Journal of Interprofessional Education & Practice 9 (2017) 95–98

Contents lists available at ScienceDirect

Journal of Interprofessional Education & Practice

journal homepage: http://www.jieponline.com

A comparison between urban academic health care center and rural community faculty members in approaches to IPE

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ARTICLE INFO

Article history:
Received 12 January 2017
Received in revised form
4 August 2017
Accepted 5 September 2017

ABSTRACT

The objective of this study is to compare attitudes and approaches to interprofessional education (IPE) between urban and rural faculty and includes description of barriers for teaching collaborative team-based care. A qualitative comparison of interview data comparing rural community based physician and pharmacy faculty members with their academic health center counterparts found a shared interest in IPE. The groups differed, however, in their methods of teaching IPE. Some of these differences appear to be driven by the differences in nature of the two types of practices. There is some evidence that lack of preparation for teaching IPE is greater among rural community than among academic health care center faculty members, suggesting an opportunity for focused faculty development efforts in this area. This is a compelling issue as health care education programs continually seek preceptors for clinical experiences that provide learners with exposure to interprofessional team-based practice in a variety of settings.

1. Introduction

Over the past three decades, educators and policy makers have promoted interprofessional health professions education (IPE) as a method to improve patient care and to restructure the ailing health care system. IPE occurs when students from two or more professions learn with, from, and about each other and it is transforming fragmented health care delivery models into more integrated systems.[1,2] To date, most interprofessional learning experiences have been developed using didactic or simulation formats,[3,4] yet, students often find these experiences artificial.[5] There is increasing consensus that IPE should be integrated into clinical education settings or other experiential context.[6] However, the lack of authentic clinical contexts for IPE is concerning given that most current health professionals were trained in a silo-based system of care.

The most widely accepted definition of collaborative team-based care is articulated as "… the provision of comprehensive health services to individuals, families, and their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals."[7] A growing body of evidence and expert opinion suggest that interprofessional care produces better outcomes, quality, and safety.[8,9] As such, accreditation standards for health professions programs mandate that students require interprofessional health education and exposure to team-based practices.

However, interprofessional care and training experiences in IPE may differ in rural practice in comparison with urban, resource intensive, interprofessional settings. Since rural practices have varying work conditions and resources, it is difficult to determine whether a universal framework for how IPE may be applicable. Recent studies examined the core competencies of general interprofessional collaborative practice and found that the competencies do exist in rural practice, yet methodology for teaching IPE has not been fully examined.[10–12] Given the benefits of interprofessional collaboration, its utilization in rural settings is critical considering that nearly half of the global population resides in a rural area.[13] It is important to understand better how interprofessional care differs in ambulatory rural versus urban academic health center settings. Accordingly, this project examined physician and pharmacist faculty working in rural communities (community faculty = CF) and compared them with urban academic health care center faculty (academic faculty = AF).

A qualitative matched pair design using structured interviews was conducted to examine differences and similarities between rural and urban models of collaborative practice, how or whether

Abbreviations: CF, rural community faculty members; AF, urban academic health care center faculty members.

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http://dx.doi.org/10.1016/j.xjep.2017.09.001
2405-4526/

team-based care was taught, and barriers to such training. Objectives of this study included:

1. Compare models of collaboration that exist in an ambulatory rural community setting with those that occur within an academic health care center in an urban setting.
2. Describe the extent to which physician and pharmacist faculty in each setting actively teach collaborative team-based care to students.
3. Describe barriers to teaching collaborative team-based care to students.

2. Materials & methods

2.1. Participant recruitment & description

This study was granted exempt status approval by the intuitional review board and data were collected during the 2014–2015 academic year. All CF (physician = 648; pharmacist = 439) involved in teaching health professions students were invited to participate through a recruitment letter. This study examined data from 26 physician faculty (13 CF, 13 AF), and 24 pharmacy faculty (12 CF, 12 AF). Of these participants, 68% identified as male and 32% identified as female. Participant median age was 46 years (M = 47.9, SD = 12.3). Median years in practice was 22 years (M = 24.1, SD = 13.7). AF practiced in an urban academic health care center on a university campus. CF worked in ambulatory rural community settings throughout the state. CF held membership as voluntary community faculty members for the university and serve as clinical preceptors as part of membership.

2.2. Research design

Once participants agreed and provided consent to participate, a research assistant conducted a structured interview (approximately 20 min) with each individual at his/her practice. Interviews were recorded and subsequently transcribed. The interview questionnaire posed questions pertaining to IPE and demographic data (age, gender, credentials, years in practice, and specialty). Demographic data was utilized for the categorical matching process as described in Instrumentation & Data Collection below. To maintain participant anonymity, names were not identified with response data.

2.3. Instrumentation & data collection

The researchers created the interview protocol to understand each provider's approach to integrating interprofessional care and guiding students toward this process of care. The interview structure was comprised of three binary questions with additional follow-up to obtain more detailed information:

1. Do the various health care professionals in your practice ever discuss patients in a group or staff meeting?
2. Do you have ongoing collaboration with any professionals outside the practice?
3. Do you teach collaborative team-based care to students?

Additionally, participants were asked to elaborate (i.e. “What are the barriers to teaching team-based care?”). Further, participants were invited to edit and affirm summaries of their responses at the time of the interview. This member checking, or response validation, was employed to ensure the accuracy and contribute to study credibility.[14]

Groups were created and sorted based on demographic criteria. The method employed was akin to the nearest neighbor technique often used in research involving statistical matches.[15] Each CF participant was matched to an AF counterpart for comparison. The matching criteria were based on a categorical matching scheme (professional role of pharmacist or physician, medical specialty, years in practice, and gender). Through the use of this process, 25 pairs were identified (13 physician, 12 pharmacy).

2.4. Analysis

Thematic analysis was conducted by three researchers using transcripts. Two researchers were doctoral-trained scholars with extensive qualitative research experience and professional backgrounds in health education. The third researcher, a research assistant, provided support with interview transcription and coding. All three researchers individually coded the transcripts and reconciled. Themes emerged as outcomes of coding, categorization, and analytic reflection[16] The Framework Method was utilized to facilitate comparative techniques through the review of data across a matrix.[17] This method provided a structured format to summarize and code data for the identification of themes. Inter-rater agreement was established through a review of coding strategies and by data interpretation by all researchers to refine themes and to ensure resolution of any disagreements.[18,19]

3. Results and discussion

3.1. Research objective 1

To compare models of collaboration that exist in the community context with those that occurred within an academic health care center, participants were asked about the nature of patient discussions among health care professionals at their site. Among all respondents, 56% indicated that no consistent meetings were scheduled but that collaboration occurred on an as-needed basis. Other meeting schedules reported: daily meetings 14%, weekly meetings 6%, weekly OR bi-weekly meetings 10%. Eight percent reported neither scheduled meetings nor as-needed basis meetings occurred.

A comparison of AF professionals to CF revealed that CF were three times more likely to engage in collaboration on an as-needed basis only and indicated a preference for ad hoc collaboration rather than regularly scheduled meetings. Notably, CF physicians were four times more likely than AF physicians to meet with collaborators at least weekly. Further, 46% of all respondents classified ad hoc collaboration as patient or case-dependent among health care professionals.

When asked if ongoing collaborations existed with professionals outside the immediate practice, the responses varied by both profession (physician or pharmacist) and geographic location (rural community or academic urban). Of all respondents, 68% reported regular collaboration with specialists outside of their own practice as the most frequent. More than a quarter (28%) of all respondents reported regular collaboration with nurses or nurse practitioners. Approximately 18% indicated that collaboration occurs only as needed for complex cases. CF were twice as likely to report regular collaboration outside their practice than AF. Physicians, both AF and CF, were twice as likely as pharmacists to collaborate outside their practice. Nearly one quarter of all pharmacists (12) reported no frequent collaboration outside of their practice.

3.2. Research objective 2

The extent to which professionals in each setting intentionally