THE WORLDS OF NURSING education and practice have developed along parallel tracks resulting in cultures with different expectations and work styles. Leaders in contemporary nursing education acknowledge the separation from practice and the difficulty of education to keep pace with the speed of change occurring in the delivery of health care. Today’s nursing leaders are setting the stage for the next evolution — bringing together skilled clinicians and administrators with peers in education to create new approaches to leading the profession forward. The American Association of Colleges of Nursing (AACN) and the Association of Nurse Executives have endorsed creating strategic alliances between community and academe (AACN, 1999). Building on the lessons learned, nursing is choosing to move beyond our separate history to create the next generation of models to lead our profession forward (Benner, Sutphen, Leonard, & Day, 2010; Campbell, Prater, Schwartz, & Ridenour, 2001; MacPhee, 2009; Stanley, Hoiting, Burton, Harris, & Norman, 2007).

Partnerships, alliances, and collaborations are prevalent in government, business, and the non-profit sectors. Partnerships share goals, common purpose, mutual respect, willingness to negotiate and compromise, informed participation, information giving, and shared decision making.

The shared practice academia effort between a public university and a private health care system situated in the island state of Hawai’i is described. The medical center and school of nursing pursued individual strategic efforts to build research capacity and used the opportunity to fund academic practice research projects.

The mutual need and recognition of the high stakes involved, in concert with stable, committed leaders at all levels, were key to the early success of their efforts.

Through the formal research partnership mechanism, a discrete focus was created for efforts and used to move to tactical, operational, and interpersonal integration in this relationship.

EXECUTIVE SUMMARY

- Today’s nursing leaders are setting the stage for the next evolution — bringing together skilled clinicians and administrators with peers in education to create new approaches to leading the profession forward.
- Partnerships share goals, common purpose, mutual respect, willingness to negotiate and compromise, informed participation, information giving, and shared decision making.
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- Through the formal research partnership mechanism, a discrete focus was created for efforts and used to move to tactical, operational, and interpersonal integration in this relationship.

Partnership to Build Research Capacity

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negotiate and compromise, informed participation, information giving, and shared decision making (Casey, 2008). Such relationships are perceived to improve outcomes for the organizations, their stakeholders, and communities. Further, they facilitate organizational learning and maturation and are fraught with risk. Debate continues regarding the benefits with some studies finding links between integration and outcomes and others showing little impact (Casey, 2008). Studies examining partnerships in the health arena find that up to half do not survive the first year and many fail to achieve their goals (Lasker, Weiss, & Miller, 2001). Characteristics associated with successful partnerships include good reasons, high stakes, right people, right leadership, strong, balanced relationships, trust and respect, good communication, and formalization (Brown, White, & Leibbrandt, 2006).

Health care organizations and academic institutions are looking for opportunities to address their concerns through external alignments. Underlying such efforts is the assumption, supported by experience and literature, that extending and creating relationships can provide benefits to each organization. Regardless of the term used, implementation occurs through relationships. The public and private sectors use a range of terms to describe the relationship building required to generate the much anticipated inter-organizational synergy. Because this effort involves crossing of traditional discipline and sector silos, the literature lacks conceptual clarity. Thus, practice and academia are just beginning to examine implementation of inter-organizational relationships in nursing. The literature describing the movement to relationship building between nursing education and practice is primarily descriptive and reflective of early engagement (Bleich, Hewlett, Miller & Bender, 2004; Broome, 2009). The aim of this article is to contribute to the inter-organizational literature by describing the development and early outcomes of a research capacity building public private partnership. The authors report on the shared practice academia effort between a public university and a private health care system situated in the island state of Hawai‘i.

Hawai‘i

Because of its physical beauty, ideal climate, unique cultural history, and cosmopolitan mixture of peoples, Hawai‘i is one of the world’s most desirable destinations. With a population of 1.2 million people on six islands, it includes communities ranging from urban in Honolulu to rural on the “neighbor” islands. The health care system is fragile: the cost of care is increasing, hospital margins are some of the lowest in the country, and chronic shortages of providers in the health care workforce create specific challenges that require local solutions.

The Queen’s Medical Center

The Queen’s Medical Center (QMC), a unit of Queen’s Health System, is a 600-bed acute care tertiary-level private hospital serving all the islands of Hawai‘i. With a professional workforce of approximately 1,000 registered nurses, 63% of whom possess a bachelor’s degree, QMC has a long history of nursing excellence. Queen’s has had a clinical ladder program for staff nurse advancement since the mid-1980s. The clinical ladder program provides staff nurses with an opportunity for career advancement while remaining at the bedside to deliver direct patient care. This program has helped create and maintain an organizational and unit culture which supports staff seeking to advance either by pursuing master’s and doctoral credentials, achieving national certification, and/or career advancement via the clinical ladder program.

Staff members receive financial support as well as guaranteed time for projects outside the unit staffing pattern. The Nursing Vision and Strategic Plan includes a commitment to education and advancing knowledge through research. It guides professional development and the well-developed shared governance practice model. Nursing leaders at QMC recognize that significantly better health outcomes are a result of care designed using best practices and evidence generated from research (Fineout-Overholt, Melnyk, & Schultz, 2005). Yet, their experience documented barriers to the conduct of such scholarship including lack of research knowledge and skills, lack of administrative support, and lack of mentoring and time. In 2004, the Queen’s Health System Foundation created the Queen Emma Nursing Institute (QENI) to promote excellence in patient care and patient outcomes through nursing care and workforce. QENI chose four focus areas: excellence in clinical research, nursing workforce development, professional nursing practice, and creating educational opportunities for nurses. Long recognized by the community for delivering high-quality care, QMC received ANCC Magnet™ designation in 2009.

University of Hawai‘i at Mānoa

The University of Hawai‘i at Mānoa (UHM) is the flagship campus within the 10 campus University of Hawai‘i (UH) System and is a Carnegie-classified research university (very high research activity RU/VH) that is moving strategically to expand graduate education and enhance funding for research. UH does not operate an academic medical center and relies on private hospitals for clinical nursing education. The school of nursing and dental hygiene (SONDH) is the only higher public education institution in Hawai‘i offering nursing degrees at the baccalaureate, mas-
ter, and doctoral levels. The school strategic plan, approved in August 2003, included five strategic research imperatives with the final imperative targeted to “support collaborative partnerships.” The plan guided development and staffing of an office of research focused on faculty scholarship development. The success of early efforts and commitment to contributing indirect revenue to further expansion created additional capacity. In 2005, the department of nursing established a standing research committee and in 2008 the school recruited the founding associate dean for research. External research support, including an award from the National Institute for Nursing Research to create a Center for Family (‘Ohana) Self-Management of Chronic Illnesses, reflected the growing research strength of the faculty and school. This P-20 Center grant provides the resources to create a research environment advancing knowledge in self-management of chronic illnesses in ethnic diverse populations.

Historically, QMC supported scholarships for accelerated and Native Hawaiian nursing students at the UHM and nurses from QMC enrolled for advanced education. UHM had an affiliating agreement with QMC for student clinical experiences. A previous shared position for a nurse researcher had ended with the retirement of the individual in the position. In summary, the QMC-UHM organizational relationship was solid.

Against this backdrop, leadership changed at each institution. QMC completed organizational restructuring and recruited the vice president and chief nursing officer (CNO), an experienced and respected nurse familiar with QMC and Hawai‘i. After a nationwide search in 2005, UHM appointed a dean new to Hawai‘i and the local health care community. One of her first actions was to create a position for a director for community partnerships and recruit a highly regarded retiring chief nurse executive from Tripler Army Medical Center for the position.

Both the CNO and dean were experienced leaders and shared a commitment to advancing nursing to improve the health of the Hawai‘i population. The CNO recognized the importance of the research practice relationship in the journey to excellence and achieving Magnet designation. More important, she was familiar with the barriers facing QMC in achieving the full implementation of the nursing vision. The dean had a mandate to build scholarship and expand the research activity of the school. At the same time, the looming nursing workforce and faculty shortage required attention to garnering legislative action to support increasing enrollments.

As the leaders began meeting together, common purpose and potential fits across the differing cultures began to emerge. Discussions of potential activities were widespread and far ranging. Concurrently, informal organizational reaching out across boundaries also took shape. QMC invited faculty to join the leadership, practice, research, and professional development councils; the dean joined the QENI local advisory committee and keynoted the Nurse’s Week program. UHM invited QMC nurses to join curriculum and other committees, to participate in the simulation learning lab, and encouraged appointments as clinical (non-compensated) faculty. These efforts were immediately successful and encouraged continued discussion regarding formalizing the relationship beyond the existing clinical affiliating agreement. The collaboration would be critical to the success of the individuals guiding it, our organizations, and ultimately, our community. The stakes were high and the partners would be accountable to our constituents for the human and fiscal resources allocated to the effort.

**The Inter-Organizational Driver**

Leaders within each organization agreed building sustainable research capacity was a priority to achieve the common purpose of improving health through nursing practice. The core driver group, consisting of the UHM (dean, associate dean for research, and director for community partnerships) and QMC (CNO and QENI director), adopted Condell and Begley’s (2007) evidence-based concept definition “research capacity building implies a funded, dynamic intervention operationalized through a range of foci and levels to augment ability to carry out research” (p. 273). Developing the required knowledge and skills to engage in research at different levels is fundamental to building capacity (McCance, Fitzsimons, Keeney, Hasson, & McKenna, 2007). The group agreed that as the relationship grew over time, specific goals would be developed. At the same time, short-term measurable targets were needed to guide and monitor immediate progress. As the collaboration was developed, each partner continued research development efforts within the individual organizations. The core group consulted and shared the literature on partnerships, collaborations, and organizational behavior on a regular basis.

**The Community-Academic Partnership**

The Institute of Medicine characterizes three types of research partnerships: (a) academically driven research initiatives, (b) research in response to the needs and input of communities, and (c) interactive research practices that involve both academic researchers and the community as equal partners. The core group created an equal partnership model with formal expectations and joint funding for projects.
Each institution contributed an equal amount of funds and in-kind faculty and staff support to the effort. From the lessons learned in that experience, the group would identify facilitators and barriers to both successful collaboration and the conduct of clinically driven nursing scholarship in Hawai‘i. The practice academic approach for the partnership is illustrated in Figure 1.

Regular meetings of QMC (chief nursing officer, QENI director) and UHM (director and associate dean for research, and director for community partnerships) were held to draft the interagency research agreement. Over 6 months, each organization’s roles and responsibilities were outlined clearly in the document including the purpose, research goals and objectives, defining the partnership itself, availability of funds, key dates, overview, content and form of application requirements, and key dates. Each participant played a significant role in drafting and revising the document true to the vision to create a sustained inter-organizational partnership. Initially, the effort was operationalized through research teams with faculty and nursing staff working jointly as co-investigators on topics of common interest. The faculty brought the academic research skills to the partnership and the medical center staff brought clinical expertise with a desire to address nursing questions. The director for community partnerships anchored this early effort by convening the meetings, developing agendas, preparing meeting summaries, and troubleshooting the effort.

A major theme of the seed grant effort was to instill passion for the research process in the nursing staff while providing seed grant funding for the faculty. Both QMC and UHM contributed funds for the seed projects and UHM agreed to manage the operations of the effort. The memorandum of understanding (MOU) was executed at a public signing event with the UHM Chancellor and CEO of the Queen’s Health System. The initial 1-year MOU established a mechanism for review and approval of research projects and provided funds to support nursing research related to the areas represented by the service lines of the medical center. Priority was given to topics related to patient safety, patient outcomes, and/or work environment.

To operationalize the partnership, the core group developed a request for proposals (RFP) using a joint or co-investigator model similar to that suggested by federal agencies. The RFP required applicants provide the required

**Figure 1. The Practice-Academic Model (UHM-QMC)**

QMC: The Queen’s Medical Center
QENI: The Queen Emma Nursing Institute, The Queen’s Medical Center
UHM: University of Hawai‘i at Mānoa School of Nursing and Dental Hygiene
elements related to proposal development so partners would have experience and practice when they later submitted for external funding. The practice setting (QMC) contributed funds for the seed grants, funding to UH for 25% administrative support. QMC staff nurses receive 8 hours per month of paid professional development time. UHM provided funds for seed grants; statistical, fiscal, and administrative support for the seed grants; administered the effort; and held the fiscal responsibility for the partnership. In addition, UHM tenure track and tenured faculty participation in the seed grants was provided under the 25% workload credit they receive for scholarship. The university contracted with a nationally known nurse researcher to assist potential investigators from both agencies with pre-award proposal development and preparation.

The specific RFP aims were to: (a) encourage collaborative research with an academic and acute care facility, (b) increase the numbers and skill of staff and advanced practice nurses participating in research, and (c) impact acute care health care outcomes. The conveners hoped to encourage a practice-academic partnership that would strengthen both organizations by supporting beginning research trajectories of clinicians and junior faculty. Figure 1 illustrates the organizing framework for this endeavor.

**Early Findings**

Recognition of the historical separation of education and practice and desire to shape the future of nursing is inadequate to bring about successful inter-organizational partnership. QMC and UHM pursued individual strategic efforts to build research capacity and used the opportunity to fund academic practice research projects.

The directors of community partnership (UHM) and QENI (QMC) assumed the responsibility to champion the effort with their respective organizations. Both made the collaboration a high priority and allocated time and considerable persuasive powers as conveners. They established the ground rules, convened the meetings, and brought the key players within the organizations to the table to achieve multiple levels of integration very quickly. Each was comfortable sharing ideas, resources, and power leading to establishing trust and openness. Through their respective organizational positions, they built the structures, processes, and skills to bridge the inevitable miscommunications and conflicts. Rapid and direct communication proved essential in addressing breakdowns in processes. The broad integrative connections across levels in both organizations proved critical to maintaining trust and respect.

Dissemination of the initial RFP announcement elicited 20 interested staff and faculty. UHM provided an inventory of faculty research interests and QMC shared current performance improvement projects and staff research interest. The associate dean for research at UHM and the QENI director drafted the research proposal criteria and guidelines for submission and coordinated visits by the national research consultant to assist staff and faculty with proposal development and writing. Major challenges included understanding and navigating both agencies’ fiscal and research approval processes.

The SONDH research committee, including representation from QMC, reviewed the proposals using criteria adapted from federal review guidelines. At least three committee members reviewed each submitted proposal. Based on reviewers’ findings, proposals were categorized as: (a) accepted for funding, (b) provisionally accepted with revisions, or (c) not accepted with recommendation for submitting in the next funding cycle. The research committee mentored investigators of proposals in categories b and c, and provided detailed suggestions for revision. Again, the scientific peer review model was used with the opportunity for the pairs to access the national consultant when developing the proposal and the research committee post review for mentoring.

The different work cultures, skill sets, and organizational systems of those developing and conducting projects were challenging. Each team was new to the relationship, activity, and the partnership context. At the end of the first year, the core committee recognized the need for a longer period of time for partnership planning and research development (6 instead of 3 months) as well as closer monitoring of the process (monthly group meetings to assess progress and assist with troubleshooting). That said, the threats were predictable, anxiety producing, manageable, and even humorous (see Table 1).

After funding the year 1 projects, the partnership created a joint research development program offered by UHM faculty at the medical center for both UHM faculty and QMC staff. Curriculum included content on demystifying the nursing research process, design and methodology to differentiate evidence-based practice and performance improvement from research, protection of human subjects, and navigating institutional review board (IRB) process. A panel of nurse partnership investigators discussed their experiences and answered questions. These 4-hour sessions were repeated monthly and more than 170 nurses attended the voluntary sessions. QENI created and distributed a brochure, “What’s it All About?” to all nursing units. The enthusiasm of the nursing staff as they began to recognize their ability to contribute to nursing science and improve patient care became pal-
pable on many of the units. At one QENI internal advisory committee meeting, a new staff member wanted to know why her unit was not involved in all the activity and planned to bring it up with her unit council. This communication by word of mouth was quite effective in creating energy for the effort.

Both UH and QMC provided support for preparation of papers to national meetings, funded conference attendance, and celebrated the accomplishments of the nurses and nursing. QMC and UHM continued to expand their visibility across the organizations and collaborated on additional workforce and education efforts. When national nursing leaders were invited to one of either organization, efforts were coordinated to be sure as many would be able to meet and hear from the leader. This involved coordinating around class and work schedules but was appreciated by the audiences.

The UHM tenure eligible faculty partners benefitted from the access to the expertise of clinicians as they defined their research trajectories. Through their joint conversations, they identified potential topics for exploration. On the continuum from novice to expert researcher, they were able to access the partnership staff. Staff members enrolled in the doctoral program were exposed to research and able to proceed to developing proposals based on their collaborative projects.

In year 1, five partnership projects received funding of $10,000-$20,000 each; year 2, two proposals were funded for $25,000 each; and in year 3, two studies were funded for $25,000 each. These early successes led to the creation of the 8-month long QMC Nursing Research Fellowship as a new partnership effort (Latimer & Kimball, 2010). The first class of 11 nurses began in September 2008 and completed the program. In brief, the fellowship consists of monthly 4-hour research development sessions and a minimum of 4

| Table 1. Inter-Organizational Partnership Facilitators, Threats, and Interventions |
| --- | --- | --- |
| Facilitators | Threats | Intervention |
| Congruent mission | Different work cultures: Time allotted to activities, meetings, and addressing emerging concerns can be problematic as the practice schedule is predetermined and academic schedule has more flexibility; expectations for activity outcomes differed. | • Senior leaders provided visible support and continuing project involvement. • Leaders publicized the partnership within the organizations and with the media. • Consultants were brought in to share expertise and guide partnerships. • Project champions mediated conflict. • Responsibilities were revised to reflect skill sets. • Research Fellows Program developed at QMC. |
| Leadership | Different skill sets: Differing skill sets of clinicians and academics influenced process of research project development. | |
| Formalization | Inadequate formalization: Agreements did not address project acknowledgment, data sharing, copyright, authorship, use and dissemination of project materials. | • Created a revised memorandum of understanding with specific content that addressed intellectual property, publication, goals, outcomes, decision making, authority, accountability, and served as the de facto governance structure. |
| Operations | Underestimating resource need: In both organizations, partnership required more operational support than estimated at all phases of the process from development through evaluation. | • Operational leaders had authority and autonomy to speak for their agencies with sufficient fiscal and personnel resources. Further, each agency contributed in-kind resources as the need arose. |
| Communication | Differing organizational processes: Each organization required adherence to specific policy and procedures related to contracts and research. Unequal and different workload requirements can lead to miscommunication. | • Scheduled monthly meetings between the operational leaders with ongoing electronic and phone communication; annual debriefing by CNO, dean, director QENI, and director, community partnerships. • Rapid response to perceived or identified concerns on any aspect of the partnership. • CNO, dean, and project champions monitored the effort and were proactive in facilitating efforts at all levels. |
Content was presented as a series with each session building upon previous sessions. The fellow program culminated with submission of a research proposal to an external funding agency.

Through the work surrounding the partnership, education and practice found common interests. A faculty member focusing her research on emotional intelligence linked with the CNO who wanted to improve nurse retention rates. Together, they conducted a survey exploring the relationship between emotional intelligence and performance, retention, and organizational commitment. Their results both informed action at QMC and were disseminated nationally through publication (Codier, Kamikawa, Kooker, & Shoultz, 2009).

**Discussion**

Applicable findings for future work include the importance of pre-screening for faculty/clinician matches on both clinical topic and ability to work together. This effort contributes to creating team-building tools and managing the team.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Status</th>
<th>Effort</th>
<th>Practice Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category: Patient Safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of pressure ulcers in the ICU</td>
<td>Complete</td>
<td>• One national presentation • One manuscript in development</td>
<td>Disposable incontinence pads have replaced linens in the medical ICU.</td>
</tr>
<tr>
<td>Nursing management of fever in patients with traumatic brain injury</td>
<td>In progress</td>
<td>• One local presentation • One national presentation</td>
<td>Fever practice guideline developed and implemented in the neuroscience ICU.</td>
</tr>
<tr>
<td>Screening and prevention of contrast-induced nephropathy</td>
<td>Complete</td>
<td>• One national presentation</td>
<td></td>
</tr>
<tr>
<td>Alternative teaching strategy for the renal client starting hemodialysis</td>
<td>In progress</td>
<td>• One manuscript accepted for publication</td>
<td></td>
</tr>
<tr>
<td><strong>Category: Quality of Patient Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comedy in chemotherapy</td>
<td>Complete</td>
<td>• One local presentation • Two national presentations in development • One manuscript in development • Planning for grant submission to NIH</td>
<td>Findings support the use of humor as an inexpensive, efficient, and effective intervention that may complement pharmacologic therapy for managing symptoms related to cancer and chemotherapy. QMC made a comedy library available to inpatients receiving chemotherapy.</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Complete</td>
<td>• One local presentation • One national presentation</td>
<td></td>
</tr>
<tr>
<td>Coping mechanisms of pregnant adolescents and their parents</td>
<td>In progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Category: Work Environment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional intelligence (EI), performance, and retention in clinical staff nurses</td>
<td>Complete</td>
<td>• Two national publications • Three national presentations</td>
<td>Conducting project to assess impact of peer coaching on management outcomes.</td>
</tr>
<tr>
<td>Developing the EI of clinical oncology nurses</td>
<td>In progress</td>
<td>• One international presentation</td>
<td>Conducting EI intervention to evaluate impact on EI scores.</td>
</tr>
<tr>
<td>Developing the EI of nurse managers using peer coaching</td>
<td>In progress</td>
<td>• One scheduled presentation</td>
<td>Intervention to evaluate impact of peer coaching on nursing manager’s EI and burnout prevention.</td>
</tr>
</tbody>
</table>

hours each month for homework. Content was presented as a series with each session building upon previous sessions. The fellow program culminated with submission of a research proposal to an external funding agency.
process to address the partnership threats identified in Table 1. Other lessons learned include the realization that the novice researchers require institutional support at both sites to conduct and complete the research in a timely manner. Learning about different IRBs contributed to the appreciation of differences in the clinical versus the academic setting.

Three funding cycles awarded a total of $150,000 and created eight active research partnership teams of clinicians and faculty (see Table 2). The partnership and the annual MOU have expanded to a 3-year period with the purpose, statement, and goals revised based on the lessons learned.

The creation of a funded research partnership effort is proving an effective mechanism to build capacity for research while creating the foundation for a sustainable long-term public private inter-organizational relationship. Facilitators included congruent mission, committed leaders, formalization, strong operation support, and exquisite communication as described in Table 1.

Although the institutional goals of the partnership are different for both institutions, there is a shared sense of purpose for the combined effort. Leaders from both institutions believe research will translate to improved patient care and increase the skill set of both clinical nurses and nursing faculty. QMC anticipates staff nurses will develop an enhanced sense of nursing practice and professionalism. Faculty who aspire to keep their program of research grounded in practice and relevant to the bedside have the ability to participate in addressing acute care questions. Each organization’s own individual research capacity grew at the same time the partnership created a greater benefit to the community.

The CNO of QMC and the dean of SONDH support and demonstrate continued involvement with the partnership. Publicity of the partnership within the institutions and in the media continues, along with initiative staffing as well as the individual institution’s financial support for the partnership grants.

**Table 3. Levels of Integration Between Collaborative Partners**

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic integration</td>
<td>Continuing, frequent contact exists among top leaders to discuss broad goals or changes.</td>
</tr>
<tr>
<td>Tactical integration</td>
<td>Middle managers or professionals together develop plans for projects or joint activities and identify changes that may enhance linkages between companies and knowledge transfer.</td>
</tr>
<tr>
<td>Operational integration</td>
<td>Allows the people carrying out the day-to-day work to have access to the information, resources, and staff they need.</td>
</tr>
<tr>
<td>Interpersonal integration</td>
<td>Strong interpersonal relationships help resolve small conflicts before they escalate.</td>
</tr>
<tr>
<td>Cultural integration</td>
<td>Requires managers and individuals involved in collaborations to be both teachers and learners in order to develop the communication skills and cultural awareness necessary to bridge their differences.</td>
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</tbody>
</table>


**Implications**

Inter-organizational relationships between nursing practice and education are highly variable. It is inherently challenging to establish and manage such efforts in today’s complex health care and educational climate. Further, promoting nursing research care in delivery organizations and academic settings outside of academic health centers creates challenges. The mutual need and recognition of the high stakes involved, in concert with stable committed leaders at all levels, were key to the early success of the effort described here. Failure could have occurred at several points and jeopardized the long-term relationship without the sustained support at multiple organizational levels. Brown, White, and Leibbrandt (2006) suggest successful collaboration requires five levels of integration between collaborative partners (see Table 3). Four years ago, the organizational leaders were meeting to explore strategic integration. Through the formal research partnership mechanism, a discrete focus was created for efforts and used to move to tactical, operational, and interpersonal integration in this relationship. Sustaining this effort and achieving cultural integration will be the focus of continuing activity.

**REFERENCES**


*continued on page 336*
Partnership to Build Research Capacity

continued from page 321


