Interprofessional Collaboration: A Serendipitous Convergence of Skills, Opportunity and Learning, to Make a Difference

Kala Chakradhar, Kelly Rogers, Kathleen Farrell, and Steve Jones

Abstract: This story on interprofessional collaboration had a truly serendipitous beginning motivated by the bane of being in academia, “publish or perish.” What unfolded seemed a deliberate coming together of a group of faculty sharing a passion for working with older populations and a desire to promote better health for the community. Representing the disciplines of social work, recreation, gerontology, nursing, anthropology, and psychology in a regional, rural, comprehensive university, our collaboration transcended multiple facets to discover pathways that would impact regional health status. Beginning with one faculty member’s drive to connect with others inclined to take on research, and the chancing upon an article addressing chronic disease self-management by another faculty member, the group snowballed to initiate a university-community partnership. This partnership, at multiple levels, helped forge a series of group-oriented chronic disease self-management workshops in the community for people experiencing chronic illness. This article shares how this collaboration played out over three years and the valuable lessons learned as we looked for ways to sustain this resource.

Keywords: interprofessional collaboration; chronic disease self-management; rural

The Genesis

It started in the fall of 2010. After several years at his institution, he (KR) had become very aware of how little time he had for research between teaching and professional service. This time shrunk even more when he agreed to serve as an interim department chair. The question became, “How will I ever keep up a research agenda with so little time?” Solution: “Collaborate with other faculty in similar boats. Surely there are others!”

One such person was a social work faculty member (KC) in his college. He knew her through college meetings and involvement in community activities. They both had students who were volunteering and completing service learning projects or internships at local nonprofits and other agencies serving seniors in the community. KC was also teaching courses in social work focusing on health care and seniors. “What were the possibilities?” he thought. KR himself represented the discipline of recreation and leisure services. He was teaching the leisure and aging course every fall semester and had developed partnerships with many of these nonprofits and agencies over the last decade. Each fall, his students provided leisure programs through service learning projects. While these projects met real community needs and his students were learning a lot, he knew he needed to do more research. Yet, he lacked expertise and initiative, and had some trepidation about starting. He could have used some help!

He sent KC an email with the idea of a collaborative research group looking at issues in gerontology. She immediately responded with an interest and some ideas of her own. It was an opening she was waiting for, being new to the U.S. and the academic community here. She had found building a research portfolio on her own very challenging, but not impossible. However, the prospect of working collaboratively with better-connected and more experienced colleagues was exciting. She had been thinking similar thoughts as KR and forwarded an article by Dr. Jane Tilly entitled “The Administration on Aging’s experiences with health, prevention and wellness” (Tilly, 2010) as a potential direction to pursue. She specifically reported on an evidence-based intervention, namely the Chronic Disease Self-management Program (CDSMP), initiated and tested by researchers at the Stanford University School of Medicine and implemented successfully in more than half of the states with older populations experiencing chronic illness. This promising prevention-focused, cost-saving, group-oriented intervention stressed that groups be led by trained lay leaders who were coping with chronic illness themselves. The article reinforced the need for expanding this program especially encouraged by the Patient Protection and Affordable Care Act (PPACA) and the specific allocation of funds for the same through the National Aging Network, Administration on Aging and the Area Agencies on Aging (AAA).

This knowledge led to some inquiries with our local AAA and the discovery that such a funded initiative was active in our state of Kentucky, but had not yet been initiated in our region, namely Western Kentucky.

Subsequently, KR further explored the Stanford website and secured the book entitled “Outcome Measures for Health Education and other Healthcare Interventions” (Lorig et al., 1996). After all, if he was to conduct research on the subject, it would be good to know what others have examined and how they went about measuring outcomes. This search would also enlighten us further and help develop a workable plan. To further kick off this potential research-cum-practice opportunity, KR created individual binders for us to store and organize the literature and materials we were exploring and gathering. KC shared this idea with the Chair of her department (SJ), a cultural anthropologist by training who taught courses in gerontology and human diversity. According to him, social work and exercise science have an explicitly applied orientation compatible with his academic training and scholarly research. It was a natural step for him to become a member of the CDSM research team since it had a goal of using social science research to change behavior in the process of solving a particular set of problems: in this case, finding ways to mitigate the effects of having a chronic illness. He was managing his own chronic illness and was more than willing to come on board.

Hey, That’s My Book!

Like many teachers, KR was excited when the outcome measures book arrived in the mail. However, there was little time to take a look at the pages within, so he packed it up and was off to the next “administration” meeting. Upon taking his seat, a nursing faculty member (KF) across the table said, “Hey, that’s my book!” Well, that was a surprising comment. He knew her from around campus, but had no idea what she was talking about. “Her book,” he thought. After all, it had just arrived in his mailbox. Surely she was mistaken.

By “my book,” she was referring to the fact that her dissertation topic was on the very subject and she was very much married to the book to which he had become recently acquainted. Anyone in the All But Dissertation (ABD) club would completely understand. Her doctoral work had been on this very program. She had implemented the chronic disease self-management intervention with a group in rural Kentucky after having acquired training as a Master Trainer. Given this hands-on expertise, she was able to inform this group of three about the protocol involved in getting such an intervention group started in the community. This Stanford training followed an interactive train-the-trainer model with the Master Training offered by Stanford based T-Trainers. These Master Trainers in turn train leaders to facilitate the community-based chronic disease workshops in addition to leading similar community groups (Stanford Patient Education, 2013). So now, we had a fourth member on board.

Show Me the Money: Completing a Grant Application

With most projects, there is an associated cost. The CDSMP intervention as created by the Stanford group required the agency setting it up to acquire a license and the leaders of the groups to be trained to implement the six-week weekly group-oriented workshop. In order to receive training and serve as a lay leader, one must have a chronic condition and/or serve as a caregiver for someone who does. Once trained, the leaders were also to obtain training workbooks to use with and distribute to group members.

Therefore, an application for the university institutional grant, having a limit of $2500, began. As we met to crystallize our objectives and rationale, we realized how invaluable this exercise would be for the predominantly rural community. One of four risk factors that seriously compromised the quality of life and life expectancy of Kentuckians was chronic disease (Jia & Lubetkin, 2009). The state of Kentucky also fell below the national average when it came to prevalence of chronic diseases like diabetes, asthma, heart disease, Alzheimer's, and unhealthy lifestyles (The Henry J. Kaiser Family Foundation, 2015). With rising health care costs and limited access to resources, especially in rural areas, switching from a palliative medical model to a participatory and prevention-based approach may provide these regions with a better quality of life and help reduce unnecessary medical costs.

KC, who taught research to social work students and whose forte was proposal writing, took the lead with the grant proposal writing and submission. KR's administrative skills helped with drawing up the budget, and KF's familiarity with CDSMP helped with the literature sources. At this stage we learned that the Institutional Review Board (IRB) did not need to be involved. The requested funds were granted!

Training Next and a Pleasant Surprise!

The serendipitous streak continued when the training needed to conduct the CDSMP just happened to present itself. The training certified participants as "lay leaders." Finding a training opportunity in the area seemed hard at first. The nursing faculty member began by reconnecting with program leaders she had worked with during her dissertation. She found a lay leader training was being offered by the State's Department of Aging and Independent Living who had Master Trainers available. The Department of Public Health had the funding and license to disseminate the CDSM program by facilitating training. Since the training was grant-funded, it was completely free of charge. This training venue specifically planned for folks like us was at the other end of the state. Much to our surprise, however, a training was to be offered that very summer at a state park only 30 minutes away. Lodging and meals for this 4 ½ day training were also free of charge and mileage was being reimbursed.

With free training and a statewide license at no cost to us, we saved all of the money from our grant. We had to be able to put the funds to use in other efficient, but justified, ways. Ultimately, we decided to use the grant money to provide healthy food options when we got the workshops started. This made sense because one of the topics being covered in the workshop dealt with making healthy food choices.

The Community Connection

This aspect of the collaboration was the most valuable in that it focused on stimulating community involvement. As envisioned by the creators of this program at Stanford, we set out with the mission and hope of making a lasting impact and sustaining this program. This community participation was to happen in different ways. At the outset, recognizing that the training in chronic disease self-management was intended for lay leaders dealing with chronic illness themselves and enlisting potential lay leaders to attend the state-funded training became our goal. Three of the four members of our initial faculty group registered for the training. In fact, two of these faculty had chronic health conditions themselves.

An important first task was to get word out to the community about this opportunity. Information was suitably drafted and disseminated through the local newspaper, word-of-mouth, announcements at meetings we attended, which we complemented with informational sessions and opportunities for signing-up both in-person and by phone. These informational sessions required us to use our already established connections (KC & KR) with the senior citizen's center, the skilled nursing facility, the retirement home, the assisted living facility, the health department, the local hospital, and the community free clinic. As can be surmised, these were the venues for the informational meetings led by KC and KR depending on their availability and kicked off by KF as well since she was already familiar with the process. The staff at these agencies helped consolidate the list of potential trainees. We had seven community members sign up in addition to the three faculty members (KC, KF, and SJ), including two from the senior citizen's center, one undergraduate student, and four from the general community. Although we worked with preparing the community recruits for the training schedule, including carpooling logistics, a lesson we learned was in being able to anticipate and address individual limitations. For one participant, the challenges of navigating the training venue and the accommodations provided led her to withdraw the very first night. Two other participants did not particularly buy into the training format and withdrew the second day. A majority of the other participants at the training outside of our recruits were staff representatives of senior citizen centers. They were from the surrounding counties addressing chronic illness themselves or were caregivers as well.

The recreation faculty member (KR) and his wife, who has Fibromyalgia, attended a later training. They went on to facilitate a workshop at the local hospital's wellness center.

The Lay Leader Training

Conceptually based on Albert Bandura’s Social Learning theory, the overarching emphasis of this training is on building self-efficacy and empowerment for not only the individual but also the community.   Education and skill-building to empower people to self-manage the challenges posed by their chronic illness are key principles (Stanford Patient Research, 2013). The training itself was both informative and, by nature of its format, interactive. This workshop and training is identical to the one offered to people with chronic disease. We assumed the role of people with chronic illness; participating and experiencing the workshop like community members would when they attend the chronic disease self- management workshops (Stanford Patient Research, 2013). It also enabled reviewing the curriculum and practicing teaching. The fact that we were at a beautiful state park with great scenery and food didn’t hurt either. By the end of our training, we felt more than prepared to conduct a workshop. The training itself, unique in its delivery, sensitized us to skills we had and did not have in initiating behavior change in those who suffer from chronic illness. It also helped us look into our own health status. We brought back training manuals and companion books and tapes (also free) to be distributed to group members who participated in the upcoming workshops.

So, What’s Next?

So, until this time what we had accomplished extended over a six-month period, it was the end of June of 2011. Our next logical step was opening up the self-management workshop opportunity to the community and enlisting members for the trained lay-leader-led groups. Seeds for this phase had already been sown in the earlier informational sessions, when attendees had been prepared for these groups in the very near future. To acclimate the non-faculty trained leaders (they were candid about their apprehension to lead), they were invited to participate in the very first CDSMP workshop led by the 3 faculty members who took the lay leader training. All four trainees chose to participate because the understanding was that they would allow them to be better equipped to lead future groups. Understandably, for the faculty their academic background provided an easy launching pad.

A crucial phase was the launching itself. The venue for the group, suitable starting and ending dates spanning 6 consecutive (preferably) weeks, and a workable two and a half hour time slot each week had to be finalized. With the senior citizen center already expressing willingness, KC drew up the schedule to take into consideration the faculty leaders' work schedules. Then followed announcement flyers, courtesy of KR, and one more round of informational sessions and dissemination of flyers to various community agencies. We named our workshop “The Living Well Workshop” following the lead of what other leaders had done. We were set to begin the second week of September of 2011 on Wednesday afternoons. In adherence to the prescribed training format, charts and other teaching aids to display weekly workshop content had to be manually prepared. PowerPoint slides and printed materials were discouraged as part of program fidelity. We were preparing and working with lay leaders from all walks of life. The trainers had to get familiar with the workshop content as well, although the format strictly prescribed keeping to a prepared script provided in the manual (Program fidelity, 2012). Ten members signed up for the very first workshop.

The Research Component of the Project

Enthused with the progress until this point, we started thinking about ways in which this intervention exercise could investigate outcomes and track changes in members’ attitudes and behaviors. Being in the health profession, the passion for service dominated the need to capitalize on a research and publication opportunity. KR was aware of another faculty member from the discipline of psychology, with gerontology as his teaching focus. The latter had expressed an interest in conducting research with older adults in the community. He had the expertise in the field of gerontology and research, but was having a hard time connecting with the nonprofits and government agencies in the area serving seniors. In fact, he was hitting a wall and becoming frustrated. His research background and experience with developing tools would help us in creating and adapting some metrics for assessing outcomes. So KD's joining our working group resulted in bringing together a mixed-methods approach to examining not only the first group's experiences but also future groups.

The evaluative exercise began with a focus group of the first group's participants who volunteered and then to a deductive pre-post quasi-experimental design with future groups. The faculty group needed adequate time to develop and review the required tools and to also obtain IRB approval before implementation. With KD taking on a key role in this tool development, two of his graduate students were also enlisted. They assisted with documentation and transcription of the focus group interactions facilitated by KC and with subsequent pre-post data collection with the second group. Since the workshop was a pioneering effort by the researchers in a rural community focused on chronic disease management, it was important to receive input from this first group of participants about the content, delivery and potential problems encountered. This IRB-approved qualitative investigation enabled the creation of a deductive quantitative design to review outcomes in future workshops. The solicitation of feedback in turn assisted in making necessary changes in the implementation of future workshops.

Thus, with the inclusion of the research component, we as a group had come full circle from where we began, growing membership and skill sets incrementally.

It wasn’t long before the group began writing the IRB application. Meetings were held to determine research goals, the population to be sampled, the methodology, and the instruments to be used. Considering that the nursing faculty member's dissertation topic was the same as the project we were undertaking, it wasn’t hard to get started. She contributed greatly to the needed background information. This, along with the careful selection of measures, led to a nearly complete application. Because both the recreation and psychology faculty members had recently completed a research project with older adults as the sample, they knew what was needed to get IRB approval. If all went well, we would soon have a publication manuscript or a conference presentation in the making!

The “Living Well Workshops” Journey

The first CDSMP group in September of 2011 led by three of us (two at any given session) with 10 members was a remarkable experience both for the group and us leaders. It was an especially insightful exploration of the group process and growth for SJ and KC who also had the opportunity to witness individual member transformations over the six weeks. Although the training we underwent committed each of us to facilitating 2 groups in 2 years, we set a goal of at least 2 a year. The next group, in February of 2012, was led by 2 of the newly trained leaders who had also participated in the first group. They were assisted by 2 of the faculty members as needed. As leaders, we could identify and encourage suitable members for lay leader training as well when the opportunity for training arose. We soon came to realize, as invested faculty, the juggling we had to do with our university schedules. Along with our classes and other university commitments, we had to get to the weekly workshop and also plan, shop and have the healthy snacks ready. It was indeed an exercise in skillful coordination and time-keeping. KC remembers an instance where she had just enough time to drive to a workshop meeting after teaching a class and consequently had no time to shop for the snacks. She quickly called KR and he promised to get the snacks in time for the break, himself snatching time between meetings.

Reaching out to Minority Groups

By this time SJ African American himself was strongly motivated to set up a workshop in his own community, 25 miles away, where he had been a long-standing resident. With all Caucasian members in the 2 workshops so far, he felt the need to reach out to the predominantly African American population there. According to the Centers for Disease Control and Prevention (CDC), the top 4 leading causes of death among African Americans in the US are chronic disease related such as heart disease, cancer, stroke, and diabetes (Black or

African American populations, 2014). This places an emphasis on the need for educational programs like CDSMP, especially with minority populations. The venue this time was the Agricultural Extension Office, who subscribed to the mission of health education and were glad to partner with us. They not only offered space, but also provided the healthy snacks for the meetings. An independent exercise of getting the word out in this community through a newspaper write-up, informational meetings, and word-of-mouth by KC and SJ led to a good 10-member group, with half of them being African American. This was in July and August of 2012.

Two more workshops followed in September 2012 and July 2013. The latter was led by KR and his wife, both of whom took the training offered again by the State. Three other members from the already completed workshops chose to take the training as well in order to be lay leaders. One of them in turn connected with another lay leader at a medical practice and went on to facilitate two workshops in 2013. The medical practice is worth a mention since it follows the medical home model. KF introduced the practitioners there to the CDSMP, who in turn committed to refer eligible patients to register for the CDSMP to be conducted at the medical facility.

The Research Agenda

The group began dissemination of this collaborative exercise in the fall of 2012 at presentations in regional, state, national and international conferences held by their respective disciplines, specifically nursing and social work. The focus of these presentations was the interprofessional collaboration and how it unfolded to accomplish a community health initiative. We were also able to tie in our experiences to a conceptual framework of interprofessional collaborative practice and draw a parallel of the competencies and principles to what we were doing. The framework identifies four domains of core competencies, namely values and ethics, roles and responsibilities, communication, and team roles needed by health professionals to provide integrated quality care. The CDSM initiative reflected the principles of being process-oriented, relationship focused through the partnerships, community-oriented (lay leaders and venues chosen), and patient and family-centered interactive sessions and action plans (Interprofessional Education Collaborative, 2011). The workshop content and implementation was sensitive to context, developmentally appropriate, applicable across professions, and outcome driven. Important to us as teaching professionals, this provided the opportunity for interprofessional education to teach students how to work effectively as part of a team (Interprofessional Education Collaborative, 2011).

The pre-post data collection began at our second workshop, including the six subsequent workshop groups, with the purpose of tracking outcomes longitudinally. The plan included a pre-test before the first session of the six-week workshop, post-tests within a week of completing the workshop, and another follow-up 3 months after the workshop the professional presentations included preliminary data and inferences from these assessments.

When getting ready to set up the minority population-focused workshop, SJ and KC, fueled by their qualitative research leaning, proposed to take on an ethnographic study of the group experience. Following IRB approvals, they worked at observing and documenting the workshop experiences in addition to facilitating the workshop. Seeing potential for expanding these workshops in that community, they explored the idea of bringing in a student to assist and learn in this qualitative endeavor.

What We Learned

The lessons learned were multiple given the multifaceted nature of this project we undertook. One aspect, as evident from our narrative, is the way that we ventured out, reached further and further, opening up possibilities we could choose to either take on or limit. We began with the intention of carving out a research agenda that would need investment in hands-on research activity to culminate in publishing.

Beginning with a potential idea of chronic disease management for older populations, we discovered multiple agencies involved from the local to the national level. It was an illustration of not only the practice-research interface and evidence-based intervention but also of funding-driven realization of benefits to the community. It was a great example of political will and policy-enabling program implementation. Through university-agency partnerships and the expanding workshop opportunities, the prevention-oriented program was able to foster community collaborations, both at the level of the group and individual.

Another lesson was related to the logistics involved in implementing the workshops, designed to meet six consecutive weeks for 2.5 hours each meeting. This is a commitment for those that participate. Finding the best location to offer workshops involved trial and error. During the informational sessions, we learned fairly quickly that assisted living residents as well as individuals in nursing facilities or retirement homes were not able to commit to the workshop timetable. Two and a half hours is quite a long time, especially for some seniors dealing with health-related issues. Facility staff were hesitant to commit to the schedule as well. We found that the best locations for workshops were daytime facilities used by seniors such as health departments, hospitals, wellness and senior citizen centers. The agricultural extension office was a valuable discovery and asset. We worked with facility staff to identify and recruit workshop participants and with media outlets to inform the community. We also learned that these workshops could have value for younger populations who are also affected by chronic disease. Self-management for the younger populations, if begun early, can be even more beneficial than with older populations.

We took away valuable lessons from the workshops themselves. Fidelity in the implementation following the scripted manuals (Program fidelity, 2012) to the T (of course, we could paraphrase!), and the structure in each meeting as we covered the content was somewhat in contrast to the flexibility and autonomy we had gotten used to in our academic lives. A unique experience was leading by example when we initiated member sharing when making an action plan for the upcoming week based on the behaviors focused upon in the meeting. Led again by leaders, meetings began with the sharing of how action plans had worked over the week. It was an invaluable insight-building exercise into our own health behaviors with a focus on change. We were accountable not only to ourselves but also to the group. The content of the CDSM workshop presented themes that reflected the disciplines of our team. These included the value and practice of physical exercise, effective techniques for engaging, communicating with and understanding social and medical service providers, and practice in role playing related to social settings associated with ones played by those with a chronic illness.

We were also touched by the many members' lives and experiences as the workshops progressed over the six weeks. Some were caregivers of aging and sick relatives in addition to being managers of their own health. There were struggles with emotions, relationships, physical limitations, sexual orientation, compulsive habits, and initiating change as well as remarkable stories of accomplishments, life journeys and resilience. There were losses through members' passing and crises in other members' lives. The group's power in instilling hope and courage, motivating change, sustaining focus, recognizing universality and creating bonds was an experience beyond what words can capture. For example, one member was dealing with her mother’s terminal illness and final days with hospice care. The workshop group's strength in supporting her was evident when she attended the sixth and last session after her mother's funeral the same day.

Lastly, and most importantly, was the interprofessional collaboration experience. Bronstein's (2003) model for interdisciplinary collaboration provides just the right platform to discern the core elements that came into play as our group of interdisciplinary faculty connected to “contribute to a common product” (Berg-Weger & Schneider as cited by Bronstein, 2003, p, 299). Using Bronstein’s model (2003, p.299), the interprofessional processes that we experienced included “interdependence, newly created professional activities, flexibility, collective ownership of goals and reflection on process.”

Interdependence: We were clearly dependent on each other to accomplish tasks while also respecting each other’s ideas and professional expertise. As cited by Bronstein (2003), we were able to capitalize on the combined knowledge and experience of our team, each knowing when to step in and when to step back and allowing the others to take over. This was apparent when it came to contacting agencies and initiating dialogue

(KC/KR/SJ), drawing up the requirements and logistics for the CDSMP (KF), creating promotional materials and filing needed research tools (KR), research and presentation (KF/KC), and keeping things glued and consolidated (KC/KR).

The CDSMP initiative in the three county regions was a *newly created professional activity.* It was the result of a collaborative navigation of interpersonal and structural processes not achievable if one worked alone.

Flexibility is described as "the deliberate occurrence of role blurring" (Bronstein, 2003, p. 300). Although all of us were tenured faculty, we differed in years of experience, academic and administrative ranking, age and gender. We struck such a harmonious balance where neither hierarchy nor gender, experience nor age threatened disruption. We were juggling responsibilities and roles, deferring to each other, accommodating and discreetly making compromises where needed in order to move forward with the task at hand. Whether it was one member not being able to meet, making sure we followed up on the workshop list, arranging snacks, having the workshop materials ready, preparing for the conference presentation, being there for the data collection or making follow up calls, we were willing to step in or take the liberty to call and revise plans. Formal roles had blurred and informal respectful interaction amidst mutual trust helped us operate with relative ease.

Collective ownership of goals was evident in the ease of decision-making due to a shared vision. We were committed to communication via e-mail, phone or face-to-face meetings to keep each other updated. Tasks were taken on, volunteered for or declined (often due to inevitable circumstances). For instance, when it came to planning a potential workshop or a conference presentation, any of us who saw potential would take the lead and get working on it, soliciting input and assistance as needed.

Finally, *reflection on process* was really the binding force for this group. We were constantly thinking and talking through our experiences as we moved along and talked about it: what amazed us, what things didn't seem to be going well, what could be better, what options there were to explore. Preparing for and presenting at professional conferences were productive ways to reflect and process. It helped to not only share in the learning but to also discover what we had not otherwise observed or thought about.

There were also some not-so-favorable learning and events that occurred raising questions about the continuity of this collaborative activity.

Will the Journey Continue?

This whole endeavor was not devoid of its challenges. As mentioned earlier, the serendipitous creation of this community program needed a substantial investment of our time. It was more than collecting data and writing a manuscript. Keeping the workshops going required planning suitable time, two and a half hour slots for 6 consecutive weeks, leaders' availability, recruitment participants and implementation. We initially hoped the new lay leaders would sustain the workshops, so we faculty members would then be able to take on the task of simply coordinating, and concentrate instead on the research component. It became a daunting exercise for the faculty to invest the time for the workshops. Recruiting participants also posed challenges. We knew our efforts had to be renewed by looking for better ways to promote and expand our community referral network.

The research component involving longitudinal outcome assessment (pre-post workshop) posed problems as well. Since participation was voluntary, members did not necessarily want to complete survey instruments. Time had to be set aside for the pre-post-tests in addition to the 6-week schedule. The lengthy nature of the assessment tools and ease of administration became another hurdle amidst the health or schedule limitations participants already had. Interestingly, none in the minority group opted to complete the assessments. Our research agenda therefore was moving at a very slow and discouraging pace at certain points in time.

As for our group, unprecedented events led to an unintended reduction in members. The psychology faculty member who assisted with the research tools moved to another job. The cultural anthropologist member (SJ) chose to retire after 35+ years in academia. KF earned full professor status and took on a book-writing project. That left two active members who have since been exploring ways to pursue data gathering with the help of the State Department of Aging and Independent Living. Our academic department oversees CDSMP leaders it has trained in the multiple agencies and tracks the workshops being implemented. So we are left with the questions of where, and how, we go from here. What follows, are our individual perspectives and what each took away from this collaboration.

Perspectives: KC's perspective

I came to this country to teach at the university level, six years after getting my doctoral degree and a hiatus from formal academic work. I had not had any academic training in this country and therefore had no academic advisors, mentors or research partners who could orient or guide me through the writing and publishing that were needed for tenure. A trusted friend helped me with my first publication and then on I had to make my own connections and tread the arduous road to publishing. This opportunity to collaborate for the purposes of research and writing was just what I was looking for. The prospect of implementing an evidence-based intervention, with a focus on prevention and better well-being for individuals challenged with chronic illness, was equally exciting.

I constantly look to bring real-world experiences to share with students in my social work classes. This research and practice exercise was just the kind I could share with students in my research and health care classes. It became a valuable teaching tool for my gerontology course and an opportunity to familiarize students with the process of group intervention as well. Every aspect of this interprofessional collaboration including grant writing, program planning and implementation, dissemination, and creating community liaisons became aspects I could exploit and incorporate into my teaching to demonstrate how they worked.

Given my social work training with group work, the group-based interventions took me back to my practice days. My group work skills were particularly valuable in facilitating sharing and interaction, and understanding group dynamics and group process. I was especially enriched by the workshops in being able to understand group members' struggles with multiple forms of chronic disease and internalize the behaviors that govern self-management.

Although it is disappointing that the workshops and research have arrived at a plateau, what we gained through this collaboration and the healthy working relationship is invaluable.

KR's Personal Perspective

After sixteen years at my current institution, I am at a crossroads in my career. Along the way, I successfully completed my dissertation and managed to satisfy my institution’s tenure committees. I am glad I ran this marathon, but I never wish to run it again. After I was granted tenure, I was eventually promoted to the rank of Associate Professor. Like many of my colleagues, I have spent the better part of the last several years consumed with teaching, professional service and administrative responsibilities, all of which are valued at my institution.

However, even at our regional comprehensive university, there is an expectation that one must publish in order to receive promotion. With an economy in the slumps and very little money for raises, it became apparent that the only way to increase my salary was through promotion. While promotion served as a primary motivation in the beginning, I have always enjoyed bringing people together for collaborative, multi-discipline projects. At the outset of this particular project, I had little concept of where things would go and who would be involved. All I knew was that in my current position, the only way I was going to get any research done was through collaboration.

I have truly enjoyed working with my colleagues on this project. The fact that the program helps people improve their quality of lives makes me feel proud to have contributed as a member of the group.

KF's Personal Perspective

After 25 years of experience in critical care and emergency nursing practice, I changed direction in my career path and joined the ranks of academia after going back to school to earn my doctorate. Frustration about the recidivism rate of patients with chronic disease led me to focus both my clinical practice and research on chronic disease management. The Stanford CDSMP guided by

Albert Bandura's self-efficacy theory guided my research study on the rural working poor. After the study, my community lay leader relocated out of state. The sustainability of the CDSMP program was difficult and although disappointed, I could no longer continue with the program.

My excitement and motivation kicked into high gear as soon as KR arrived at the university meeting with the outcome measurement book and we began to talk about the plans to do collaborative community service and research. An interprofessional collaboration was needed to sustain this program in our rural region and I envisioned success! The formulation of our interprofessional team was the impetus to reach out to our community needs while fostering interprofessional education and research. A win-win for all involved.

SJ's perspective

A central thread in my reactions to the workshop experience was my ability to see the words and actions of workshop participants from their perspective. This perspective is a fundamental principle in the subfield of Cultural Anthropology. This ability to see the world as those being studied is called the *emic or insider's perspective.* The analyst or observer is able to “walk a mile in another’s moccasins” to see the world as participants being observed see it. Anthropologists do not argue that they can see the world exactly as their respondents do, but the view of the analyst or observer is a close approximation of that of the investigated population. An insider's view is absolutely essential in the development of effective techniques to control the effects of chronic illnesses.

My views as an anthropologist were enhanced by the fact the respondents in the CDSM Workshops and I shared an important characteristic: I too have suffered and continue to suffer from a chronic disease, namely Type II Diabetes. I have many of the same common experiences dealing with doctors, many of the same fears (especially the universal fear of losing one’s independence), the dread of losing a limb (another limb in my case) to mention some of many examples.

As a trained cultural anthropologist, I assume that people who suffer from chronic diseases have a somewhat common experience, a common culture they share with one another. While there are cultural similarities that those with a chronic disease share with non-sufferers, there are enough similarities within the chronic disease community to classify it as a single, somewhat discrete social system. Social science investigation of the CDSM culture will make it possible to develop better techniques to teach those who suffer from a chronic illness more effective and verified methods of disease control.

In summary, the main lesson I learned was that those who suffer from chronic diseases have to be taught how to record, preserve and communicate relevant information through their network of medical providers. Doctors and related medical specialists have to do a better job of seeking relevant information related to other diagnoses provided to the patient. As a professional with an earned doctorate degree, in my role as a diabetic patient, I was still challenged to comprehend, record and pass on information from one member of my “team” of doctors and other medical specialists to another member of the group. I often thought to myself: how does this process work with a patient who is poor and has a low level of formal education?

As a result of working with the CDSM team, I have developed a more informed, holistic approach to the subject matter in question.

Conclusion

Interprofessional collaboration is a ubiquitous process in healthcare settings, mental health and school settings but our experience in a university setting extending to the community was a unique one. The lessons learned by initiating a series of group-oriented chronic disease self-management programs through this healthy collaboration were valuable. The experience gained has implications for teaching, research and preventive health care.

References

Black or African American Populations. (2012). Retrieved from http://www.cdc.gov/minorityhealth/populations/remp/black.html

Bronstein, L. R. (2003). A model for interprofessional collaboration, *Social Work, 48*(3), 297-306.

Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative. Retrieved from http://www.aacn.nche.edu/education-resources/ipecreport.pdf

Jia, H. & Lubetkin, E. I. (2009). The state-wide burden of obesity, smoking, low-income and chronic diseases in the United States, *Journal of Public Health, 31*(4): 496-505. doi: 10.1093/pubmed/fdp012

Lorig, K., Stewart, A., Ritter, P., González, V., Laurent, D., & Lynch, J. (1996). Outcome measures for health education and other health care interventions. Thousand Oaks, CA: Sage Publications, Inc. doi: http://dx.doi.org/10.4135/9781452232966

Program Fidelity Manual: Stanford Self-Management Programs 2012 Update (2012). Retrieved from http://patienteducation.stanford.edu/licensing/FidelityManual2012.pdf

Stanford Patient Education Research Center (2013) http://patienteducation.stanford.edu/training/Introduction%20to%20Stanford%20Trainings%20for%20Participants.pdf

The Henry J. Kaiser Family Foundation. (2015). State Health Facts. http://kff.org/statedata/.

Tilly, J. (2010). The Administration on Aging's experiences with health, prevention, and wellness. *Generations, 34*(1), 20-25.

***About the Authors*:** Kala Chakradhar, Assistant Professor, Department of Community Leadership and Human Services, College of Health Sciences and Human Services, Murray State University (kchakradhar@murraystate.edu); Dr. Kelly Rogers is Associate Professor, Department Chair of Community Leadership and Human Services at Murray State University (krogers2@murraystate.edu); Dr. Kathleen Farrell, DNSc, APRN, ACNP-BC, CCNS, CCRN is a Professor at Murray State University (kfarrell@murraystate.edu); Dr. Steve Jones is Professor Emeritus at Murray State University (sjones@murraystate.edu)