COLLABORATIVE HEALTHCARE

INTERPROFESSIONAL PRACTICE, EDUCATION, AND EVALUATION

A publication of **Jefferson Center for Interprofessional Education**

Impact of an Interprofessional Leadership Program on Collaboration in Practice

Purpose

The purpose of this project was to improve attitudes towards collaboration between nurse and physician leaders and to describe the changes in attitudes and behaviors following completion of an interprofessional education (IPE) leadership development program.

Significance

The Institute of Medicine (IOM) 1999 study, *To Err is Human: Building a Safer Health System*, demonstrated that poor collaboration among clinicians can contribute to negative patient outcomes and further outlined that traditional methods of learning in healthcare result in nurses and physicians becoming isolated from one another and thus unprepared to work collaboratively (Delunas & Rouse, 2014). The nurse-physician (RN-MD) relationship is complex and is influenced by differences in both methods of academic preparation and the perceived value and definition of collaboration between the two groups (Hughes and Fitzpatrick, 2010). Unhealthy relationships such as those that are hostile or disruptive can result in lower levels of job satisfaction, retention, and safety and quality of care delivery (Rosenstein & O'Daniel, 2005; Manojlovich & DeCicco, 2007). The collaborative relationship includes mutual trust, open communication and respect for the skills of each discipline (Schmalenberg, et al., 2005).

For true collaborative relationships to develop, each professional must value the other discipline's contribution, creating mutual or equal power in their relationship (Nelson, King, & Brodine, 2008). This requires confronting the perception that each party has of the other's role. The theoretical framework that supports this process is Critical Social Theory (Freire 1972 as cited in Fulton, 1997), which promotes social phenomenon as being explained by evaluating the history of the social development. The theory framework is dependent on the assumption that knowledge of the current state will facilitate change in the relationship. Utilizing social theory allows for the application of praxis, or reflection with action. Praxis is the first step towards empowerment to change. Identifying the attitudes towards collaboration will provide objective data on the true state of perceptions and provide for reflection with actions that facilitate the RN-MD empowerment to change their relationship.

Background

In the practice analysis of the organizational setting in Central Florida, there was evidence of dissatisfaction in the RN-MD relationships within the clinical roles both in the unit practice setting and within the leadership team. It was demonstrated that nursing and medical leadership structures are in silos and often have limited collaborative clinical agendas. There was a lack of shared decision making and poor communication in regards to the decision-making process. In recent years, there has been a shift towards innovation and adaptability through a shared IPE leadership program for RN and MD leaders, but the evaluation of the effectiveness of the intervention had not been established.

Methodology

The intervention included an eight-month interprofessional leadership development program. The curriculum for the program was developed by Lt. General (Ret.) Mark Hertling. Monthly course work involved a four-hour didactic session and tabletop simulation exercises. The program concluded with an experiential leadership review of strategy and team dynamics in Gettysburg, Pennsylvania. Curriculum is divided into four units: 1) Core Values, 2) Influencing Performance, 3) Collaboration, and 4) Systems Thinking (Hertling, 2015). A mixed methods study of the current program participants (n=56) included quantitative results of a pre- and post-survey, the Jefferson Scale of Attitudes Toward Physician-Nurse Collaboration (JSAPNC), (Hojat et. al, 2003). A second method, a descriptive, qualitative study, was completed with past program participants (n=21), which included semi-structured interviews regarding behaviors that have occurred as a result of their participation in the program.

Results

Eleven of the 15 JSAPNC questions reflected higher mean scores on post-test results with two questions resulting in statistically significant changes. T-tests were utilized to compare the mean scores on the pre- and post-tests. Post hoc testing of the JSAPNC was compared to determine the question items with the major changes in scores between the pre- and post-tests. Repeated measure MANOVA was utilized to evaluate differences between group disciplines and there were no statistically significant differences on tests of between subject effects or over time. The two statements with statistically significant changes between pre-and post-test scores, "Nurses are qualified to assess and respond to psychological aspects of patients' needs" (t=-2.46, P=.017) and "Nurses should be involved in making policy decisions concerning hospital support services upon which their work depends" (t=-3.41, P=.001) indicate improved attitudes towards the collaborative impact of the nursing discipline, caring versus curing. The construct of these questions reflects the orientation of roles (Hojat et al., 1999). Petri (2010) describes role awareness as an antecedent to the concept of collaboration.

In directed content analysis (Hseih & Shannon, 2005), existing research focuses the variables of interest to guide the creation of the initial coding pattern. Data analysis required sampling, data collection and

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analysis to occur concurrently. Transcripts of the interviews were read and participants' key words or phrases that described collaborative behaviors were selected. The key words became the basis of the initial coding and emerging themes. Analysis of the qualitative interviews revealed five themes of behavior changes among participants with consistency and included: 1) increased self-awareness, 2) valuing diverse perspectives, 3) enhanced communication through listening, 4) familiarity which engenders trust and 5) increased participation in leadership activities. A summary of data collected with the themes and most notable quotes is presented in Appendix A.

Repeated behaviors identified by participants included the identification of their own values, awareness of the importance of value and leadership action congruence, an appreciation of their own leadership development gaps and an awareness of their ability to impact others. Participants reported gaining new respect for diverse perspectives and roles. Behaviors consistently described by participants included the utilization of listening techniques and problem resolution through effective communication. Participants reported an increased sense of value of the roles and perspectives of others. Participants also reported behavior and perception changes that included empowerment to lead, ownership of practice and increased participation in leadership. A notable item is that all participants in the IPE intervention viewed themselves as responsible for organizational leadership and success. The most frequently reported behavior change noted among participants was improved relationships between course participants and the long-lasting trust it engendered. The attitudes among the current program participants can be trended in the quantative survey results as question constructs reflect improved attitudes in categories of collaborative behavior that align with the key themes of the self-reported behaviors in practice of past program participants.

Implications for Practice

Findings from the project indicate that the IPE program resulted in both physicians and nurses engaging in collaborative behaviors with consistency nine months following the program completion. Findings do confirm previous research that collaboration is a social process and confirms that processes of RN-MD leadership collaboration are present in the current practice setting among IPE participants (Fewster-Thuente, 2015). The study identified a successful structure for shared learning which included a focus on value identification, congruence with organizational values, role clarity, teamwork, communication, and an empowerment framework that creates motivation to lead. Implications from this study include the benefit of organizational support for IPE programs as they may improve collaborative behaviors and attitudes towards collaboration in practice. Hospitals are facing increasing cost constraints and the investment in leadership development programs where the program outcomes benefit not only the individual participant but the organization overall will be an important consideration in selecting effective future programs to develop.

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Appendix A: Physician and Nurse Collaborative Behavior Themes

Behavior Themes	Study Participants' Quotes
Increased Self-Awareness	**MD:** *"It allowed me to raise awareness of my actions. How I conduct myself really does affect the success of not only my interpersonal relationships with the patients but also the staff and administrators."* **MD:** *"The program is phenomenal. It has changed me. It has even helped me to be a better father. Learning about myself. What is it that drives me? What are my values? What am I trying to accomplish? Just stopping and being aware."* **RN:** *"I realized all of a sudden, it opened my eyes to things I didn't see before. One of the biggest things is that while everyone wants a seat at the table, we have to learn table manners. So if we are making demands if we are slamming things down, no one will want you at the table. Check yourself on how you are bringing yourself to the table."*
Valuing diverse perspectives	**MD:** *"Really before I say anything or think anything, I try to put myself in their shoes. Not just nurses but janitors or whoever. Even the system's shoes. What in the system is making it like this? An introspective review that I definitely do more since the class."* **MD:** *"I try to look more at the other person's perspective a lot more. Now, more than I did beforehand. I try to look at their perspective and what motivates them more. I try to stop and think about what they are they are thinking and what they might value."* **RN:** *"Many think leading is being the loudest voice in the room. But leading happens best by influencing. Influencing behaviors starts by appealing to values. And values start by valuing the other person. What they bring to the table."*
Enhanced Communication Through Listening	**MD:** *"Kind of reminding you to listen more than you talk. Obviously I had heard that before but you tend to get into practice and you think you know everything and sometimes I think we forget to listen to other people."* **MD:** *"It helped me professionally but also personally. I am a better listener. This sounds wrong to say but if you are really smart, if you have a high IQ, you think you know everything. You don't listen. When people are talking, you jump to the conclusion instead of listening. Before you say anything, listen. Think. What is this person thinking, what is their problem, their concerns, background, their perspective. Then you understand better."* **RN:** *"I would say that a meeting where a PLD person is running the meeting it is definitely more collaborative, more listening. It is more based on a relationship and how it will impact the team and that person. It really takes the level of stress down many notches."*
Familiarity which then engenders trust	**MD:** *"At the beginning of the class it was definitely an, "us- versus- the -hospital" kind of dynamic. By the end we started seeing each other as human and taking each other's point of view."* **RN:** *"When you see each other in the meeting and you knew each other from the class, there is a different, sort of unspoken way of understanding."* **RN:** *"Anybody that I know in the class, whenever they see me, they pull out their coin and we trust each other. It established a relationship that wasn't there before. The more we got to know each other the more we saw how important it was."*
Increased leadership participation	**MD:** *"I feel empowered to be a leader. I have a seat at the table. That is new. Because we participated in the program we are willing to be tapped for other projects and are seen as someone who will work together to solve challenges."* **MD:** *"A weird situation is that we had to get rid of a partner in my group. It hit home that I have to take more responsibility for this partner and the medical profession and take a bigger look at things instead of staying in my little cocoon."* **RN:** *"I definitely see a difference in the physicians who attended the course versus those who didn't. Take Dr. ___ for example, I see he has an ownership in the outcomes and that his commitment is the same as mine."*