ORIGINAL SCIENTIFIC PAPER

SHORT RESEARCH REPORT: RURAL

# A model of multidisciplinary professional development for health professionals in rural Canterbury, New Zealand

Susan Bidwell MA, MLIS, MPH; Andrea Copeland BPharm, DPH

Pegasus Health (Charitable) Ltd, 401 Madras Street, Christchurch 8013, New Zealand

## ABSTRACT

**INTRODUCTION:** Pegasus Health Charitable Ltd, a Christchurch Primary Health Organisation, is contracted by the Canterbury District Health Board to provide continuing professional development for primary care practitioners in the region. Rurally located health practitioners have largely been unable to participate because of the travel time and distances involved.

**AIM:** The initiative reported in this paper aimed to fill this gap by developing an accessible and high-quality multidisciplinary model of professional development for general practitioners, nurse practitioners, practice nurses and community pharmacists in rural areas of North Canterbury, New Zealand.

**METHODS:** A survey was conducted to learn from the experiences of 14 health professionals in an existing multidisciplinary group, which had developed as a local initiative in one rural community.

**RESULTS:** The survey had an 86% response rate. All respondents believed the multidisciplinary format worked well, had improved collaborative working and increased the consistency of patient care. Access to professional development had improved and the meetings provided a useful forum for the mostly part-time staff to interact as a group. The main caution noted was the potential to become inward looking without being exposed to fresh ideas from other practices.

**DISCUSSION:** The multidisciplinary model was considered workable and valuable by the survey respondents. Based on our findings, the multidisciplinary model has been formalised by the Pegasus team responsible, and three new groups are now operating successfully in rural areas of North Canterbury.

**KEYWORDS:** Continuing professional development; rural

J PRIM HEALTH CARE
2017;9(4):292–296.
doi:10.1071/HC17049
Published online 12 December 2017

**CORRESPONDENCE TO:**
**Susan Bidwell**
Pegasus Health (Charitable) Ltd, PO Box 741, Christchurch 8140, New Zealand
susan.bidwell@pegasus.org.nz

## Introduction

Pegasus Health Charitable Limited is a Primary Health Organisation in Canterbury that is contracted by the Canterbury District Health Board to provide continuing professional development for primary care clinicians in the region. Each year, six topics of current interest are developed by the Pegasus Health Clinical Quality and Education Team, with external clinical input from relevant experts. Topics are delivered using a peer-led Small Group model with a trained leader who facilitates discussion. Starting with general practitioners (GPs) in 1992, the model evolved to include Small Groups for practice nurses in 1998 and community pharmacists in 2010, with nurse practitioners included in GP Small Groups since 2016. However, clinicians based in rural settings have generally found it difficult to participate in Small Groups because of the distances involved in travelling to the meetings. Rural practitioners face more difficulties in accessing continuing

professional development programmes than their urban colleagues.[1–6]

An initiative by the Pegasus Clinical Quality and Education team aimed to provide more satisfactory and accessible professional development for these rural areas. Three new groups were proposed: in Kaikoura, Rotherham/Hanmer Springs and Amberley/Cheviot. All except Amberley are more than 100 km away from Christchurch city. Each area has a unique local context and mix of health professionals who might want to participate in continuing education. It was not feasible to duplicate the urban model of separate Small Groups for each discipline because of the low numbers of health professionals in these areas and the geographical distances between them. Additionally, clinicians in rural settings indicated they preferred the multidisciplinary approach that more closely reflected the way they practised.

Before implementing a new model of Small Group professional development for rural health professionals, we wished to learn from the multidisciplinary Small Group that was already operating at Oxford in North Canterbury (54 km from Christchurch). It had originally been established on the initiative of a local GP who merged the materials provided by the Pegasus team to create a multidisciplinary session. In addition, all participants received the background material developed for their own discipline.

## Methods

The Clinical Quality and Education team developed a SurveyMonkey® (San Manteo, CA, USA) questionnaire (see Appendix 1). It was distributed by the GP group leader to 14 regular attendees of the Oxford Small Group at the end of August 2016 and remained open until the end of the first week in October. The anonymous questionnaire was designed to elicit opinions about the effect of the multidisciplinary format on collaborative working and patient care, as well as whether access to professional development programmes had improved. The analysis of quantitative data was done through SurveyMonkey®; responses to the open questions were analysed separately.

### WHAT THIS GAP FILLS

What is already known: Rural health practitioners experience difficulties related to professional isolation and lack of opportunities for professional development.

What this study adds: A peer-led multidisciplinary Small Group programme for health professionals in a rural area of North Canterbury has proved to be highly valued and has improved access to professional development.

## Results

There was an 86% (12/14 people) response rate to the survey. Attendance records showed that this number corresponds closely to the core group of health professionals who regularly attended the multidisciplinary meetings.

All respondents agreed that the multidisciplinary group worked well:

> The most obvious example is the relationship with the Pharmacy. The input they provide in conjunction with the knowledge we have of patients have allowed excellent patient centred decisions to be made (Participant 6).

Eleven respondents made comments. They noted that perspectives from all disciplines were now incorporated in decisions about caring for individual patients and that good team work had resulted in a more consistent approach to patient care. Group discussions in a relaxed atmosphere meant that collective decisions were carried through into practice change, further reinforcing relationships and team work.

Most respondents indicated that they had made specific changes to their practice as a direct result of attending the group, and some had revisited the changes to assess their effect:

> I have reduced codeine prescriptions [as a result of] the personalised feedback. Also, we have changed how we do back-pocket scripts. I know nurses are starting to introduce the idea to acute patients that they won't necessarily need antibiotics (Participant 1).

Other improvements included the formulation of team protocols for consistent patient follow up and increasing referrals to the Green Prescription programme. The overall theme of the comments was the increased consistency of care across medicine, nursing and pharmacy that had resulted from the multidisciplinary format, underpinned by the quality of the content prepared by the Pegasus team. Together, these provided a high level of confidence that Oxford patients had 'consistent access to updated best practice'.

All respondents agreed that the multidisciplinary group had improved their access to professional development and their incentive to attend. Moreover, it provided a forum for staff to meet together even if their working hours did not coincide:

> We don't have travel time or costs of going elsewhere. As a group, we are able to have a more relaxed discussion afterwards. It forms a good opportunity to get together outside of work hours, reinforcing the team approach of our practice. This is particularly of benefit as we all work part time and don't necessarily see each other (Participant 2).

Most agreed that the multidisciplinary content was sufficiently relevant for them, but two respondents would have welcomed more that was specific to their own discipline. The primary disadvantage noted was the potential to become inward looking without exposure to fresh ideas from other practices. They also observed that while meeting together as a practice promoted good discussion, it also had the potential to silence an individual if their ideas did not align with those of their colleagues. No instance of this happening was reported.

## Discussion

The survey results showed that the multidisciplinary group was considered to have improved team work and interdisciplinary communication, and benefitted patient care. Access to professional development had also improved, with value being put on both the high-quality content of the formal Pegasus sessions and the opportunity for the part-time staff to meet socially outside working hours. This was consistent with a recent study in a rural Australian primary care practice that found that both formal and informal contexts contributed to inter-professional working and learning.[7]

There was some suggestion that the increased access may have been at the expense of not always delivering content that was specific and relevant to each profession. This may be a result of the multidisciplinary format, but the Small Group programme was never intended to cover all professional development needs. All health professionals, both urban and rural, would normally complement their attendance of the Small Group programme with education in other forms, such as conferences, lectures and short courses.

A multidisciplinary approach is considered essential for addressing the rising incidence of chronic disease in ageing populations and ensuring adequate future health.[8–10] However, longstanding cultural behaviours, funding and organisational models, and lack of understanding of the roles other people perform remain barriers to working collaboratively.[6,11–13] Multidisciplinary learning is a crucial element in overcoming these barriers.[8,10,14] Theoretical frameworks and guidelines for competencies are available but practical examples, especially in primary care, are limited.[15–17] Rural general practices tend to be ahead of their urban counterparts in the adoption of multidisciplinary teamwork as it allows clinicians to manage workloads more effectively, provide reciprocal support to one another, and deliver more integrated care to patients.[1,4,7,18] Mutual understanding and trust is also promoted, which in turn contributes to more patient-centred care.[6,7]

The more advanced collaboration of rural practices is recognised as being valuable for student teaching and learning, with rural placements included in a range of health professional training curricula.[7,18,19] The professional development needs of qualified staff in rural practices do not appear to have received much attention, despite the known difficulties they face compared to their urban colleagues.[4] Aside from reports of one-off courses[20] or networks developed for treating a specific condition,[4] we were unable to find any programme similar to ours where rural health professionals from a range of disciplines

had access to an ongoing structured programme of professional development.

## Limitations

This was a study of one group of rural primary care practitioners in one area of Canterbury and is not necessarily representative of other areas in New Zealand. Because of the small number of participants and the anonymous nature of the survey, we were unable to provide any analysis of participants' ages, gender or professional affiliation.

## Conclusion

The survey results confirmed that the multidisciplinary group model is workable and valued in rural areas. All three of the proposed new multidisciplinary groups are now active with trained peer Small Group leaders. Additionally, the Clinical Quality and Education team of Pegasus Health has now formalised the multidisciplinary format and has taken over editing the educational material so that quality, consistency and relevance for all disciplines is maintained. We believe that our programme is breaking new ground and may be unique in providing evidence-based continuing professional development for health practitioners in a multidisciplinary setting. We expect to report further when the new groups are more established.

### References

1. Bourke L, Sheridan C, Russell U, et al. Developing a conceptual understanding of rural health practice. Aust J Rural Health. 2004;12(5):181–6. doi:10.1111/j.1440-1854.2004.00601.x
2. Jones JA, Humphreys JS, Adena MA. Doctors' perspectives on the viability of rural practice. Rural Remote Health. 2004;4(2):305.
3. McNeil K, Mitchell R, Parker V. The paradoxical effects of workforce shortages on rural interprofessional practice. Scand J Caring Sci. 2015;29(1):73–82. doi:10.1111/scs.12129
4. Little F, Brown L, Grotowski M, et al. Nourishing networks: an interprofessional learning model and its application to the Australian rural health workforce. Rural Remote Health. 2012;12:2022.
5. Myhre DL, Bajaj S, Jackson W. Determinants of an urban origin student choosing rural practice: a scoping review. Rural Remote Health. 2015;15(3):3483.
6. Parker V, McNeil K, Higgins I, et al. How health professionals conceive and construct interprofessional practice in rural settings: a qualitative study. BMC Health Serv Res. 2013;13:500. doi:10.1186/1472-6963-13-500
7. Spencer J, Woodroffe J, Cross M, et al. "A golden opportunity": Exploring interprofessional learning and practice in rural clinical settings. J Interprof Care. 2015;29(4):389–91. doi:10.3109/13561820.2014.970250
8. Canadian Interprofessional Health Collaborative. A National Interprofessional Competency Framework. Vancouver, BC: Canadian Interprofessional Heath Collaborative; 2010.
9. Ministry of Health. Working together for Better Primary Health Care: overcoming barriers to workforce change and innovation. Report to the Ministry of Health from the Workforce Taskforce. Wellington: Ministry of Health; 2008.
10. World Health Organisation. Framework for Action on Interprofessional Education and Collaborative Practice. Geneva: World Health Organisation; 2010.
11. Elissen AM, van Raak AJ, Paulus AT. Can we make sense of multidisciplinary co-operation in primary care by considering routines and rules? Health Soc Care Community. 2011;19(1):33–42. doi:10.1111/j.1365-2524.2010.00946.x
12. McDonald J, Jayasuriya R, Harris MF. The influence of power dynamics and trust on multidisciplinary collaboration: a qualitative case study of type 2 diabetes mellitus. BMC Health Serv Res. 2012;12:63. doi:10.1186/1472-6963-12-63
13. Nandan M, Scott PA. Interprofessional practice and education: holistic approaches to complex health care challenges. J Allied Health. 2014;43(3):150–6.
14. Félix-Bortolotti M. Primary health care workforce policy intricacies: multidisciplinary team case analysis. Part 2. J Eval Clin Pract. 2011;17(2):400–4. doi:10.1111/j.1365-2753.2011.01647.x
15. Hogg W, Lemelin J, Dahrouge S, et al. Randomized controlled trial of anticipatory and preventive multidisciplinary team care: for complex patients in a community-based primary care setting. Can Fam Physician. 2009;55(12):e76–85.
16. Reeves S, Perrier L, Goldman J, et al. Interprofessional education: effects on professional practice and healthcare outcomes (update). Cochrane Database Syst Rev. 2013;(3):CD002213.
17. Strachan AN, Graham AC, Hormis AP, et al. What were the perceptions of primary care teams on learning from a single multidisciplinary simulation-based training intervention? Educ Prim Care. 2011;22(4):229–34. doi:10.1080/14739879.2011.11494005
18. Hays RB. Interprofessional education in rural practice: how, when and where? Rural Remote Health. 2008;8(2):939.
19. Smith T, Stone N, Bull R, et al. Australian Rural Health Education Network's position on interprofessional education and practice in health care. Rural Remote Health. 2007;7(4):866.
20. Puskar K, Mitchell AM, Albrecht SA, et al. Interprofessional collaborative practice incorporating training for alcohol and drug use screening for healthcare providers in rural areas. J Interprof Care. 2016;30(4):542–4. doi:10.1080/13561820.2016.1178219

**COMPETING INTERESTS**
None.

## Appendix 1. Questionnaire for the Oxford multidisciplinary Small Group members

### Purpose of the questionnaire

The Pegasus Education team are in the process of setting up several new multidisciplinary Small Groups in other areas of rural Canterbury. We want to learn from the success of the Oxford group so we can set up the new groups in the best possible way. Please help us by answering the questionnaire as fully as you can; the questionnaire is anonymous and your answers are confidential.

### Section 1: Understanding how the Oxford multidisciplinary education group works

Q1. Do you think the multidisciplinary format of the Oxford Small Group works well? Yes/No

Q2. Is there anything that could work better? Please explain.

Q3. Has participating in the Oxford Small Group meetings influenced the way you practice? Yes/No

If yes, please select the option(s) that apply:

- ☐ The group collectively determines a way that they will change their practice as a result of attending the meeting (e.g. the group decides on a common approach to back-pocket prescriptions).
- ☐ The group discusses specific actions that are required at an individual or practice level to make these changes.
- ☐ The group uses prompts, reminders, or tools to support or reinforce these specific actions.
- ☐ The group revisits the changes to see if they have made an impact in terms of improving teamwork and/or patient care.

Q4. In general, has participating in the Oxford Small Group meetings:

- ☐ Fostered improved teamwork across the health professionals in your area? Yes/No

Improved patient care through improved working relationships? Yes/No
If you answered yes, to either of the above, please give an example:

### Section 2: Understanding the impact on individual professional development

Q5. Does participating in the Oxford Small Group meetings help you to meet your professional development needs? (Yes/No)

Q6. Are you happy with the level of information in the Oxford Small Group meetings that is specific to your own profession? (Yes/No)

If you answered No to Q5 or Q6, please indicate your professional role (optional).

Q7. Please comment on the respective advantages and disadvantages of participating in Small Group education meetings with those you work with, compared to meetings with peers outside your own practice team.

Q8. Do you have any comments about your experience in the multidisciplinary Small Group?

Thank you for completing the survey.