LEADERSHIP IN
INTERPROFESSIONAL
HEALTH EDUCATION
AND PRACTICE

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This book is an example of collaboration from beginning to end. The contributors to this book are all experienced educators, health professionals, or community members who are part of community–academic partnerships. Forty leaders from across the United States who are involved in rural, interdisciplinary training of health professional students gathered at Leadership in Rural Health Interprofessional Education: A Working Conference for Leaders in Rural Health Care in Denver, Colorado.

We are grateful for the support of our institutions: Creighton University, Saint Louis University, and University of Colorado Denver, including the conference coordinated by the Office of Interprofessional Scholarship, Service and Education (OISSE) at Creighton University. The conference would not have taken place without the financial support of the Health Resources and Services Administration (HRSA) Grant #1D36HP03158 for Circles of Learning: Community and Clinic as Interdisciplinary Classroom, a Quentin N. Burdick Interdisciplinary Training Project.

We thank David Cella for taking a risk to come to Denver to see what we were up to. His vision for the book and support for the project are much appreciated. We also thank Maro Asadoorian, our task master, who was responsible for keeping the editors organized and on a timeline. This is not an easy task. Julia Waugaman’s gentle yet skilled hand in editing has greatly enhanced our book.

Finally, we hope that this book will be the first of many interprofessional contributions to health professions education and practice that will target underserved communities and the elimination of health disparities.
UNITED KINGDOM PERSPECTIVE

Few regions of Britain compare with the remote expanses of North America, save perhaps for the highlands and islands of Scotland, nor is the rural health deficit as stark as that portrayed in this book. Yet most of the 90 percent of Britons who live in the cities are blissfully unaware of the privation hidden behind the friendly façade of rural life in seemingly idyllic towns and villages where they may retreat to unwind on weekends.

Rural communities in Britain were protected for many years from the full force of economic and social change. A nation that remembered food rationing in the Second World War subsidized agriculture heavily, assisted later by the European Community, in the mistaken belief that as an island it must be self-sufficient in food. As a result, farming flourished during the post-war years. Productivity soared with the benefit of modern agricultural methods, while “townies” made snide remarks about “featherbedded farmers.” If that held a grain of truth for the fertile fens of East Anglia, it was wide of the mark in the uplands of Northern England, Scotland, and Wales, where farming had never been much above subsistence level.
Farmers were not prepared for the harsh winds of economic reality as national and European subsidies were redistributed and withdrawn, exacerbated by the ravages of BSE (mad cow disease) and foot and mouth, which drove some into bankruptcy. Sons of farmers now in their fifties are reluctant to follow them onto the land. Stress masquerades as fortitude, but cannot fool the watchful doctor or nurse. The bedrock of the rural economy has been shaken as the last staple industry has been overtaken by a post-industrial society where wealth comes largely from invisible earnings in the city of London.

City shoppers have grown accustomed to cheap imported food from the prairies of Canada and the pastures of New Zealand, while superstores recently threatened to import milk from Ireland and even Poland to undercut “uncompetitive” local producers. Thankfully, some of the major retailers relented and signed long-term agreements. Mindful of the power of “the big four” supermarket chains, the central government appointed an ombudsman, ostensibly to protect the interests of farmers as much as consumers, yet only to find its good intentions greeted with skepticism.

“Rationalization” and “diversification” are now the catchwords as farms merge in search of economies of scale and bed and breakfast signs go up at the roadside gate. Farming may have always had its “ups and downs,” as some country folk may still maintain, while crisis creeps up on unsuspecting rural communities. Long-term trends militate against preservation of traditional rural life. Second-home owners from the cities first bought redundant farmsteads, then competed for housing that local young people desperately needed before long distance commuters to the cities moved in, followed by the successful self-employed who set up their high-tech offices in the outbuildings.

“Off-comers” may contribute to the local economy and help to sustain local services, but property prices escalate beyond the reach of local people. Many village schools and post offices-cum-grocery stores face closure, despite the influx from the cities. Most railway branch lines were “axed” fifty years ago, replaced by bus services later deemed to be uneconomic and withdrawn. Decline in local services hits poor, young, elderly, and disabled people hardest, as they lack private transportation to be able to access services and entertainment in the cities. The Countryside Alliance, a rainbow coalition comprising everyone from Masters of Hounds to the Women’s Institute, demonstrates en masse in Hyde Park for or against everything from reinstating fox hunting to saving local hospitals, as a bemused metropolis looks on.
Poverty in the countryside is for the most part hidden, masked by the relative affluence of the incoming population, but wages remain low for many in the indigenous population, and prices remain high, compared with the cities, not only for housing but also for food and transportation. Some 900,000 country dwellers (according to the latest official figures) live below the poverty line. Quality of life suffers, as measured by economists and sociologists, although many locals still count themselves lucky to live in the countryside—a countryside to which others flock. Tourism generates ten times more income than farming and helps rescue the economy in scenic areas, even though many of the jobs created are for seasonal migrant labor. Scarred and rundown mining villages miss out.

Improving education, employment, housing, and transportation tend to be higher priorities than health care in rural communities. The National Health Service is charged with the responsibility of delivering the same range and quality of care everywhere. Primary care is generally well-provided in rural areas, with many new purpose-built premises designed to bring specialist services closer, but proposals for polyclinics are dismissed by general practitioners (family physicians) as London-centric in conception and antipathetic to the doctor–patient relationship.

District hospitals are threatened with closure before alternative community-based provision becomes available, as services are redeployed from towns to cities. Hospitals are no longer owned by the local community, nor are their staff working as closely in partnership with primary care professionals. Hospital appointments entail longer and costlier journeys, save for those patients entitled to use the ambulance, while elderly relatives without cars rely on the goodwill of neighbours to provide transportation for visits. Reaching the Accident and Emergency Unit may entail a long and separate journey, while air ambulance services rely desperately on charitable donations raised at domino drives in village halls.

Responsibility rests with local authorities to sustain and restore the quality of rural life in partnership with NHS Trusts, police authorities, and community groups. Elected representatives, senior managers, and grassroots activists provide the leadership. Collaboration is assumed within community development strategies whose success depends upon wide-ranging participation.

Professional education is being strengthened as the latest wave of new universities is established in rural counties by upgrading or merging institutes of higher and further education. Multi-site universities result, working with feeder colleges to improve access to higher education in regions where take-up has been traditionally low. Priority is invariably given to the development
of vocational courses for service industries, in the proven expectation that a significant percentage of graduates will opt to work locally in key occupations such as school teaching, medicine, nursing, and social work. The new generation of universities is strategically placed to promote not only professional but also interprofessional education (IPE) that is responsive to rural needs and priorities.

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CANADA PERSPECTIVE

The Canadian Health Services Research Foundation describes “rural” as: “communities based on geographic isolation, economic and labour force characteristics, and availability of services and amenities.”

Canada covers a landmass second only to Russia, yet its population is scarcely larger than 35 million people. Much of that population occupies a band of about 200 miles across its entire border with the United States of America. Canada has a large Aboriginal population that is widely dispersed and whose health needs have been documented in many reports. Providing a range of health and social care services to the rural population presents considerable challenges.

Many of those challenges are related both to the distance between rural and urban communities, and to the scarcity of health and human services in rural areas. The spectrum of health problems is wide and includes low life expectancy at birth, high mortality and suicide rates, and above-average chronic disease rates. These health challenges are compounded by low access to physicians, a relatively small number of health care providers, and inadequate access to specialists in all fields. Providing considerable services to very ill patients over large geographic areas is a feat that is accomplished by a very small number of health care providers whose working life expectancy under such conditions is considerably shorter than that of colleagues in urban areas.

The ability of rural communities, health authorities, post-secondary institutions, and others to provide and support the education of health profes-
sionals, particularly at the pre-licensure level, is therefore a highly complex issue. Providing leadership in rural health education and practice is heavily dependent on community capacity; i.e., the ability of a rural community to handle a quantity (number and mix) of students and also to provide a high quality practice education experience.

There is growing recognition of the benefits to rural communities and to students (and ultimately to the health care system) from learning in rural communities as part of their educational experience. In British Columbia, Canada’s most westerly province, a number of such programs have been initiated over the past several years. These programs include the Interprofessional Rural Program of BC, the Aboriginal Health Elective, and the Vancouver Island Interprofessional Health Project. In addition, there are long-standing uniprofessional rural placements provided through most education programs. Although significant momentum is underway with similar programs across Canada, it has become clear that there is an urgent need to engage a wide range of stakeholders in order to achieve a number of common goals. All jurisdictions recognize that there is a need to carry forward at least the following actions:

- Promote knowledge exchange about models, activities, successes, and challenges relating to interprofessional placements linked to rural practice and research
- Engage in meaningful dialogue regarding a longer term sustainable model, including principles and components for expanding interprofessional practice education linked to rural practice and research
- Identify an action plan that is endorsed by key stakeholders in both urban and rural communities

In the past four years, through the agency and financial support of Health Canada, many rural interprofessional initiatives have been started that are actively engaged in realizing the actions outlined above. Canada’s good fortune in mounting these initiatives was that it was able to learn from the Quentin Burdick program in the United States and profit from much of the learning in that program, whose lessons are amply illustrated in a number of chapters in this volume. Canada and the United States share many commonalities in their rural populations and are presented with many of the same problems in providing access to health care. The fundamental underlying attempts to connect the academic and rural communities are generic to both countries, as are our mutual attempts to provide excellent models of interprofessional care through collaborative teamwork.
The wealth of materials focusing on leadership represented in this volume speak to the long history of successes (and failures) in our efforts to mount a sustained interprofessional culture in both countries. The challenges of rural interprofessional practice are many, yet they hold great promise for realizing the long sought-after goal of systemic change to enhance and improve the quality of care given to all people who enter the health care system in our two countries. These challenges, articulately addressed in the contents of this book, are worth carrying forward.

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UNITED STATES OF AMERICA PERSPECTIVE

The concept of rural is first, and foremost, a statement about geography. But defining more specifically what rural means is not straightforward, as geographers have noted. In their survey of the literature, Williams and Cutchin identified seven ways in which rural has been descriptively defined: land use, demographic structure, non-metropolitan area, environmental characteristics, and, less commonly, population density, population characteristics, and commuting patterns. They also identified “universals” that define the overall characteristics of rural areas.2

First, there are the poor socioeconomic circumstances of rural areas that contribute to health disparities. Globalization, the shift to service economies, technological change, and resource depletion are economic forces identified by Williams and Cutchin that have generated “restructuring” processes, impoverishing many rural places. Population shifts to more urban areas have left the poorest and most vulnerable behind. Second, rural places exist within a larger political context where an urban bias in the distribution of health care resources has dominated. Third, the cultural character of rural places is tremendously varied, and appropriate provision of health promotion and health care takes this cultural diversity into account. The geographic remoteness of rural places coupled with their universal characteristics underlies
problems with provider supply, distribution and availability, recruitment and retention, and accessibility for the provision of health care to meet the needs of rural populations. All of these factors are implicated in the more severe nature of health problems that plague residents of rural areas. Although the traditional approach to addressing rural health problems has been to try to increase access to health services, experts are calling for more emphasis on a public/population health approach to the health needs of rural sub-populations, recognizing the need for geographically and culturally sensitive approaches to modifying health behaviors in combination with the provision of health services.

Paradoxically, in contrast to the universals identified, drawing on Halfacree, Williams and Cutchin argue that the particular health care problems of any specific rural place represent a unique combination of geographic and social variables that generates highly local circumstances, and these circumstances need to be explored with residents and understood holistically for successful care provision.

The nature of rural America and the challenge of providing comprehensive health care to rural Americans follows this more universal pattern. The U.S. Census in 2000 estimated that 20 percent of the U.S. population lives in rural areas; in 2007 the estimate for the rural (non-metropolitan) population was 17 percent, spread across 80 percent of the land area. Although the vast majority of those living in rural areas are classified as White (non-Hispanic), 18 percent of the rural population is minority.

From a cultural perspective, data from 2002 showed that three times as many minorities in rural areas lived in poverty as compared to rural Whites (non-Hispanic). As of 2002, among African-Americans, who represent the largest of the rural minority populations, one-third were poor, compared to 13 percent of Whites. Among Native Americans, the only minority group with a greater presence in non-metro than in metro counties, a percentage similar to that of African-Americans were poor. Although most Hispanics reside in large metropolitan areas, the presence of persons of Hispanic background has doubled in rural areas since 1990, and 25 percent of them are poor when compared to rural (non-Hispanic) Whites. Asians make up the smallest minority in rural areas, and their poor make up a lesser percentage than that of rural Whites (non-Hispanic). Asians are the exception in another way; they are not geographically concentrated in particular regional areas and physical environments of the U.S. as are the other three minority populations. Additionally, according to the United States Department of

Rural U.S. residents have poorer health than urban residents on many health indicators. This includes indicators of multiple chronic illnesses and activity limitation rates related to these illnesses, traffic-related injuries, suicide rates, dental problems, and risk factors, such as obesity, that implicate health-related lifestyle behaviors.

Most rural areas in the United States are designated health professions shortage areas (HPSAs) for primary medical care. The physician shortage in rural areas of the United States has been long-standing; presently only about 9 percent of U.S. physicians practice in rural areas, and the majority of these are prepared at a small number of comprehensive medical schools, mostly in the Midwest. Twenty-two percent of nurse practitioners practice in rural areas. Nurses, pharmacists, dentists, and mental and behavioral health professionals also are all in undersupply in rural areas. Although the Association of Schools of Allied Health Professions has proposed expansion of scope of practice for allied health professionals to help address rural shortages, several of these professions, including occupational and physical therapy, clinical laboratory sciences, dental hygiene, and respiratory therapy are experiencing or are expected to experience serious shortages by 2014. Trained emergency medical service personnel are also in serious undersupply in rural areas.

Since the new millennium, key Institute of Medicine (IOM) reports have focused on the issues of health care quality and safety in our health care system and strategies for addressing those concerns. Concerns for quality and safety apply as much in rural health care as they do to metropolitan areas. However, the content of reports and the nature of recommendations for change, guidelines, regulations, and initiatives that have grown out of the patient safety movement are a good example of the urban bias that contributes to perpetuating disparities in care available to populations living in isolated rural areas. The emphasis of the patient safety movement has been largely on the nature of care in larger urban and suburban hospitals. There needs to be greater attention to the rural contexts of health care quality and patient safety issues. Such contexts include the distinct nature of rural hospitals and the geographically dispersed and varied nature of rural ambulatory health care services.
Williams and Cutchin note that, increasingly, telemedicine is offered as a technical solution to addressing many of the issues surrounding the provision of health care in rural areas, but this solution creates its own “have-nots.” The potential for telemedicine to address rural health disparities through access to specialist services as well as continuing education of local health care providers currently is best exemplified by the Arizona Telemedicine Program, created in 1996 as a partnership between the Arizona State Legislature and the University of Arizona Health Sciences Center in Tucson. It has its own telecommunications network with 65 direct links and 85 links through affiliates throughout the state, which include many remote Native American health services sites as well as State Department of Corrections rural prison health care sites. However, the resources and scope of this program far surpass what is available throughout most of the U.S.

It is often said that the best place for interprofessional team training in the health care professions is in rural areas. [A similar argument has been made that rural settings have certain advantages as test sites for quality improvement efforts.] The prevalence of unmet needs and the scarcity of health care personnel necessitating use of all available resources in a cooperative and coordinated fashion provide ample opportunities for students to both observe and enhance teamwork and to provide some of the needed services in physically and culturally diverse rural settings. In fact, under the Health Resource Service Administration (HRSA), federal programs for interprofessional training in the health professions in the United States since the 1970s have targeted rural areas. This has been done with the hope of recruiting and retaining future health professionals to practice in rural areas and through the training programs, indirectly improving the quality of health care, especially with prevention, health promotion, and screening services. Notably, these programs have included Area Health Education Centers (AHECs), geriatric education centers (GECs), and rural interdisciplinary training, the latter culminating in the Quentin Burdick Rural Training Program. Unfortunately, the Burdick program has completely lost its funding in the current federal administration, while others have been repeatedly threatened or have lost their funding intermittently.

The contents of this book, rooted in the experience of those who deliver health care and interprofessional team training in rural environments in the United States, illustrate the variety of universal rural issues relevant to effective interprofessional care and training identified by Williams and Cutchin.
and successfully capture how those universal issues play out as they are uniquely mixed in a variety of rural U.S. localities and cultures.

The book begins with a general introduction to the field of rural health IPE and practice. One chapter in the introduction, unusual for this type of book, is focused on IPE and the common good. The authors explore the cognitive and moral framework required to motivate individual faculty, administrators, and, in turn, students, of various health professions, as well as the educational and professional organizations they are a part of, to learn and work together to serve the common good of their patients and society. Although not made specific to the book’s rural focus, the chapter seems particularly relevant to inequity issues of rural care provision and health care training to serve rural populations. This chapter effectively frames the moral and ethical context for numerous chapters describing specific experiences of rural health care and training in the book. Another chapter addresses the limitations of current accreditation guidelines for fostering interprofessional learning in health professions curricula. Other issues raised by these introductory chapters focus on theories of IPE, assessing interprofessional competencies, promoting interprofessional practice in rural settings, and engaging faculty in interprofessional scholarship, education, and service.

In a recent article discussing the foci for IPE, Barr adds a fourth focus to three that previously have been identified (preparing individuals for collaborative practice, learning to work in teams, and developing services to improve care). The fourth focus is to improve the quality of life in communities. Barr noted that this focus has much in common with the community–campus partnerships movement and service learning. The second section in this book places rural IPE squarely in a community context, and various chapters explore the dynamics of relationships between educational institutions and the communities where interprofessional learning takes place, always emphasizing the partnership status and “give back” that rural, underserved communities need and deserve as part of the exchange that transpires around student learning. There has been much pressure on federally funded IPE programs’ evaluation to show that these programs make a difference in patient outcomes. The rural model of community-embedded IPE has clear potential to demonstrate these linkages, as many chapters of this book illustrate.

The third section of the book brings attention to the diverse local contexts, including cultural contexts, rural care, and training from a variety of perspectives. One chapter focuses on how federally funded Area Health Education Centers (AHECs) have fostered rural interprofessional training, A.
chapter in Section Four provides a specific example of how an academic health center has used AHECs statewide to organize rural interprofessional training. In Section Three, one chapter provides important insights into how Wagner’s chronic illness model, with a focus on diabetes care, can be adapted to a rural setting to improve outcomes.

Gross under-representation of minorities in the health care workforce is an important issue in rural settings, as it is more broadly, with the greatest disparities for Native American health personnel. One chapter in Section Three calls attention to a successful effort to prepare Hispanic and Native American occupational therapists. Other chapters in Section Three and Section Four illustrate how a particular isolated Native American community has built on-site health services and resources that are sensitive to the unique needs and culture of the community and how a culturally sensitive model of IPE has been integrated into that setting. Other chapters throughout the book, especially others in Section Four on “Better Practice Exemplars,” also contain excellent examples of culturally sensitive interprofessional training and care. One chapter each in Section Three and Section Four, respectively, reminds us of the possibilities for extending training into remote areas through the use of telehealth technology and the important role of health literacy in improving health promotion among culturally diverse rural populations.

The timing of this book is an important reminder of the continuing need for leadership in resolving health care disparities in rural communities and the potential for interprofessional care and training to contribute to addressing those health disparities. The contents of the book repeatedly demonstrate what can be accomplished through health care services tailored to unique rural settings and populations as well as university-rural community partnerships for service provision and interprofessional student team training experiences. It keeps attention focused on the values and contributions of rural interprofessional training when the funding of interprofessional team training has mostly shifted to a focus on patient safety in the context of institutional, and usually urban, settings.

A final important reminder of what it takes to prepare health care professionals for a future of greater collaboration and to deliver truly patient-centered, team-oriented care is suggested by the collective authorship of the book. A great deal of the literature on IPE and practice is generated by or focuses on the two dominant health professions of medicine and nursing, whereas the health professions collectively encompass many more discrete fields of expertise, without which the quality of health care individuals and populations receive would be greatly compromised. This is certainly true in
rural areas in the United States where the professions are challenged together to meet the health and health-related needs of diverse rural populations. The authors of this book represent the diverse health professions of physical therapy, occupational therapy, pharmacy, social work, physician assistants, library science, and health educators, as well as medicine and nursing. Many of the chapters are written in partnership with representatives of the communities described, as well as leaders in health advocacy groups. Collectively, their contributions capture what rural health care leadership for IPE and practice in the United States is all about.

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REFERENCES


