community and the larger political, economic, social, and legal environments? 2. What are the strengths and limitations of UFHC, as perceived by members of the consortium, as the clinic strives to address the needs of the community within the context of the profession and the health care delivery system?

Chapter II

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

The literature reviewed for this project included articles related to nurse managed clinics, community participation in health care, community development, and interorganizational linkages. Riesch (1992) reviewed and analyzed anecdotal literature from the 1960's until 1990, relating to the development and implementation of nurse managed clinics. She concluded that nurse managed clinics "must develop alliances with the traditional health care system and other institutions to insure survival" (p.22). Mackey and McNiel (1997) drew a similar conclusion, stating that the survival of nurse managed clinics is "...directly dependent upon relationships with other health care providers and organizations" (p. 52). They contended that many academic based nursing clinics fail when the grant funding ends, because the clinics fail to make private sector partnerships in the community.

The idea of community participation in primary health care has been discussed in the literature since the mid-1960's (Sawyer, 1995). The ideal definition of community participation according to Sawyer (1995) is "...an active process in which the community identifies its needs and works in partnership with health professionals to meet its needs for improved health" (p.18). In addition, Barger (1995) stated that community participation helps integrate the primary health care center into the community, and helps develop programs that are "...useful and acceptable to community residents" (p. 206).

Chalmers and Bramadat (1996) expanded the definition of community participation into community development. Community development occurs when there is community participation in selected aspects of everyday life, such as economics and politics. They argue that economically all sectors of society are interdependent, and that cooperation between the sectors of society is necessary for effective community development. Further, Chalmers and Bramadat argued that nurses need to be involved in

community development because access to adequate economic resources is a forerunner to health.

Studies of other organizations, such as day care centers and newspapers, associated community participation and organizational linkages with the survival of institutions (Baum & Oliver, 1991; Miner, Amburgey, & Stearns, 1990). These studies found that institutions that were linked to other legitimate organizations in the community, such as government agencies or schools, had lower failure rates than those with no linkages within the community. Pfeffer and Salancik (1978) discussed four primary benefits of interorganizational linkages. They stated that interorganizational linkages provide: (1) information, (2) a channel of communication, (3) exposure of the organization to other organizations in the community, and (4) legitimacy to the organization. They concluded that linkages "help stabilize the organization's exchanges with its environment and reduce uncertainty" (p. 145).

The conceptual framework for this research was based on the general systems theory which states that all individuals, groups, or organizations are part of systems, and that all of the systems have interrelating parts that interact with each other (Murray & Zentner, 1997). Systems theory explains the linkages and interdependency of each system upon the others and how a change in one part effects the other parts. An open system is one with linkages to other systems for exchanging energy and information. It is able to evolve and develop new relationships. A closed system is one that does not interact with other systems in the environment and becomes ineffective as it can not evolve and develop new relationships to sustain it.

Systems theory can be related to the delivery of primary health care in Union. The community's economics, politics, and other organizations effect UFHC by influencing factors critical to clinic functioning such as funding and clientele. The clinic in turn effects the community's economics, politics, and other organizations. For example, UFHC provides needed health care services which increases local revenue and

effects the quality of life for the residents. By maintaining and strengthening the linkages with the other organizations within the community, UFHC will remain stable and be able to develop new relationships that will help sustain it for the long term.

Chapter III

METHODS

Design

This study used a descriptive, qualitative method to identify and describe the relationship of UFHC to other organizations in the community, as well as identify and describe strengths and limitations of UFHC as perceived by others. A key informant from each consortium group was interviewed using a semi-structured interview schedule. This type of interview ensured that the subject discussed the topic of interest, while still allowing room for individual opinions to be expressed (Polit & Hungler, 1995). The interviews were conducted in person, as the response rate is higher than that expected for telephone interviews (Polit & Hungler, 1995). Key informants from the consortium groups were chosen to be interviewed as they have been involved with UFHC, should be knowledgeable about the community, and would identify and define concepts that can be further studied with the general community.

Sample

Interviews were conducted with a key informant from each of the consortium agencies and are known and involved in the community and with UFHC.

Inclusion criteria. The individual to be interviewed must represent a consortium group agency and should be in a leadership or community relations position in that agency.

Exclusion criteria. A person who does not represent a consortium group agency or is not in a leadership or community relations position.

Sample size. As there are nine consortium agencies, there were nine people interviewed. The advantage of having a small sample is that it is more feasible to do interviews with a small number. The disadvantage of having a small sample is the risk of obtaining results that may not be representative of the community.

Procedures

The researcher contacted the subject by phone to arrange for an approximate one hour interview. This was done two to ten days prior to the interview. The subjects were informed about the nature of the interviews and asked for their participation. All of the nine consortium members contacted agreed to participate in the project. Consortium agencies contacted included EOU, OHSU at EOU, City of Union, Union County CHD, GRH, UFHC, OSU Extension Service, and NEOAHEC. The interviews were audio tape recorded for review, with permission of the subject, and the interviewer took notes during the interview. The tapes were not transcribed, but were reviewed for concepts, clarification, and to add details missing in the notes. The interviews took from fifteen minutes to one hour. Follow up phone calls were made three months after the interviews, and six of the nine members were reached for follow up.

Instrument. The instrument used for the interviews consisted of 21 open-ended questions used to semi-structure the interview (see Appendix B). The questions related to the subject's involvement with UFHC, the impact they perceive UFHC has on the community, the services shared, and the community needs that are perceived by the subject.

Setting. The interviews were conducted in a private location that was convenient to the subject. This setting allowed for a private conversation, and decreased the subject's burden by not requiring them to travel for the interview.

Protection of human subjects. Prior to the start of the interview an information sheet, approved by OHSU Institutional Review Board, was given to the subject, and they were asked for permission to tape record the interview (see Appendix A). The recorded tapes were stored in a secure location, and destroyed after data analysis was complete. The subject's names and specific agency names were not to be used in any presentation or publication of the findings.

Assumptions

The assumptions of this study are that UFHC is an open system that exchanges information and energy with it's environment, and that these exchanges are necessary to sustain it. The environments are the community and the political, economic, social and legal environments.

Limitations

The limitations of using focus group interviews versus individual interviews were considered prior to the start of data collection. A focus group interview would obtain information in an efficient manner, and subjects may spark each other's ideas. However, people involved in focus group interviews may have a hard time expressing their true opinions in front of the group, and there may be a decreased chance of subject participation (Polit & Hungler, 1995). Individual interviews, compared to focus groups, have the disadvantage of taking a lot of time to obtain an equivalent amount of data (Polit & Hungler, 1995). In addition, key informants may present the bias of their own agency and other groups involved in the community that could add information to the study are omitted. This will be addressed by involving other groups in later stages of the study to be conducted by other researchers.

Chapter IV

RESULTS

The data were analyzed using content analysis looking for themes related to the two research questions. Two researchers reviewed the tapes independently and their notes were compared. Themes related to each research question were categorized, and these categories were discussed between the two researchers until consensus was reached.

Analysis of the data disclosed many themes related to the interorganizatioanl relationships of UFHC, as well as the strengths and limitations of the clinic. The interviews also brought forth many other issues and recommendations that were not anticipated at the beginning of the project.

Question 1

The first research question asked was "how are the interorganizational relationships of UFHC (a) developed, (b) maintained, and (c) new relationships identified with the larger political, economic, social, and legal environments." Table 1 presents themes identified related to this question.

Question 2

The second research question was "what are the strengths and limitations of UFHC, as perceived by the members of the consortium, as the clinic strives to address the needs of the community within the context of the profession and the health care delivery system?" Table 2 presents themes identified related to this question.

Table 1

Themes Pertaining to Interorganizational Relationships	Examples
Relationships Developed	
organizational commitment/cooperation	• a mission to provide access to health care • a need for services in an underserved area and working together to provide those services
grant requirement	• a consortium was needed for the federal grant
student opportunity	• school to work opportunities for high school and college students • nursing student clinical rotation site
Relationships Maintained	
personal commitment	• personal intrigue with the project and it's complexities • support of the clinic • wanting to see a new facility built
professional/organizational commitment	• access to care • common goal of having health care available in the community
obligatory commitment	• federal grant requirement of budget and quarterly reports--accountable for implementation of the grant

Table 1 continued

New Relationships Suggested residents of communities	• Cove, North Powder
government agencies	• the legislature, Senior and Disabled Services Division (SDSD), Adult and Family Services (AFS), and the employment division
political/special interest groups	• city/state government, local Independent Practice Association (IPA), local ranchers' association
other	• Grande Ronde Hospital, Center for Human Development, Eastern Oregon University, Eastern Oregon University student body representative, other professional groups such as dentistry, podiatry, and optometry
Relationships not Maintained	• lack of time • lack of notification of meetings
Recommendations	• refocus and set new goals; have a retreat with all members present to discuss goals • have a positive attitude • better communication among members about projects and meetings

Table 2

Themes Pertaining to Strengths and Limitations of UFHC	Examples
Strengths	
economic	• provides financial gain for community • grant funding for start up of clinic
social/emotional	• positive image of clinic • sense of community ownership and cooperation • open-mindedness of nurse practitioners • alternative to "stuffy medical clinic"
location/physical	• provides access to services in the community • people use resources where they are located
political	• may help attract new residents to community • draws attention to community's needs for other services • provides ability for other agencies to collaborate with community

Table 2 continued

Limitations	
economic	• reliance on grant
social/emotional	• lack of understanding by community of Nurse Practitioner skills • no male provider in clinic • lack of confidentiality due to lack of space
location/physical	• lack of space to provide other services such as mental health • lack of separation of working space and waiting area • lack of space limits the number of patients nurse practitioners can see each day • located on the edge of town, viewed as "peripheral to community"
political	• nurse practitioners need a better relationship with hospital and physicians
Recommendations	
economic	• explore other grant opportunities • create and endowment through either state government or private donor funding • continue to provide excellent health care in order to increase number of clients
social/emotional	• community outreach and education about Nurse Practitioners, their skills and abilities • have a male practitioner available at the clinic • improve confidentiality -- could be improved with a different facility
location/physical	• larger, new facility in the center of town
political	• improve relationships with hospital and physicians

Chapter 5

DISCUSSION

The research questions for this research project were broad, yielding a large amount of data to answer the questions. As the data were analyzed, it became obvious that concepts had been overlooked in the original review of the literature. Thus, as data analysis progressed, the literature was consulted again in an attempt to organize the data. It also became obvious to this researcher that it would be very difficult to cite examples from the consortium members without jeopardizing their anonymity. For this reason the data cited are general, and without verbatim quotes.

Question 1

The first research question, "how are the interorganizational relationships of UFHC developed, maintained, and new relationships identified with the community, and the larger political, economic, social, and legal environments?" was asked to explore how organizations became involved and stayed involved with UFHC consortium. This would help identify and enhance future relationships that UFHC might seek out.

Relationships Developed

Organizational commitment & cooperation. Organizational commitment/cooperation was one method of developing relationships for UFHC. Cooperation among organizations is a result of organizations attempting to carry out services or attain certain goals such as meeting the needs of a community. Hall, et. al, (1981), state that cooperation, which they call coordination, comes about as each organization is trying to deal with the environment. Thus it makes sense for local organizations to work together to help each other achieve their goals in order to enhance the services provided to this community. With cooperation among organizations, there will be an organizational linkage. As discussed in the review of the literature, organizational linkages can help stabilize the organization.

Grant requirement and student opportunity. Several subjects stated that their organizations became involved as a requirement of the federal grant. The grant required that there be a consortium to supply guidance and assistance with the issues related to delivering primary health care services. When OHSU obtained the grant, members of organizations involved with health care, education, and agriculture were asked to be part of the consortium. Pfeffer & Salancik (1978) state that "possibly it is the belief that one can influence the organization that motivated outsiders to accept appointments to boards" (p.165). Similar to the previous discussion on organizational commitment and cooperation, if an organization has a need, when an opportunity to fulfill that need arises, the organization will likely seize the opportunity. It is a network of reciprocity. For example, as a requirement of the grant, an organization provided input on the issues of the provision of primary health care to the consortium, in turn, the organization was able to place students in UFHC for various experiences. Thus each organization had a goal that was fulfilled.

Relationships Maintained

Commitment was the overall theme as to why organizations stayed involved with the consortium. This theme had subcomponents of personal commitment, professional/organizational commitment, and obligatory commitment.

Personal commitment. Personal commitment was cited as personal intrigue with the project and it's complexities, support of the center, wanting to get a new facility built, and personal enjoyment. With each of these ideas there is no mention of mandated or formalized involvement. Hall, et al. (1981) describe this type of commitment as voluntary. The person has no motive, other than personal satisfaction, to be involved with the consortium.

Professional/organizational commitment. Professional/organizational commitment was cited as commitment to providing access to care, shared services, and common goals of having health care available. Hall, et al. (1981) describe this type of

commitment as standardized/voluntary. There is some element of formal agreement, for example the sharing of services, but there is no mandate requiring that those services be shared.

Obligatory commitment. Obligatory commitment was cited as the grant "causing" commitment by requiring that goals be set, reports submitted to the funding body, and as membership on the consortium being made part of a job. This type of commitment would be described by Hall, et al. (1981) as mandated commitment. This type of commitment is governed by rigid rules that are externally imposed.

These types of commitment are not mutually exclusive. For example, the subjects who stated that they had obligatory commitment to the consortium also stated that they had personal commitment. They were "required" to be involved, but also were personally interested in the project.

Lack of commitment. Not all of the subjects stated that they remained as involved as they had originally planned. Reasons cited were a lack of time, and a lack of notification of meetings. The subjects did state that there would be renewed interest if a project was targeted that sparked mutual interest. This theme would require further exploration.

New relationships suggested

Each consortium member was asked if they knew of any other individuals or organizations who should be involved in the consortium. This is one way of identifying potentially beneficial new relationships. Pfeffer and Salancik (1978) discuss this method of seeking out new relationships. They state that people use social networks when attempting to make decisions, in order to decrease uncertainty about those decisions. They argue that by seeking out others' input, an organization would have new lines of communication and would be able to plan their activities more predictably.

Residents. As noted in the review of the literature, community participation in primary health care is an important theme. As the people of the community are going to

be the consumers of the services, their input is needed for program development. Most of the subjects identified the need for community involvement with the consortium and the decisions about program development. Also, if previous research holds true, lack of community support could be a potential cause for failure of the clinic (Barger, 1995; Mackey & McNeil, 1997).

Government agencies. Government agencies such as the state legislature were identified as potential linkages that should perhaps be pursued. A linkage to the legislature might help bring economic stability by providing a base of funding for the clinic.

Political/Special interest groups. The organizations specifically mentioned that fit this category were the city councils, the local IPA, and local rancher organizations. Pfeffer and Salancik (1978) state interorganizational linkages provide information, a channel of communication, and exposure of the organization to other organizations in the area. By developing relationships with these political/special interest groups, UFHC could take advantage of these of interorganizational linkages.

Other organizations. The last category mentioned was other organizations. Although UFHC has relationships established with EOU, GRH, and CHD it was mentioned that these relationships could be further developed and strenthened. Other potential relationships identified were local churches, EOU student body representative, and other professional organizations Further developing these relationships would offer the benefits of interorganizational relationships, as well as potentially allowing expansion of the services offered at the clinic.

Question 2

The second research question was "what are the strengths and limitations of UFHC, as perceived by members of the consortium, as the clinic strives to address the needs of the community within the context of the profession and the health care delivery system?" It was intended to explore the positive aspects of the clinic or "what is

working," as well as the negative aspects, or "what is not working," in order to capitalize the strengths, correct the limitations and improve the quality of care being provided to the community. During analysis of this question a variety of strengths and limitations were identified. They were divided into four categories which are discussed below.

Strengths

Economic. The strength identified in this category was that the clinic brings financial gain to the community. The consortium members mentioned several ways that this happens. The first was the federal grant which assisted the start-up of the clinic. Another way is that as there is more business at the clinic, there is more money brought into the community. This is consistent with systems theory. For example, people who use the clinic must pay for the services, and, if they receive a prescription, they may use the local pharmacy to fill that prescription. Thus the action of one organization effects the other. Similar to Chalmers and Bramadat's (1996) assertions, the clinic is assisting in community development by bringing financial gain to the community.

Social/Emotional. Strengths identified here were that the clinic has a positive image in the community, and there is a sense of community ownership and pride in UFHC. These are important, because without a positive image and sense of community pride, there would likely be a lack of community support. Consistent with Barger's (1995) assertion that community participation is essential in integrating a clinic into the community and developing programs that the community needs, community support was mentioned by consortium members as being "key" to maintaining the clinic in the community. Other consortium members mentioned that the nurse practitioners deliver high quality care, and are open-minded and willing to discuss ideas. These aspects are important in community participation as community members must feel comfortable discussing their needs and working with the health professionals to meet those needs. Another strength mentioned by several consortium members was that the clinic provides an opportunity for students to have various experiences such as externships, nursing

clinicals, and school to work opportunities. These opportunities enhance the students' knowledge, as well as provide exposure of the clinic to other organizations in the area.

Location/Physical. Having a primary health care clinic located in the community was identified as a strength because it allows people easy access to primary health care. In addition, it allows other organizations an opportunity to provide their services to the community.

Political. Political strengths mentioned were that the clinic may help attract new residents and draw attention to the needs of the community while providing an avenue for other agencies to collaborate with the community. By drawing attention to the needs of the community for other services, other agencies could help by stepping in and assisting to provide those services. Working within the systems theory, the clinic could assist by providing the physical space for the other agencies to provide those services. By working together, the two agencies could potentially help improve the quality of life for the people in the community, which might help attract new residents to the community.

Limitations

Economic. The economic limitation identified was the need for obtaining a stable funding base to replace the grant. Other sources of funding for clinic maintenance and a new facility need to be explored. Lack of money was also mentioned as one possible reason that services, staff, and hours have not been expanded. Recommendations from consortium members to remedy the lack of funding were to explore other grant opportunities, approach the community for a bond, to create an endowment either through state government funding or private donors, and to continue to provide excellent health care to the community in order to increase the number of patients seen.

Social/Emotional. The social/emotional limitations cited included a lack of community understanding about the type of care nurse practitioners can provide and the lack of a male provider in the clinic. In addition, the potential lack of confidentiality

secondary to a lack of space in the clinic was cited. In the past, health care providers in the community have been physicians. One consortium member stated that the community may perceive the nurse practitioners as less professional, not because they are less professional, but because they hold a different certification than a physician. Many of the other consortium members also stated that the community has difficulty understanding what services a nurse practitioner can offer. Also, as the primary providers in the clinic are all women, some consortium members stated that men may want to seek care elsewhere. The consortium members recommendations for addressing these concerns are to have more community outreach and education about nurse practitioners and their scope of practice, and to have a male practitioner available at the clinic. The concern about confidentiality is secondary to a lack of space in the clinic, and it was noted that a different facility could alleviate some of that concern.

Location/Physical. The most frequent concern mentioned by the consortium members was that the facility is too small to provide all of the health care services needed by the community. The facility has a very small waiting area, two exam rooms, and one room that can be used for exams if needed. Some consortium members expressed concern that because of the small space, the practitioners are limited in the number of patients they can see each day. Also, other services, such as mental health services, have been moved to other locations in the community because of a lack of space. The clinic, located at the edge of town, may be perceived as peripheral to the community. A recommendation for correcting this was to build a new facility in the center of town large enough to provide primary health care services, as well as other services such as mental health, social services, and group activities.

Political. Political limitations stated included that the nurse practitioners need a better relationship with the hospital and physicians in the area. This linkage is critical to the clinic's future as without it, the clinic would not have a system of referral and continuing care for patients needing diagnostic workup or hospitalization.

Summary

This research project was the first step in a larger research project being conducted by Dr. Bowden and Dr. Monahan. The purpose of this study was to obtain an external scan of UFHC environment in order to provide data for program evaluation, an assessment of needs, and strategic planning. Part of this external scan included looking at the interorganizational relationships, and the strengths and limitations of UFHC. The research may also benefit other nurse practitioners who are setting up and maintaining practices in rural areas.

The first research question revealed themes related to the development, maintenance, and identification of new relationships of UFHC as well as recommendations for future activities. The themes related to development included organizational commitment and cooperation, grant requirement, and student opportunity. The overriding theme related to maintenance of interorganizational relationships was that of commitment. Commitment was further broken down into personal, professional/organizational, or obligatory commitment. Consortium members provided ideas about other organizations that could be involved in the consortium. These groups consisted of residents of the communities, government agencies, political/special interest groups, and other organizations.

The second research question revealed ideas about the strengths and limitations of UFHC in order to help enhance the strengths, and ameliorate the limitations. Four categories of strengths and limitations of the clinic were identified: economic, social/emotional, location/physical, and political. There were also recommendations from the consortium members as to how to correct the limitations.

Limitations and implications for research

While this study has provided a beginning for further research four weaknesses in the design are noted. As the data were obtained by individual interviews with key informants from each consortium group, there may be some personal bias or agency bias.

The use focus group interviews would have had the advantage of subjects sparking each other's ideas, or could have made it more difficult for subjects of be honest and participate (Polit & Hungler, 1995). Another limitation is that only six of the nine subjects were reached for follow up phone calls. However, the data obtained from the subjects reached during follow up calls did not add any new themes to the data already collected. Thus this does not appear to have jeopardized the validity of the research findings. Another way that follow up information could have been obtained would have been to have follow up interviews. This would have been a way to obtain more in depth information, and to validate data previously obtained. A third limitation was the small sample size. However, all agencies represented in the consortium did participate, and this project was intended to be a first step toward further research. A fourth limitation was that only one researcher coded the information initially, rather than having two researchers code the information independently and compare for interrater reliability.

Because this is the first piece of a larger project and the sample was necessarily small and specific, further research needs to be completed with a broader population in order to generalize the data to other settings. The data needs to be further reviewed looking for research questions that can be taken to the larger population and validated. Another area of potential research would be the concepts and processes critical to interorganizational links as an organization matures.

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Appendix A

IRB #4435 EX
Approved June 1997

OREGON HEALTH SCIENCES UNIVERSITY
Information Sheet

Title: Assessment and evaluation of Union Family Health Center's context.

Principal Investigators:
Rita Monahan, RN, EdD, Associate Professor, School of Nursing/Eastern, 962-3383
Jeanne Bowden, RN, PhD, Associate Dean, School of Nursing/Eastern, 962-3384

Research Assistant:
Traci Frye, RN, Graduate Student, School of Nursing/Eastern, 962-3646

Purpose: You have been invited to participate in this research study because you have been identified as a leader of a community group who is knowledgeable about the community. The purposes of this study are to (1) define how community and environmental relationships of the Union Family Health Center are identified, maintained, and developed within the community, and (2) to identify the strengths and limitations of the Union Family Helath Center as it strives to address the needs of the community within it's current context. You will be involved in two phone calls, and one interview of approximately one hour.

Procedures: A researcher (a primary investigator or research assistant) will call and make an appointment with a representative of each agency for an approximate one hour interview. Over the phone and prior to the start of the interview, the researcher will explain the nature of the interview, the purpose of data collection, and secure permission to audio tape record the interview. The interview will proceed even if you decline to have the interview audio tape recorded. An interview schedule consisting of open-ended questions will be used to semi-structure the dialogue. The researcher will take notes during the interview and review the audio tape after the interview to check notes for accuracy and completeness. Approximately one week after the interview, the researcher will contact you by phone to clarify the prior discussion as needed and to solicit additional comments.

Risks and discomforts: Other than your time, there are no anticipated risks or discomforts.

Benefits: You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information that may benefit the clinic in the future.

Benefits: You may or may not personally benefit from participating in this study. However, by serving as a subject, you may contribute new information that may benefit the clinic in the future.

Confidentiality: Neither your name nor your identity will be used for publication or publicity purposes. The interview notes and tapes will be stored in secure locations. The tapes will be destroyed after data analysis is complete.

Costs: There are no costs to you for participation in this study.

Liability: The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

Participation: If you have any questions regarding you rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at (503) 494-7887.

You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at Oregon Health Sciences University, or the Union Family Health Center.

Appendix B

Data collection instrument

Involvement

1. What is your involvement with the UFHC?

2. Why did you/your organization become involved in the UFHC consortium?

3. Has your involvement been at the level you originally planned? Why have you stayed involved? OR Why haven't you stayed involved?

4. How do you envision working with the UFHC in the future?

5. How would you like to be involved with current/future care services/committees/projects?

6. Are there other individuals/organizations you can think of who should be involved in the consortium?

Impact

1. How do you perceive the UFHC?

OR What do you think is the image of the UFHC?

2. How has the presence of the UFHC made a difference to you/your organization/ the community?

3. If you could change the UFHC consortium, would some differences increase your current involvement?

Services shared

1. Currently, what services are you/your organization sharing with the UFHC?

2. Are there other ways that the UFHC and you/your organization might share resources?

3. Are there other health care services you want available that are not presently available?

4. How would your agency be willing/prepared/able to assist with providing these services?

5. If the UFHC were to change in size or services, what effects would that have on your organization?

Needs

1. What type of health care would you like available for your staff/employees?

2. In what ways could the UFHC be more responsive to your needs?

3. Are there changes that you would like to see in the delivery of care to make the UFHC more responsive to the needs of the community?
the facility?
the staff?
the services?
the hours?

4. Are there other ways that the UFHC and your organization can partner together to meet the needs of Union, Cove and North Powder?

5. What resources have enabled the UFHC to function effectively? Who controls these resources?

6. What other resources and talents will be needed by the consortium to function effectively in the future?
OR What other resources and talents are critical for the functioning of the UFHC?
OR What individuals or groups will be able

to provide the resources and talents that will

be critical in the future?

Other

1. Is there anything else you would like to say?

Appendix C

OREGON HEALTH SCIENCES UNIVERSITY
Research Support Office (RSO), L106 (503) 494-7887

MEMO

Date: June 25, 1997

To: *Rita Monahan, RN,EdD*

From: Robert D. Koler, M.D., Chair Institutional Review Board, L106

Subject: ***4435EX*** [redacted]
Assessment and Evaluation of Union Family Health Center's Context

Special Communication

☐ The RSO has not received a response to the request made on _____ for revisions of the above protocol/consent form. These were due in the RSO on _____.

☐ The attached advertisement has been approved as presented. Any changes to this advertisement must be submitted to the RSO for IRB approval.

☐ The IRB reviewed the attached advertisement on _____. The following changes will need to be made before approval is given. [1]

☐ The above study involves only discarded tissues/samples that do not include *identifiable private data/information obtained in a form associable with an individual*. Therefore, the study does not require IRB review.

☐ The above study meets the criteria for waiver of consent.

✖ We received your response to IRB recommendations on 6/10/97.
This study is exempt based on criteria category #2.

[1] see appended copy for suggested editing