1-1-2012

Turf, Team, and Town: A Geriatric Interprofessional Education Program

Nancy MacRae

University of New England, nmacrae@une.edu

Follow this and additional works at: http://dune.une.edu/ot_facpubs

Part of the [Curriculum and Instruction Commons](#), [Dentistry Commons](#), [Occupational Therapy Commons](#), and the [Physical Therapy Commons](#)

Recommended Citation

MacRae, Nancy, "Turf, Team, and Town: A Geriatric Interprofessional Education Program" (2012). *Occupational Therapy Faculty Publications*. Paper 1.

http://dune.une.edu/ot_facpubs/1

This Article is brought to you for free and open access by the Occupational Therapy Department at DUNE: DigitalUNE. It has been accepted for inclusion in Occupational Therapy Faculty Publications by an authorized administrator of DUNE: DigitalUNE. For more information, please contact bkenyon@une.edu.

Turf, team, and town: A geriatric interprofessional education program

Nancy MacRae

Occupational Therapy Department, University of New England, Portland, ME, USA
Tel.: +1 207 221 4106; Fax: +1 207 523 1920; E-mail: nmacrae@une.edu

Received 6 October 2010

Accepted 9 August 2011

Abstract. *Objective and participants:* This program provides an interprofessional course to students, allowing them to learn together with each other and their elder teachers.

Goals: include refining their professional parameters (turf), learning how to successfully collaborate with other professionals (team), and determining how to effectively design intervention plans for elders within their own communities (town). Various methods of evaluation, such as journals, participation in rounds, and OSCEs, used to assess students' status are described.

Results: Both students and faculty gained clearer perceptions of other professions through their work with each other and the ability to more effectively communicate with other profession. Both also learned, through their relationships with their elder teachers, more about how their specific professions' contributions can affect elders and how elders perceive and contribute to their own communities.

Conclusions: This program has been a successful venture. The challenge is now to devise a way to provide similar experiences to a larger group of students.

Keywords: Elder, team, dental externs, occupational therapy, physician assistant, physical therapy

1. Background

Interdisciplinary or interprofessional team work is when two or more professions or disciplines work, learn, and problem solve together in a collaborative way, sharing responsibility for a total plan of intervention for a client. Continuous lines of communication and preservation of specialized functions among members are essential [1–3]. This basic form of interprofessionalism was foundational to the inception of the Interprofessional Geriatric Education Program (IGEP) at the University of New England's (UNE), Westbrook College of Health Professions (WCHP). The team concept was espoused, as it held promise for being able to more effectively, efficiently, and ultimately, better treat clients [4,5]. With the upcoming explosion of a graying population [6], the complexity of co-morbidities in elders and the inability to autonomously and competently

render holistic care to the elders [7,8] a team approach has become essential.

Academic institutions educating future professionals have the above challenges to address to prepare future health care providers for 21st century practice. As such they must adapt learning and clinical experience to expose students and faculty, both educationally and clinically, to team-based, person-centered models. Enthusiastic and energetic leaders who can adapt to change and help to manage change are then needed to seek funding, design community partnerships, and evoke and sustain administrative and departmental support to provide team learning opportunities [7,9]. Meeting accreditation standards, addressing turf issues, and appropriate scheduling, and logistic issues are just some of the problems that need to be flexibly addressed [5]. Leaders who are not only advocates of this program, but also reflective practitioners with learning goals as the focus, are necessities for success [1,10].

2. History of program

There are three evolutionary points for the development of IGEP. The first started at UNE's College of Osteopathic Medicine (COM) in 1996. A Doctor of Osteopathy (DO), a Physician Assistant, (PA) and a Geriatric Nurse (RN) composed the interdisciplinary faculty team of program architects. This initial 'geriatric practicum' was primarily focused on COM students. With the advocacy of the PA and nursing, other non-medical school programs began a limited participation. The programs were social work, dental hygiene, and PA. In 2000, the PA program withdrew from the above program due to its desire to be more non-hierarchical [7,11]. The second point was in 2001, when the PA department of the College of Health Professions started an in-house interdisciplinary program for elders with social work and dental hygiene. The PA program secured a three year federal (2003–2007) grant from the Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), allowing an expansion of the geriatric education of the PA student body into the first iteration of IGEP. The grant's relevant objectives were:

- To expand the interprofessional model by including additional professions and expanding the learning across the academic year
- To identify and develop basic team-based abilities and values
- To be able to describe the value-added components gained from this interprofessional experience
- To develop and provide faculty development on interprofessional geriatric education

The PEW report of 1995 advocated the need for relationship-centered care. The IGEP model sees that as a multifaceted model. Not only is the focus on establishing a therapeutic relationship with the elder teacher, but also with all other professional students and faculty, as well as the community. Being concerned about the elder, his/her continued quality of life needs the sustaining energy and support of one's peers to help create the best holistic view and intervention plan for the elder [13–15].

From IGEP's inception, first year PA students have been required to participate and provide a solid student population for the program. The two semester course provides PA students with an overview of the variability of elder life including the experience of those living independently in the community to those living in assisted living sites to those residing in nursing home set-

tings. The independence to dependence journey highlighted the increasingly restrictive plight, particularly in regards to choice, of frail and ill elders. This experience provided the basis for the PA's geriatric practical and clinical experience, while allowing faculty to nurture and model this experience in an interprofessional manner. The Interdepartmental investment and participation in IGEP's in-house model proved infinitely more difficult, due to time, curriculum, and interest constraints. Faculty participation was dependent on the initiative and passion of faculty members who advocated interprofessional approaches and enjoyed practice with elders. They encouraged their students to choose participation as an elective and/or as part of a specific class assignment.

Thus, participation has varied, as have the numbers of students in programs, and the program demands on and responsibilities of interested faculty [1,4]. This presents a variety of challenges to a coordinator in assuring continuity of the program and students experiences; conversely, IGEP is continually changing and evolving, intriguing and maintaining a high level of interest for those who do participate from year to year.

The academic year of 2005–2006 presented the usual challenges but also had some unique gifts: the involvement of senior dental externs from Boston University and a few occupational therapy (OT) graduate students in the project. Both of these groups of students came with a modicum of clinical experience that surpassed the developing PA students but fit perfectly with the use of a **consultant model** to the PAs. Physical therapy students joined the program in the 2008–2009 academic year.

3. Program beliefs

The current functioning of IGEP is based on a number of beliefs:

1. the elder is seen as a teacher
2. relationship-centered care is primary [15]
3. the professional journey occurs within a horizontal landscape, not a vertical one
4. turf, team, and town concepts need to be considered

Since the elder is at the center of this program, he/she is seen as the teacher. The elder is asked to participate to help health care students learn from them. They are given respect and even receive a certificate of appreciation once their visits with students end. At many inde-

pendently living and assisted living community sites, being an elder teacher is a status symbol, with some vying to participate. Those elders who have consistently participated are awarded community adjunct faculty status within the college. Elders value these tangible rewards for their contributions; their contributions correlate with Erikson's psychosocial theory and his stage of generativity [12], and help to make this program unique.

A crucial part of supporting this vision of elder as teacher is to have community sites that are willing to participate and support both the education and intrusion of students and faculty into their daily lives. One PA faculty member has the responsibility of gaining sites, educating sites as to what will occur, soliciting elder teachers, and reserving spaces for pre and post conferences that occur before and after visits. This preparation, coordination, and flexible adjustment facilitate the smooth operation of IGEP for the involved students and faculty. Having interprofessional students and faculty allowed for a more holistic review of the interventions that elders were receiving, thus allowing for inclusive feedback.

4. Program schedule

IGEP sessions are held twice per week, during the fall and spring semesters. A routine day of IGEP is from 8–12 in the morning at the designated site. PA students are delegated to five teams of about 9–10 students. Those who are regular team members have four assigned dates to see elders: students are assigned dates to see their elders: 4 times with one elder in the fall semester; 2 times with one elder in an assisted living site and 2 times with one elder at a nursing home facility in the spring semester. After each sequence of 5 teams, an 'enrichment' four hour didactic session, covering such areas as depressions, dementia, sexuality, and adaptive equipment, is presented to correlate with their current learning or prepare them for their next experiences. From 8–9 am the various team members meet in a designated room where they are introduced and the day's activities are reviewed. Team home visits occur (in assisted living apartments or nursing home rooms) from 9–10:30 am where team members may change, depending on the participating professions and their roles. Since OT is using a consultant model, each student is assigned to see 2–3 elders per session. Faculty-facilitated rounds occur from 10:30 – 12 in two designated rooms, allowing for smaller groups to dis-

cuss specified elders. Disciplinary feedback is given by each representative student, with questions and comments proffered to provide as complete a 'picture' of the elder as possible. These questions and comments may necessitate adaptations or revisions of a profession's portion of the elder's plan. Rounds are often punctuated with 'a-ha' moments when what one professional has said connects to reports from others which allows a different and clearer view of the elder. This facilitates students and faculty developing a more comprehensive holistic approach of planned intervention to develop. Issues of concern also are discussed, such as elder abuse or polypharmacy complications. Teaching to the moment is a powerful tool to assist student integration and synthesis of what has been learned.

5. Turf, team and town

The concept of turf, team, and town, first espoused by Dr. Elizabeth Rudenberg in 2004, flows easily from the above. Turf represents the foundational basis for each profession, their values, cognitive maps [2,16], and domains of practice. Security with these foundations co-exists with the challenge of becoming an integral and functioning member of an interprofessional team [10].

Team work requires energy and work on the part of all. Each profession comes to rounds with his/her own perspective or "cognitive map", ones that often need to be explained to others in non-professional jargon. Each team member needs to be secure in his/her own profession [2,17], open to sharing with and learning from others, able to function collaboratively, deal with conflict, and assume responsibility [4]. Clear communication, respect for each other, and a sense of humor are also necessary requisites for effective interprofessional teamwork. Working on a basic belief that everyone can contribute makes this an easier reality. Such interdependency leads to a synergy, which facilitates appropriate and effective intervention. The PA faculty coordinators have modeled this interdependent approach with respect, trust, and equity toward all team members. This is modeled with consistent respect of the participating faculty and students, always insuring they have opportunities, both formal and informal, to talk together. Students are also informed that they can ask for assistance or expect feedback from any of the faculty.

Town is the community where elders reside, whether independently or within an institutionalized setting.

Fig. 1. Learning and teaching the IGEP way.

The homes of the elders are respected. The relationship established between the community and the academic university allows students to learn in a real environment, where an appreciation of place or context can occur.

The graphic (refer to Fig. 1) of "learning and teaching the IGEP way" displays the girding concepts of turf, team, and town. The elder teacher always remains at the center but the other participants: student, faculty and community, act in a dynamic multi-directional way, like flowing air, reinforcing the need for flexibility and openness, as well as highlighting the reciprocal nature of learning.

6. Team members

Participants in IGEP pursue a number of paths to become members of the team. Invitations have been extended to all professions within WCHP. Membership has varied during the years but currently consists of occupational therapy (OT), physical therapy (PT), and dental externs from Boston University, who use our community Dental Hygiene Clinic as one of their (public health) clinical rotations. OT students, during their final didactic semester and post 6 months of internship, can elect to take this as a 3 credit course: one credit is designated for the clinical visits and joint didactic ses-

sions, while the other 2 credits are devoted to a directed study where the students decide on an interprofessional project. Due to their clinical experience, they act as consultants, seeing two or more elders each time. Occupational therapy addresses occupational functioning and adaptive equipment needs, and makes recommendations to insure safety, to maintain and/or increase occupational interests, and to insure a better understanding of the elder as a unique individual. PT students visit once as part of a course, completing various aspects of a history and physical exam, on which they report their findings at rounds. The dental externs, also in a consulting role, see up to four elders each time, providing oral health screenings, educating other team members on how to perform similar preventive screenings, and reporting their findings at rounds. Their internship lasts only a portion of a semester.

An example of the value placed on elder teachers is when the PA faculty acted on their feedback regarding the depression screening being used. Elders were offended by some of the questions, causing some of the students to ask only what they perceived to be non-offensive questions. This feedback led two of the IGEP faculty members to meet with selected elders to collectively redefine a new tool, one that would eliminate offensive questions. The elders made the final decisions about what, why, and who would create the criteria to be used in the PA interview process. A qualitative piece

OT/PT STUDENT EVALUATION		
	YES	NO
1. Student asks patient why referred to OT/PT, if understand OT/PT		
2. Student asks patient when this problem began (onset).		
3. Student asks patient "what makes this better/worse?"		
4. Student asks patient to describe the quality & quantity of the problem.		
5. Student asks patient if the problem radiates or occurs elsewhere.		
6. Student asks about previous fall, incidence of unsteadiness, symptoms that might precipitate falling.		
7. Student asks patient about past medical history.		
8. Student asks patient about medications, including OTC's and dietary supplements/herbals.		
9. Student asks about patient's employment, occupations, and exercise/interests.		
10. Student asks about patient's typical day.		
11. Student asks about social support system.		
12. Student asks about status of ADLs/IADLs.		
13. Student examines patient performance of ADL or IADL.		
14. Student conducts home safety evaluation.		
15. Student examines function ROM & strength in upper and lower extremities.		
16. Student examines relevant sensory status.		
17. Student lists current adaptive equipment, evaluates need for further adaptive equipment.		
18. Student demonstrates sensitivity to patient's preferences regarding touch, pain and position.		
19. Student evaluates pain as needed, frequently asks about pain level.		
20. Student proposes plan of care, justifies, and includes recommendations and referrals.		
21. Student asks before touching.		

PA EVALUATION		
	YES	NO
1. Student asks why patient has come to be seen today.		
2. Student asks patient when this problem started.		
3. Student asks patient to specifically describe the problem		
4. Asks whether there were any prior occurrences of falls.		
5. Student asks if there were warning signs or symptoms before fall.		
6. Student asks whether there was any head injury sustained this time.		
7. Student asks if there were any other injuries from the fall.		
8. Student asks if s/he has had any recent fever or chills.		
9. Student asks if s/he has had recent changes in urinary symptoms.		
10. Student asks patient if s/he has had recent headaches.		
11. Student asks patient if s/he has had any loss of consciousness.		
12. Student asks patient if s/he felt lightheaded or dizzy recently.		
13. Student asks patient if s/he has had any new onset of numbness, loss of strength, tingling.		
14. Student asks if patient has had recent chest pain, palpitations or SOB.		
15. Student asks patient about past medical, surgical history, recent illness or hospitalizations.		
16. Student asks about patient's family history.		
17. Student asks about medications, including OTC's, dietary supplements, and herbals.		
18. Student asks about understand and adherence to medication regimen.		
19. Student asks patient about allergies & nature of reactions, prn.		
20. Student asks patient about habits (tobacco, alcohol, and illicit drugs.)		
21. Student asks about living arrangements, social support, exercise, interests.		
22. Student tests motor function of lower extremities.		
23. Student tests reflexes of lower extremities.		
24. Student tests sensory function of lower extremities.		
25. Student tests cerebellar function of lower extremities.		
26. Student listens with stethoscope on anterior chest in four places.		
27. Student listens with stethoscope on both sides of anterior neck.		

Fig. 2. Geriatric interview for depression – Short form. interview format: Use these questions for both quantitative and qualitative data about your "teacher". Ask the questions for "How you have been feeling over the past month?" For each question: circle "YES" or "NO" and follow up with a questions such as "Tell me more about that." Record their answer verbatim (as best you can) without losing attention to nonverbal/body language.

was also added to empower the elders to freely discuss how their coping skills influenced their current quality of life. With this addition and students using active listening techniques, elders became friendlier and less stressed when talking about depression. A copy of this revised depression evaluation is found in Fig. 3.

7. Student evaluation

Evaluations of students' performance occur in a number of ways; it is both formative and summative. Formative evaluation consists of direct observation, with supervision by one of the faculty members, usu-

	Question	YES	NO	Details: "Tell me more about this."
1	Are you basically satisfied with your life?			
2	Have you dropped many of your activities and interests?			
3	Do you often get bored?			
4	Are you in good spirits most of the time?			
5	Do you feel happy most of the time?			
6	Do you prefer to stay at home rather than going out and doing new things?			
7	Do you have trouble concentrating?			
8	Do you think it is wonderful to be alive now?			
9	Do you feel full of energy?			
10	Do you think that most people are better off than you?			

Fig. 3. Scoring: All shaded blocks indicate depression, for a possible score of 0–10. There is no research available to interpret scores on these 10 items, therefore you can only rely on subjective impressions. Adapted from Geriatric Depressions Scale Short Form, Sheikh and Yesavage: *Clin Gerontol* 5:165, 1986. Revised 2007 by University of New England's Anne Summer, RN, PA, IGE Program, Mary Fogg, Ph.D., Elizabeth Wheeler, Ph.D., and Joe Wolfberg, MS, IGEP in collaboration with twelve community teachers for an interview to identify depression.

ally one from their discipline, but not always, and oral presentations from each represented profession that occur at rounds. Additionally, PA and PT students submit written plans of care; OT and PA students, and dental externs write journals, with reflections about their experiences, findings, and recommended treatment. Summative evaluations consisted of a final paper by dental externs and participation in an objective structured clinical exam (OSCE) by PA and OT students. OSCEs were originally used for two reasons: to assess program outcomes on the development of clinical assessment skills and evaluate the abilities of students to be effective members of interdisciplinary teams. OSCE uses standardized patients to role play cases. Case selection and professions-specific checklists are used to reflect student learning goals. Examples of the forms used by the PA and OT departments are found in Fig. 2. Encounters are video monitored and recorded. Feedback and debriefing from the standardized patients, peers and faculty occur, addressing how care might be improved, as well as interprofessional knowledge and performance. Each participating profession has a specific student self-assessment, often involving students viewing and critiquing their own video performance.

Self-assessment in the form of reflection is another type of evaluation used. Reflection is viewed as a critical part of learning from and integrating what was learned into future practice. Reflections are perceived as catalysts for clinical learning [18], promoting transfer of knowledge and facilitating the development of reflective practitioners [19–21]. Since experience, activity, and reflective thought are necessary for learning to occur [22], reflection, while engaged in practice, 'reflect-in-action' or after the experience, 'reflect-on-action' [23,24], is seen as critical to encourage students to gain as much as possible from this real-life simulation experience.

8. Program feedback

Qualitative reflective feedback from students and elders validate the power of this experience. Student reflections include the following which reflect the power of participation in this experience on development as a team member:

It was a good experience to evaluate the clients with the physician assistants because I had to figure out

when it was appropriate for me to jump in, and we had to work together in order to incorporate both of our assessments of the client.

As for interacting with other professions in the future, I will not allow myself to assume I have more experience or understand what their role is in treating the client.

It has really been nice to work with my team partners. My partners remind me to look at the whole picture and give me an alternative outlook on the patients and their lives . . . It is reassuring to have multiple brains and multiple perspectives working on achieving the same goal of our patients.

Elder comments have included:

I wouldn't know what to say; these young people don't want to hear about what I think, or what I've done. (Elder at recruitment sessions.)

These students listen, they care; they will be different, and they will make a difference. (Same elder, 1 year later)

Thank you so much, your program gave our mother back to us. Mom had become withdrawn, feeling useless – then you got her involved with your students. She started talking and laughing again; telling us how she was 'teaching' and 'changing the future'. We gave her love, but you and your students gave her a reason to live. (Family of elder teacher).

The above comments highlight the importance of generativity and the leaving of a legacy.

9. The future

As student numbers have increased more teams of students with more days assigned to sites have had to be created. A usual base of 10–11 PA students, 2 OT students, 2 dental externs, and up to 5 PT students, plus supervising faculty, means our teams are full to the bursting point. It has become a problem of riches, one that has required flexibility in how to not overwhelm the elder teachers. It has also necessitated a formulation of a new design, one which will benefit all participants, without overtaxing the elders or the sites. Such large numbers can also undermine the opportunity for meaningful interprofessional interaction of students, and from learning through the consistent continuation of the experience.

While IGEP has changed the lives of the involved team members, it has done so for only a small fraction

of the WCHP students. Both faculty and students who do participate find their perceptions of other professions (team) become clearer and generate even more respect for what they do. This occurs through observing other professions make contributions to rounds, contributions that help in understanding intervention plans and in detecting potential errors... Their Students' perception of their own profession's contributions (turf) and their idea of community or town, through the guidance of their elder teachers, also change. A renewed interprofessional education movement within the college aspires to design new ways to provide a myriad of interprofessional experiences to a larger portion of our student body and faculty. Such exposure better prepares them for the future challenges of our health care system, and for advocating in a collaborative manner for the quality and holistic care of all clients. The question that remains is how this objective will be realized.

Acknowledgements

The author thanks the following peers for their support and help in developing this description of IGEP: Carl Toney, Joseph Wolfberg, Peter Vachon, Anne Summer, and James Cavanaugh.

References

- [1] Hall, P. and Weaver, L. Interdisciplinary education and teamwork: A long and winding road. *Medical Education*, 35, (2001), 867-875.
- [2] Petrie, H.G. Do you see what I see? The epistemology of interdisciplinary inquiry. *Journal of Aesthetic Education*, 10(1), (1976), 29-43.
- [3] Clark, P.G., Spence, D.L., Sheehan, J.L. A service/learning model for interdisciplinary teamwork in health and aging. *Gerontol Geriatric Education*, 6(4), (1996), 376.
- [4] Mickan, S.M. and Rodger, S.A. Effective health care teams. A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*, 19(4), (2005), 358-370.
- [5] Paul, S. and Peterson, C.Q. Interprofessional collaboration: Issues for practice and research. *Occupational Therapy Health Care*, 15(3/4), (2001), 1-12.
- [6] U.S. Department of Health and Human Services, Administration on Aging, *A profile of older Americans*: 2009.
- [7] Yeager, S. Interdisciplinary collaboration: The heart and soul of health care. *Crit. Care Nurs. N Am*, 17, (2005), 143-148.
- [8] Norsen, L., Opladen, J., Quinn, J. *On't Nurs Clin North Practice Model: Collaborative Practice*, Amr, 7, (1995), 43-52.
- [9] Cleak, H. and Williamson, D. Preparing health science students for interdisciplinary professional practice. *Journal of Allied Health*, 36(3), (Fall 2007), 141-150.

- [10] Freeth D. and Reeves, S. Learning to work together: Using the presage, process, product (3P) model to highlight decisions and possibilities. *Journal of Interprofessional Care*, 18(1), (2004), 43-56.
- [11] Kenny, G. (2002). The importance of nursing values in interprofessional collaboration. *British Journal of Nursing*, 11, (2002), 65-68.
- [12] Erikson, E.H., Erikson, J.M., Kivnik, H.Q. (1986). *Vital involvement in old age: The experience of old age in our time*. New York, NY: W. W. Norton and Company.
- [13] Drinka, T.J.K. and Clark, P.G. *Health Care Teamwork: Interdisciplinary Practice and Teaching*, Westport, CT: Auburn House, (2000).
- [14] O'Neil, E.H. and The PEW Health Professions Commission. *Recreating health professional practice for a new century*. San Francisco, CA: PEW Health professional Commission, 1998
- [15] The Pew Health Professiona Commission. *Third annual report. Critical challenges: Revitalizing the health professions for the twenty-first century*. University of California, San Francisco, CA: Center for the Health Professions, 1995.
- [16] D'Amour, D., Ferrada-Videla, M., San Martin Ridriguez, L. and Beaulieu, M.D. The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, 18(2) (2005), 183-196
- [17] Mariano, C. The case for interdisciplinary collaboration. *Nursing Outlook* 37(6), (1999), 285-288.
- [18] Tanner, C.A. Thinking like a nurse: A research-based model of clinical judgment in nursing. *Journal of Nursing Education*, 45, (2006), 204-211.
- [19] Nielson, A., Stragnell, S. and Jester, P. Guide for reflection using the clinical judgment model. *Journal of Nursing Education*, 46(11), (2007), 513-516.
- [20] Lasater, K. Clinical judgment development: Using simulation to create an assessment rubric. *Journal of Nursing Education*, 46, (2007), 496-503.
- [21] Turley, C., Fostering reflective practice. *Radiation Therapist*, 18(1) (2009), 66-68.
- [22] Kolb, D.A. *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Press, 1984.
- [23] Schon, D.A. *Educating the Reflective Practitioner*. San Francisco, CA: Jossey-Bass, 1987.
- [24] Buchbinder, B., Alt, P.M., Eskow, K., Forbes, W., Hester, E. and Strick, M. Creating learning prisms with an interdisciplinary case study workshop. *Innovative Higher Education*, 29(4), (2005), 257-274.