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Initial Development and Consultation Process for Pacific University's Interdisciplinary Health Clinic

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Initial Development and Consultation Process for Pacific University's Interdisciplinary Health Clinic

Abstract
Pacific University's College of Health Professions expressed interest in developing an interdisciplinary health clinic. The clinic vision was to provide academic, research, and direct clinical care experiences to the students and faculty of the professional programs. The existing programs plus two new programs represent disciplines that do not have a history of working together in an interdisciplinary health clinic environment. Each professional discipline has its own ethics, standards, referral basis, billing methods, student supervision requirements, and degree of independence of practice; factors which, if not addressed, could lead to dissention and a lack of integration in an interdisciplinary health clinic. An organizational development undertaking such as this required coordination and discussion among the existing professional programs. More specifically, it required a preliminary consultation to lay the foundation for future development efforts related to the formation of an interdisciplinary health clinic. The goal of this project was to identify issues and strategies for creating an effective interdisciplinary health clinic. This study was designed using two consultants to collect, analyze, and organize programmatic information and to provide recommendations regarding the development process of the clinic. The study design process necessitated that the consultants consider organizational process variables and factors that could influence the success of the consultation. Data was collected through reviews of similar clinics reported in the literature reviews of professional ethical codes and standards of practice, and interviews with school deans, directors, and selected faculty members. Results were focused on practical application to an integrated health clinic and the process of the deans and directors of the professional programs was discussed as a foundation for future development efforts. The recommendations focused both on organizational process dynamics to ensure collective support for the development and implementation of the clinic as well as selected practice issues that require resolution during the development stage of an interdisciplinary health clinic on Pacific University’s Health Professions Campus.

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INITIAL DEVELOPMENT AND CONSULTATION PROCESS FOR
PACIFIC UNIVERSITY'S INTERDISCIPLINARY HEALTH CLINIC

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY
FOREST GROVE, OREGON

BY
GREGORY ALLEN MAY

IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

JULY 27th, 2007

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ABSTRACT

Pacific University's College of Health Professions expressed interest in developing an interdisciplinary health clinic. The clinic vision was to provide academic, research, and direct clinical care experiences to the students and faculty of the professional programs. The existing programs plus two new programs represent disciplines that do not have a history of working together in an interdisciplinary health clinic environment. Each professional discipline has its own ethics, standards, referral basis, billing methods, student supervision requirements, and degree of independence of practice; factors which, if not addressed, could lead to dissention and a lack of integration in an interdisciplinary health clinic. An organizational development undertaking such as this required coordination and discussion among the existing professional programs. More specifically, it required a preliminary consultation to lay the foundation for future development efforts related to the formation of an interdisciplinary health clinic.

The goal of this project was to identify issues and strategies for creating an effective interdisciplinary health clinic. This study was designed using two consultants to collect, analyze, and organize programmatic information and to provide recommendations regarding the development process of the clinic. The study design process necessitated that the consultants consider organizational process variables and factors that could influence the success of the consultation.

Data was collected through reviews of similar clinics reported in the literature, reviews of professional ethical codes and standards of practice, and interviews with school deans, directors, and selected faculty members. Results were focused on practical application to an integrated health clinic and the process of the deans and directors of the
professional programs was discussed as a foundation for future development efforts. The recommendations focused both on organizational process dynamics to ensure collective support for the development and implementation of the clinic as well as selected practice issues that require resolution during the development stage of an interdisciplinary health clinic on Pacific University’s Health Professions Campus.
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INTRODUCTION

Pacific University’s 2010 Strategic Plan “help(s) clearly define Pacific University as the Northwest’s only comprehensive, private liberal arts, education, and health professions university” (n.d.). Consistent with Pacific University’s vision and goals, Pacific University’s College of Health Professions Campus in Hillsboro, Oregon opened in the Fall of 2006 (n.d.). The College of Health Professions includes the School of Dental Health Science, School of Occupational Therapy, School of Physical Therapy, School of Physician Assistant Studies, School of Pharmacy, and School of Professional Psychology. While the College of Optometry is expected to integrate with the College of Health Professions Campus and participate in the formation of an integrated health clinic, it would remain a separate academic college entity under Pacific University.

Unique to a university with an array of affiliated professional health care programs is the opportunity to create and implement an interdisciplinary training health clinic. The development of Pacific University’s new College of Health Professions Campus would provide a variety of educationally enriching opportunities; many of which have yet to be realized. Pacific University’s plans include a two-phase model of development. Phase 1 included the formation of the College of Health Professions and opening of the College of Health Professions Campus. Phase 2 is expected to include expansion of the College of Health Professions Campus and opening of an interdisciplinary health clinic. An interdisciplinary clinic located on the new College of Health Professions Campus would provide integrated, professional training for students and high-quality health care services for the surrounding community. The clinic would include all of the professional schools under the College of Health Professions (i.e.,
Dental Health Science, Occupational Therapy, Physical Therapy, Physician Assistant Studies, Pharmacy, and Professional Psychology) as well as the College of Optometry.

As the College of Health Professions is relatively new and there are few models for an integrated health clinic with these health profession disciplines, a consultation was carried out to determine a collaborative vision, identify practical issues, discuss cultural development, and integrate leadership evolution for such a clinic.

A consultation process such as this one required the consultant to be aware of many issues. I identified specific issues as relevant to the establishment of an integrated health clinic on Pacific University’s College of Health Professions’ Campus and early development process based on my understanding of Pacific University’s Strategic Plan and in consultation with Jay Thomas, Ph.D. Issues included in the review of literature include the following: utilization of clinical psychologist students as process consultants, foundational understanding of executive group dynamics, use of consultants as agents of change in organizations, integration of existing systems within an organization, and existing interdisciplinary health clinic models.
REVIEW OF LITERATURE

Articles were selected for this review based on their relevance to the initial development process of an interdisciplinary health clinic with consultation considerations, placing an emphasis on executive group functioning and process consultation. Some articles were included for theoretical conceptualizations unique to program development and executive consultation concepts. Literature searches were conducted using PSYCHINFO and articles were selected using, both individually and in combination with each other, the following terms: interdisciplinary health clinic, organizational development, program development, professional consultation, process consultation, industrial-organizational psychology, executive interviewing, executive coaching, top-level managers, and organizational change and stress. In addition, relevant sources referenced in these articles were also reviewed.

The use of psychologists as process consultants is discussed in the literature and was identified as desirable in certain situations. One situation where process consultants can be helpful is facilitating executive groups toward a common goal or mission, such as organizational integration. The proposed interdisciplinary health clinic at Pacific University’s College of Health Professions Campus provides such a developmental condition that use of psychology students as process consultants to the executive group appears warranted. Finally, a brief review of existing interdisciplinary health clinic models highlights the unique attributes an interdisciplinary health clinic at Pacific University’s College of Health Professions would provide.
Psychologists as Process Consultants

Consultation is defined in a variety of ways. For the purpose of this study I will define it as “any form of consultation implies that one person is helping another person” (Schein, 1999, p. 3). Based on this broad conceptualization of what constitutes consultation, it is evident that clinical psychologists are well trained in numerous skills and techniques that may help another person. It is also easy to understand how consultants have become a valued component of organizational development. The consultation relationship is a series of interpersonal communications with the desired outcome of trust and openness (Blanton & Alley, 1978). To be effective in the role of consultant, an individual must have clinical sensitivity and encourage specificity and exploration of assumptions. Individuals trained as clinical psychologists are trained in these skills and can translate and apply their clinical skills and understanding of the human condition to organizational conditions (Sperry, 1996).

While similarities have been noted, contrasts also exist between skills utilized in the different roles of clinical psychologist and organizational consultant. The difference is often explained in terms of a clinical psychologist placing an emphasis on ego (or individual) orientation, and an organizational consultant emphasizing task orientation (Maddi, 1997). It has been suggested that the clinical psychologist’s tendency to highlight the ego-oriented stance has a mellowing effect on excessive task orientation activities; whereas, program development is often excessively task oriented.

Consistent with the premise that clinical and consulting skills have much in common, university counseling centers are identified as effective internal consultants to other facets of the university (Cooper, 2003). Expert, doctor-patient, and process
consultation are three approaches to organizational consultation (Schein, 1987). Both the expert and doctor-patient approaches require the consultant to have additional expertise specific to the consultation question. Process consultation demands the consultant be highly skilled interpersonally and have excellent communication skills, but is not focused exclusively on the content being discussed. Process consultation includes attention to both what is being communicated (content) and how it is being communicated (process).

The process consultant does not have an additional source of knowledge beyond the ability to assess and interact with other individuals during difficult processes. Clinical psychologists are trained in all forms of effective communication, assessment or diagnosis of complex situations, summarizing information, and providing suggestions for future interventions or directions. Similar to clinical psychologists, organizational consultants are their own most valuable tool or instrument for gathering data, making inferences, interpreting data and inferences, and designing interventions on their conclusions (Levinson, 1994). Diagnostic implications result from every action or intervention taken by organizational consultants, including assessment procedures like interviews, observations, questionnaires, etc. (Levinson, 1991). Use of assessment procedures by process consultants in executive groups provides the consultant with an understanding of the group’s process and provides consultants more information from which recommendations or assistance can be offered.

Executive Group Process

For the purpose of this study, I will define executive group process as the manner in which a group of executives relate and communicate with each other. I chose this definition because when consultants attempt to assist any group of executives, clear and
effective communication is paramount. Clear communication requires clarification and specificity, skills in which psychologists in the role of process consultants are specifically trained. As organizational leaders, the manner in which executives relate and communicate to each other creates the foundation for the organizational culture.

Organizational culture and leadership in the organization are intricately linked. The “dynamic processes of culture creation and management are the essence of leadership and make one realize they are two sides of the same coin” (Schein, 2004, p. 1). This conceptualization requires an evolutionary and bi-directional perspective of leadership where the leader initially defines the culture based on assumptions. Once the culture, based on the leader’s assumptions, is established and accepted, it is the organizational culture that will determine acceptable leadership. If these assumptions create adaptive problems for the organization within its environment, it is the responsibility of the leader to observe the limitations of the organizational culture and evolve the culture adaptively. The organization’s success will depend on the balance between a leader fostering adaptation and the culture providing stability for the leader.

The interplay of organizational leadership and culture limits an organization’s own ability, and the ability of a consultant, to intervene and change organizational culture. Kurt Lewin has been quoted as stating that a consultant will not really understand a system until trying to change it (Schein, 2003). Therefore, it is preferred to remain proactive in the creation of leadership and culture, rather than attempt to alter an established social or group norm. It is important to note that organizational culture may not need to be formally assessed for the developmental process to continue. Organizational culture must, however, be acknowledged and the persistent power it
possesses must be flexibly worked (Schein, 2003). In addition to organizational leadership and culture, the political environment of the organization is always present (Margulies, 1988). Organizational consultants must be aware of the political climate and effectively deal with power shifts and power differentials that exist within interpersonal relationships. These power shifts and differentials that exist within interpersonal relationships frequently result in conflict among executive group members and, thus, impact the effectiveness of the group toward achieving the desired goal or task.

Reduced effectiveness of the executive group created by interpersonal conflict is frequently alleviated by the process consultant through focusing on identification of strengths and differences as a tool to improve satisfaction and harmonious functioning between executives (Rudisill & Edwards, 2002). In a group of high-level executives, coaching the executive group is not identical to team building, team development, or group therapy (Diedrich, 2001). It is a collaborative process where the process consultant has an on-going relationship with individual executives both in isolation as well as within the context of functioning in a group of executives.

Top-level executives are expected to function as both representatives of their health profession school or college and as administrators charged with organization-wide planning and decision-making (Berg, 2005). Inherent tensions of this situation may result from “turf disputes,” connections made between personal dispositions of executives based on views which are representational of a department, long standing histories of difficult interactions between executive members, and difficulty balancing productivity and/or profitability of the individual department with the overall productivity and/or profitability of the organization as a whole. Team members can lose site of the big
picture, communication can become restricted, presented information can become
distorted in how it is perceived, ethnocentric views of other team members develop, and
mistrust grows. It is vital for process consultants to acknowledge that the group process
described is not likely the result of individual personality differences or personality
conflicts. The misdiagnosis of the source of tension by consultants in an executive group
will often result in loss of membership, addition of new members, and disruption of the
group process (Berg, 2005). In an effort to alleviate tension in the executive group,
process consultants often assist with focusing executive groups on the organizational
mission as a shared vision. In Pacific University’s College of Health Professions’ case,
the mission is organizational integration of the existing professional health programs into
an interdisciplinary health clinic.

Organizational Integration

Organizational change is multifaceted and requires considerable coordination and
effective leadership during the transitional period (Caldwell, 2003). A variety of ethical
and practical considerations are likely to occur during the development process of an
interdisciplinary health clinic on Pacific University’s Health Professions Campus as it
will require integration of existing professional health programs. Each health profession
provides a unique set of ethical codes of conduct and subsequent ethical considerations.
Ethical considerations become even more complex for academic health centers due to the
multiple stakeholder interests. Leaders of academic health centers are consistently
confronted with ethical dilemmas with very little guidance at accounting for all the
different stakeholder perspectives or interests, or practice ethical decision-making based
on these perspectives and interests (Chervenak & McCullough, 2004).
Significant coordination and discussion of potential ethical complications of providing an interdisciplinary health clinic is needed. This is important for financial stability, continued academic excellence, and ethical health care interactions with the community that the clinic would serve. This process is both task and process dependent. It is important to gather correct information in a timely manner and possibly more important to cooperatively, actively solve ethical complications. This process might include implementation of a framework for identifying, preventing, and managing ethical conflicts (Chervenak & McCullough, 2004).

New group process and political power shifts occur when multiple groups are merged. Such is the case with the merging of the professional health programs into an interdisciplinary health clinic at Pacific University's College of Health Professions Campus. A variety of potential dynamics are identified in the literature regarding organizational mergers and it is worthy to note that not all, and perhaps none, of these dynamics may occur during the formation of an interdisciplinary health clinic. The following list is not comprehensive and is only representative of common features of mergers that require attention for successful merges: (1) pace and rate of change, (2) information access for employees, (3) lowered commitment, (4) loss of organizational members, (5) malleability of the organizational culture, (6) potential for culture clash, and (7) long-term versus transitional integration period goals (Buono & Bowditch, 1989; Buono, Weiss, & Bowditch, 1990).

It will be vital to establish a shared understanding among the professional health programs at Pacific University in relation to the pace and rate of change. While the overall pace and rate was set with Pacific University's 2010 Strategic Plan,
developmental milestones for individual professional programs will be essential. In addition, information access for employees will relate to the potential for lowered commitment and loss of organizational members; individual professional programs, deans or directors, and faculty.

While all the professional health programs are part of Pacific University, perceived differences among program cultures may increase the potential for culture clash. The more malleable the organizational cultures are perceived to be, the more likely the merger will succeed. Finally, both long-term and integration period goals are essential for a successful merger of existing professional programs at Pacific University. Fortunately, there is at least one model for integrating existing university affiliated professional health programs into an interdisciplinary health clinic and a template for the development process.

Existing Interdisciplinary Health Clinic Models

There were no existing models of interdisciplinary health clinics that incorporated the specific professional disciplines represented by Pacific University’s College of Health Professions and College of Optometry reported in the literature. Many interdisciplinary health clinics appeared to be designed and operated with specific patient needs based on shared demographics that were not comparable to the expected demographics of an integrated health clinic on Pacific University’s College of Health Professions Campus. Most notable were interdisciplinary health clinics designed for mentally retarded individuals. While many interdisciplinary health teams are incorporated within existing health facilities, very few health clinics dedicated to interdisciplinary care, academic training, and research opportunities currently exist.
The University of New England's Integrated Interdisciplinary Health and Healing (I2H2) was identified as a program model with academic, clinical, and research design comparable to Pacific University's College of Health Professions Campus. Similarities included the following: (1) I2H2 allows students to take classes and interact with students from a range of health care disciplines (n.d.). (2) I2H2 offers Associate Degree programs in Dental Hygiene and Nursing; Baccalaureate Programs in Dental Hygiene, Health Services Management, and Nursing; and Graduate Programs in Nurse Anesthesia, Occupational Therapy, Physical Therapy, Physicians Assistant, and Social Work (n.d.). (3) I2H2 included renovations and new developments that were completed during two phases, 2001 and 2003, respectively, and funded with assistance from federal grants (n.d.). (4) I2H2 collaborates with other care providers such as Mercy Hospital, Maine Medical Center, and Togus Veterans Administration Hospital. (5) I2H2 is being fostered by the establishment of several interdisciplinary research and education centers, such as the Center for Transcultural Health, the Center for Health Ethics, Law, and Policy, the University of New England/Spurwink Center for Research, and the Center for the Arts and Social Transformation. In addition, I2H2 has established the Clinical Simulation Program as one aspect of the Performance Enhancement and Evaluation Center, a facility devoted to improving clinical patient evaluation and management skills of health professions students and practitioners (n.d.).

The use of psychologists as process consultants to executive groups during periods of organizational integration was identified as valuable. Specifically, the use of consultants was shown to facilitate executive group process when working toward a common goal or mission. Pacific University's 2010 Strategic Plan outlines a shared
vision which includes organizational integration of the professional health programs in an interdisciplinary health clinic on the College of Health Professions Campus. As existing models for an interdisciplinary health clinic that include the health professions represented at Pacific University are scarce, it is prudent to use psychology students as process consultants during the early development process. This study outlines a procedure for facilitating the executive group process (i.e. deans and directors of the health profession programs) and provides information specific to Pacific University’s College of Health Professions’ developmental process in forming an interdisciplinary health clinic.
STATEMENT OF THE PROBLEM AND PURPOSE OF THE STUDY

Statement of the Problem

An undertaking such as the development of an interdisciplinary health clinic by incorporating existing university affiliated professional programs requires extensive planning and preparation. Specific areas identified as instrumental or detrimental to effective program development, executive group functioning, and the consultation process include organizational culture, ethical considerations, practical considerations, executive group dynamics, and early organizational development. The literature varied from anecdotal to extremely situation bound, limiting the applicability of theoretical and practical solutions to the current situation of interest. Therefore, major and significant contributions to the fields of industrial/organizational and consulting psychology were implemented and slightly adapted to apply to the development of an interdisciplinary health clinic.

The development of an interdisciplinary health clinic requires consultation to ensure that optimal integration of the existing professional programs is achieved. The need for consultation provided the opportunity for doctoral candidates from the School of Professional Psychology to gain experience acting in the role of process consultant during the initial development and formation of an interdisciplinary health clinic on Pacific University’s new College of Health Professions Campus. The inherent power differential that exists between a dean or director and a student consultant did not lend itself to the expert or doctor-patient approach models. Therefore, the process consultant model approach was implemented in an effort to limit formal organizational diagnosis, reduce power differentials, and balance the ego and task perspectives. Clinical psychology
doctoral candidate students provided sufficient support to facilitate communication and dissemination of information during the initial development process; access to information and clear communication were essential aspects of a successful program development process.

The information gathered during the course of this consultation activity provided a foundation from which to build an interdisciplinary health clinic on Pacific University’s College of Health Professions Campus. Commonalities and differences were highlighted, organizational culture was assessed, and future directions were suggested. Dissemination of this information was essential for a successful developmental and future implementation processes related to the formation of an interdisciplinary health clinic. With this in mind, a consultation was planned to evaluate potential issues and opportunities far in advance of any actual integrated health clinic opening. The consultation was planned and executed in accordance with the issues identified in the review of relevant literature.

Purpose of the Study

The purpose of this study was to provide the leaders of Pacific University’s College of Health Professions and School of Optometry with information that had academic implications and clinical applications. Educational implications of forming an interdisciplinary health clinic included both future educational opportunities for Pacific University’s College of Health Professions Schools and the College of Optometry students as well as a learning experience for the organizational consultant students from the School of Professional Psychology during the initial development phase. A practical application of this study was that it provided a foundational model for future professional
health university institutions to merge into a single, integrated interdisciplinary health clinic. This study also demonstrated how clinical psychologists may be received as practitioners in the field of organizational consulting psychology, and more specifically, how student clinical psychologists with specialty training in organizational consulting may be utilized as internal consultants for university development at large.
METHOD

Participants

Participants for this study were primarily the deans and directors of the six schools of the College of Health Professions and the Interim Dean of the College of Optometry. They include the following: John White, Ph.D., OTR/L, Program Director for the School of Occupational Therapy; Harry (Randy) Randolph, PA-C, MPAS, Program Director of the School of Physician Assistant Studies; Richard Rutt, Ph.D., Director of the School of Physical Therapy; Robert Rosenow, PHARM.D., O.D., Dean for the School of Pharmacy; Lisa Rowley, RDH, M.S., Program Director for the School of Dental Health Science; Michel Hersen, Ph.D., ABPP, Dean for the School of Professional Psychology; and Kenneth Eakland, O.D., Interim Dean of the College of Optometry and Associate Dean for the College of Optometry. Additional faculty identified by the dean or director as essential to the developmental process or if judged to have a body of knowledge or area of expertise important for program development were also interviewed.

Design and Procedure

Due to the extensive and complex nature of developing an interdisciplinary health clinic, consultation during the early development process was carried out over four stages. These stages were utilized by the consultants to ensure the results accurately reflected the current professional practice of each program. In addition, the use of a stage model by the consultants was intended to ensure all deans and directors were provided the opportunity to represent their individual programs as desired. The ultimate goal of the consultation was to collect information regarding programmatic perspectives and
distribute this information to the deans and directors to provide a foundation for future
development of an interdisciplinary health clinic.

During the first stage, background information and documentation was reviewed
to develop an interview protocol. Specifically, ethical codes and standards for
professional practice were reviewed for similarities and differences among the different
disciplines. Identified similarities and differences were then incorporated into
consultation dynamics based on the presented literature review (e.g., executive dynamics)
and preliminary understanding of the College of Health Professions’ vision of an
interdisciplinary health clinic. The purpose of this review of relevant literature, ethical
and standards of professional practice, and vision of an interdisciplinary health clinic was
to provide the consultants a conceptualization of the developmental process. In addition,
this review and preliminary understanding allowed the consultants to create an interview
protocol (Appendix A) with questions relevant to the development process needs and
future goals of forming an interdisciplinary health clinic. Interview protocol questions
were, ultimately, designed to provoke thought and reflection on the part of the deans and
directors participating in the development of an interdisciplinary health clinic, as well as
highlight areas needing further discussion and consultation.

In stage two, the deans, directors, and selected faculty were interviewed.
Interview meetings were arranged via email and conducted over the course of
approximately one month. While two consultants participated during all but one of the
interviews, both consultants took notes separately to ensure comprehensive information
gathering and allow for individual differences in perspectives related to the interviewees’
responses. For one of the interviews, only one consultant was available. While the
interview protocol questions served as the foundation for all interviews, consultants frequently asked additional follow-up questions of participants based on the interviewees’ responses in an effort to guarantee clear communication and understanding on the consultants’ behalf. After being interviewed, the consultants integrated collected data and individual results were returned to the participating deans and directors for revisions as they desired (Appendix B). This step was done to ensure accurate reflection of that individual’s responses and to provide the deans and directors the opportunity to make revisions as they deemed necessary to facilitate future collaborative efforts. In other words, interviewees were provided the opportunity to edit their responses knowing the other deans and directors would be provided their information. All participants were receptive to being interviewed and three participants provided revisions to their individual interview results. Each interviewee’s individual responses, post revision, are presented in Appendices C – I.

Phase III included the integration, synthesis, and summarization of the data gathered during the interviews. This was achieved by reviewing the individual interview results and identifying themes consistent across all interview results. Topics identified as consistently reflected in interview results were then categorized into specific themes based on their application to the development process of an interdisciplinary health clinic. These themes included a collective vision of an integrated health clinic, the desired organizational culture of an integrated health clinic on the College of Health Professions Campus, power distribution among individual professional programs, physical space and systems design, and technology and resources required for an integrated health clinic.
Information contained in individual responses but not consistent across results were reported in the form of additional concerns and additional benefits.

The final phase consisted of distribution of an integrated report summarizing group information and providing suggestions for the on-going development process for an interdisciplinary health clinic on Pacific University's College of Health Professions Campus. The report was sent to all participants and the Executive Dean and Vice Provost of the College of Health Professions. Also included with the report for reference were the ethical codes of each professional discipline.

Data to be Collected and Analysis of the Data

The expertise and experience of the deans and directors served as the foundation for topics on which to collect data. Numerous practical considerations and potential complications inherent in delivering academic training as well as services to the community emerged. Some concerns identified early in the development process were the physical proximity of supervision required by each profession, billing of insurance, revenue or money issues between the professions, leadership styles, filing system (paper or electronic), intake and assignment, physical requirements, and HIPPA coordination.

Data collected from review of documents and interviews was synthesized and a qualitative summary was provided in the form of a formal report to the participants and the Executive Dean and Vice Provost of the College of Health Professions. Emphasis was placed on topics identified and supported in the literature as essential aspects of organizational development and consultation processes. In addition, significant emerging themes that did not fall into a pre-ordained category were gathered and presented for future discussion in the final report. Assessment of the organizational culture,
organizational development process, and experiences of the student consultants were utilized and incorporated into the recommendations provided.
RESULTS

Overall, the results were positive and reflected support, excitement, and investment in an interdisciplinary health clinic on Pacific University’s College of Health Professions Campus. Also reflected were concerns and apprehension related to the change/transitional process. Individual’s referred to Phase 1 and Phase 2 in their responses based on Pacific University’s two-phase model of development for the College of Health Professions Campus. Based on themes identified in the literature and tailored to the responses provided by the participants, information was organized into the following areas of interest: (1) clinic vision, (2) organizational culture, (3) power distribution, (4) space/systems, (5) technology/resources, (6) additional concerns, and (7) additional benefits. Due to the diverse, varied, and intricate information discussed during each interview, many of the areas of interest were further divided to highlight specific components identified as integral to the development process.

Clinic vision included educational impact, client care impact, College of Health Professions’ or individual program’s impact, relationships, and remaining questions. Culture was divided into culture, students, and process. Power distribution did not require additional subtopics. Space/systems consisted of physical design, billing and documentation, and systems. Technology/resources was sectioned into financial, staffing, and technology. Additional concerns included process, systems, expansion/growing pains, and clinic. Additional benefits consisted of knowledge, advocacy, and College of Health Professions’ or individual program’s developmental opportunities. Finally, recommendations for the developmental process of creating an interdisciplinary health clinic were provided.
Clinic Vision

Clinic vision was conceptualized as the collective mission or desired impact of the College of Health Professions and School of Optometry in forming an interdisciplinary health clinic. Identified themes included the educational impact, impact on client care provided, impact on the College of Health Professions’ Campus as well as individual professional programs, relationships with community partners, and questions remaining to be answered.

Educational Impact

Expectation of the educational impact was positive both on the programmatic and College of Health Professions levels. For the individual programs, the conceptualization of their professional role will expand and shift the focus of curriculum and clinical work. In addition, cross-pollination as a real-life experience among the programs was identified as providing the foundation for an interdisciplinary culture.

In relation to the College of Health Professions, an interdisciplinary health clinic could be an example of cutting edge health care by providing a proactive and preventative approach to total wellness. The proactive approach affords the clinic the opportunity to deviate from traditional medical models to provide triaged patient care that imparts skills training/education that can decrease the incidence of health care visits. An interdisciplinary health clinic would provide a supplemental practicum site where students can learn to effectively triage patient care with other professionals to enhance overall care. The clinic could provide a real world experience in effective interaction with diverse professional groups and the possibility of observational learning for students. Finally, working with an underserved population would provide students with a better
understanding of the difficulties faced by diverse clients and provide internships, job shadowing opportunities, or work-study positions to Pacific undergraduates for both educational and marketing purposes.

Client Care Impact

The impact on client care was mixed. Most programs expected it to be positive, there was some concern expressed. Many of the interviewed programs agreed that an interdisciplinary health care approach to patient care was desirable, that an interdisciplinary health clinic could emphasize care in context providing a community focus that offered applicable real-life skills training, and that an interdisciplinary health clinic provided the opportunity for external consultation to any program that identified the need. Most also agreed that an integrated referral system was a potential benefit to the client population served by an interdisciplinary health clinic. However, one concern was service overkill. Could an interdisciplinary health clinic adversely impact the patient population by presenting too many diverse programs?

College of Health Professions/Individual Program Impact

The creation of an interdisciplinary health clinic would have the potential to infuse a new sense of a collective identity among the professional programs in the College of Health Professions. The majority of applied experiences are outsourced and an interdisciplinary health clinic was viewed as a supplementary rotation for all programs that will focus more on preventative health care and consultative services. The clinic could help identify client needs through assessment and provide appropriate referrals. An interdisciplinary health clinic would not supplant existing clinics or rotations, but instead offer additional experiential training.
Relationships

Considerable concern was expressed about the potential impact on relationships with community members. An interdisciplinary health clinic should strive to provide specialty services that do not compete or interfere with established community relationships with existing services. However, it could also create an in-house referral system with VA Garcia in order to facilitate additional health care if indicated through assessment.

Remaining Questions

A number of questions regarding the clinic vision were identified. They included the following: (1) What is the mission of an interdisciplinary health clinic and what is the strategic plan to accomplish this mission? (2) Who will develop the marketing plan for an interdisciplinary health clinic and how will it be implemented? (3) What plan is in place to transition from theory to a concrete plan for development of an interdisciplinary health clinic? (4) What is the timeline? (5) Who is the primary provider and how will reimbursement occur? (6) How and when will other programs become involved with the patient? (7) What protocols will be established for this process? (8) Will each program have designated staff or will a centralized administrative system be established? (9) Will an interdisciplinary health clinic be designed as a training facility for students or a for-profit clinic focused on patient care? (10) Will an interdisciplinary health clinic promote a proactive preventative approach or a reactive curative approach to patient care? (11) Is there a clear vision how each individual program fits in an interdisciplinary health clinic?
Culture

Culture was defined as "how things will get done", or more specifically, the desired way of doing things in an integrated health clinic. Themes that emerged from the interview results relating to culture were divided into an overall College of Health Professions Campus culture, student culture, and the culture of the developmental process.

Culture

The most consistent expressed desire was to create an atmosphere where new ideas can be expressed and received as topics of conversation and discussion. While the culture of an interdisciplinary health clinic should be collegial and respectful, all programs want to remain autonomous entities. Through investment in an interdisciplinary health clinic, programs will be able to participate in something larger than their respective curriculum. Some examples identified as opportunities for collaboration included continuation of integrated case conferences/grand round presentations and integration of classes, lectures, club meetings, and social gatherings. Specific areas for potential collaboration included the following: (1) ethics, (2) multi-cultural/diversity topics, and (3) evidenced-based practices. Scheduling difficulties were identified as the most likely deterrent to establishing the desired culture described above.

Students

All of those interviewed agree that the College of Health Professions and an interdisciplinary health clinic provided substantial educational, research, and applied clinical opportunities for the student population at Pacific University. If a collective College of Health Professions student culture is fostered some programs expressed concern that students may lose their current connection or student identity with their
individual program. Identification as both a student of the College of Health Professions and the individual student’s program is ideal, but it is difficult to create this balance. The opportunity to utilize knowledge from other programs’ perspective or focus on an integrated health care topic for capstone projects, theses, and dissertations was seen as a potential benefit. A universal dress code for an interdisciplinary health clinic was consistently identified as an area of potential conflict among the programs.

Process

Most of those interviewed expressed a mix of enthusiasm and skepticism about the developmental process of the College of Health Professions and an interdisciplinary health clinic. They all agreed that the concept of an interdisciplinary health clinic is promising, but some doubted the reality and practicality of the concept of an interdisciplinary health clinic. All interviewees were aware that this would be a difficult transition.

Some interviewees expressed concern that the College of Health Professions and an interdisciplinary health clinic will reflect one or two dominant or established programs’ culture rather than a new, integrated culture. Programs are currently operating as isolated silos of information and finances; a shared resource conceptualization was identified as likely enhancing the quality of program interactions.

Most of the deans and directors agreed that increased communication and dissemination of information, coupled with increased time allotment, will engender an environment of collaboration where shared resources and integrated health care become a reality. In other words, if all participating programs are fully invested in the developmental process it would foster the culture described as desirable for the College
of Health Professions and an interdisciplinary health clinic. Some believed that a “fear of the process” may hinder the development of the College of Health Professions and an interdisciplinary health clinic and that this approach to the developmental process would inevitably create animosity among the professional programs. The belief was that the developmental process, whatever it is, should likely continue and be reflected in the College of Health Professions and an interdisciplinary health clinic culture.

Power Distribution

Power Distribution was intended to incorporate issues related to the desired autonomy of the individual professional programs and potential struggles that could occur via integration. This theme incorporated financial and resource concerns, in addition to the question of forming a way to resolve them.

The ideal arrangement identified by most programs was affiliation with the College of Health Professions while retaining autonomy as individual programs. The envisioned power distribution for most programs was one based on equity; i.e., equal representation for each professional program regardless of program size or financial contributions. Several programs reported conceding significant concessions during Phase 1 of the College of Health Professions Campus development. These programs willingly gave up Phase 1 resources for compensation in Phase 2 of the College of Health Professions Campus development as an interdisciplinary health clinic will be created during Phase 2. These accommodations were believed to help facilitate cordial interaction among the professional programs during the initial stage. A more heated exchange between the programs may ensue during Phase 2 due to limited resources and space. One
question identified during interviewing was how internal disagreements between professional programs would be handled and resolved during this latter phase?

**Space/Systems**

Space/Systems included information related to the physical space located in the buildings at the College of Health Professions Campus and the systems needed to operate an integrated health clinic. Themes were divided into the physical design, billing and documentation, and required systems needed for an interdisciplinary health clinic.

**Physical Design**

In relation to the physical design of an interdisciplinary health clinic within the context of Phase 2 development of the College of Health Professions Campus, interview results were divided into specific requests or expectations and questions regarding community space, client or patient interaction with students, and accommodating specific program curriculum demands. In terms of specific requests or expectations, the most common and consistent was the need for an auditorium as a necessary piece to consider in the design of Phase 2. A large community hall would allow for integrated lectures or classes and provide the space needed for conventions that could provide an additional source of income for the university.

The second most common and consistent request regarding the physical design of an interdisciplinary health clinic was related to clients or patients served by the clinic. Specifically, the physical design implemented in Phase 1 does not facilitate a smooth transition from one program’s clinic to another program’s clinic. Concern regarding student interaction with clients or patients was one aspect of the difficulty with Phase 1 design. In other words, intermingling of students and patients was expected to negatively
impact overall satisfaction with the services provided by the clinic. Questions related to this issue included the following: (1) Will the architecture in Phase 2 create a streamlined system for patient flow? (2) Will the student common areas be in close proximity to client or patient traffic areas? (3) What is the expected interaction between patients and students traveling between classes?

Finally, individual programs have specific mandated curriculum needs, such as laboratories, which must be met in Phase 2. Several of the programs need to have designated laboratories designed to specific requirements for accreditation and requested that this be considered when designing Phase 2 of an interdisciplinary health clinic. Several programs requested that a fitness center be included to help facilitate preventative patient care. All interviewees requested that they be involved in architecture meetings during Phase 2 development to describe the individual needs of their program. Questions related to these program specific issues included the following: (1) How will resources and space be allocated in Phase 2? (2) What decisions have been made at this point in the process? (3) Will there be sufficient exam rooms available for all of the programs? (4) How will student, patient, and faculty parking demands be accommodated? (5) Will the architecture be able to accommodate the demands of each program? Again, all interviewees agreed that space and resource allocation would proceed much smoother during Phase 2 if the directors and deans are provided with sufficient time to interact and discuss the various needs of each program, weighed against the constraints inherent in the design.
Billing and Documents

Many of the programs do not currently have billing systems in place. For those who do, it was perceived that an initial venture in an electronic billing/filing system may seem financially prohibitive, but could potentially eliminate several concerns in one investment (e.g., HIPPA violations, etc.). In relation to this possibility, one question was what the HIPPA codes for integrated health systems are? Other questions included the following: (1) How will billing be handled? (2) Will each individual program establish and maintain its own system, or will one inclusive centralized system be created? (3) Who will have access to patient charts and when?

Systems

The required skill sets for students involved in an interdisciplinary health clinic would change. This change would need to be reflected in each program’s curriculum (e.g., assessment, screening, referral recognition, evaluation, etc). In addition to each program’s individual curriculum, how or who will handle the scheduling for integrated classes and lectures and how will this integrated schedule accommodate individual scheduling differences of each program?

Technology/Resources

Technology/Resources was intended to address perceived limitations and specific needs identified as essential to the daily operations of an interdisciplinary health clinic. These concerns and potential advancements to providing client care were categorized into areas of financial, staffing, and technology.

Financial
All deans and directors held the belief that the development of the College of Health Professions and an interdisciplinary health clinic would require a willingness to commit substantial resources at the beginning. Many expressed interest in securing grant funding for research and to help offset the cost of providing integrated health care; substantial grant opportunities are available to integrated health care systems and research institutions. By securing grant funding, the College of Health Professions and an interdisciplinary health clinic would become less dependent on tuition- or client-based funding.

Some programs expressed concern regarding the allocation of resources, believing that currently it is equitable. Some programs have insufficient funding to purchase start-up and operational materials and there would be considerable expense in addition associated with designing an integrated interdisciplinary health clinic system (confidential records, billing, etc.). For additional information regarding such a system refer to the technology section of the results below.

Staffing

Most interviewees expressed concern regarding the distribution of responsibilities among program faculty. Areas of responsibility commonly identified included research, academic, and clinical duties. Some of those interviewed said their programs do not currently have all three aspects represented by their faculty, and many of the deans and directors expressed interest in cross appointments of faculty based on specialty. Some noted their current faculty have expressed hesitancy in incorporating all three aspects and would prefer to focus on only one or two aspects.
Most deans and directors identified an increase in faculty as essential to the developmental process of the College of Health Professions. An interdisciplinary health clinic would likely require an additional layer of faculty who already possess the skills and information, and/or provision of training for current faculty related to interdisciplinary health care, knowledge of other training models, and population specific skills. Their belief was that new faculty would improve the faculty to student ratio and ensure each program would be provided with research, academic, and clinical faculty. Additional faculty would also allow some faculty to limit their specialization to one or two areas of responsibility or focus. An interdisciplinary health clinic at the College of Health Professions Campus would require the addition and coordinated sharing of administrative staff.

Technology

Consistently reflected in individual responses was the need to develop a standard of language for an interdisciplinary health clinic in regards to all record keeping functions. Program specific language and abbreviations could lead to misinterpretations and mistakes. Interdisciplinary health clinic paperwork needs to serve both a clinical function and meet the specific demands of the separate professional programs. An electronic health record system was identified as potentially reducing HIPPA violations and might facilitate ease of use for the clinicians involved in an interdisciplinary health clinic. Most of the deans and directors reported a common goal of one cumulative file per client or patient. Additional questions related to technology and health records included the following: (1) Will the clinic use an in-house release of information? (2) How will the file be shared and who has access?
Additional Concerns

The Additional Concerns section was utilized to cluster items identified as potentially detrimental to the development of an interdisciplinary health clinic and not already included in other content areas. Themes were further grouped into concerns related to the development process, existing compared to desired systems, expansion or growing pains, and those specific to an interdisciplinary health clinic.

Process

Most of the deans and directors acknowledged that a lack of inclusion in Phase 1 fostered a feeling of alienation among many faculty members. Several of them recognized that the lack of planning in Phase 1 created avoidable difficulties and were concerned that there would be insufficient planning in the design of Phase 2 which would increase feelings of alienation. Many believed that conflicts among professional programs’ vision of what an interdisciplinary health clinic could, or should, be would initiate creative innovation in the process of successfully resolving conflict. There was a general concern among many of the program deans and directors that complacency would set in with the completion of Phase 1. The concern was that the problems of Phase 1 would pass to Phase 2 if extensive planning was not conducted. A specific concern related to the development process was that a divide could occur between professional schools and the undergraduate programs with the removal of the professional programs from Pacific’s main campus. Several interviewees expressed the belief that proximity in itself would foster increased positive interaction between the professional programs.
Systems

There was a general concern that other professional programs might be unwilling to relinquish previously established systems or practices that would not be conducive or compatible to an integrated health clinic mentality (e.g., billing or record keeping). Another concern consistent throughout all individual interview results was how transportation between Forest Grove and the College of Health Professions Campus and an interdisciplinary health clinic would be maintained for students without vehicles.

Expansion/Growing Pains

Several of the deans and directors expressed their belief that building space had already been allocated for Phase 2 and wondered how growth would be possible. One general concern was the current faculty’s ability to meet all the educational and clinical needs of an integrated health clinic as not all professors can assist in clinical supervision. In addition, few of the participating deans and directors have experience establishing, managing, marketing, and developing training clinics. Many interviewees emphasized maintaining a positive relationship with Virginia Garcia as essential and should not be underestimated.

An interdisciplinary health clinic would need support, especially financial, from the main Pacific University to successfully market an interdisciplinary health clinic. Additional concerns related to expansion/growing pains included the following questions: (1) What growing pains can be planned for? (2) Will a system be in place to account for and contain growing pains? (3) Once the programs are ensconced in their respective areas of an interdisciplinary health clinic, how will program growth be accommodated? (4) How will the College of Health Professions be structured organizationally? (5) Will each
program have equal representation? (6) How will additional professional programs be incorporated into the existing design (e.g., nursing program)? Additional concerns related to expansion/growing pains specific to financial concerns included the following questions: (1) What is the current budget for an interdisciplinary health clinic and how will it be funded? (2) Will the funding be equitable or based on an incentive plan? (3) Will the primary funding source be tuition or fees for services rendered at the clinic? (4) Will a sliding scale be utilized in the various clinics? (5) Will the College of Health Professions and/or an interdisciplinary health clinic be established as a separate entity from Pacific University for liability reasons?

Clinic

An interdisciplinary health clinic would involve several professional programs triaging care for each individual patient or client. There was a concern that this might create a real or perceived different standard of care for patients or clients who were involved in this system. Specific criteria were identified as needing to be established on how individuals qualify for the service. One interviewee noted that research posits 30% to 80% of patients admitted to clinics have psychosocial difficulties. This point indicated to this interviewee the importance of intensive referral training for all of the professional programs to improve patient care. Also, an interdisciplinary health clinic would allow for interesting research possibilities. Pre- and post-outcome measurements would need to be implemented to assess the effectiveness of the clinic from the patient or client perspective.

All of the professional programs who participate in an interdisciplinary health clinic would need to agree on a strategy for safety standards. It might be beneficial to
establish an interdisciplinary health clinic in a series of stages with clearly defined objectives rather than a one-phase approach. The targeted population demographics might create funding difficulties if relying on a fee for services. Several interviewees indicated disappointment that the previously discussed interdisciplinary health clinic vision was not realized during Phase 1 of the College of Health Professions Campus.

Remaining questions identified through individual interviews related to concerns regarding an interdisciplinary health clinic included the following: (1) What is the purpose of integration? (2) If the goal of integration is to benefit the client or patient, how can it function while limiting intrusiveness? (3) How will patient confidentiality be maintained in general waiting areas? (4) Who is the primary provider for the patient if triaged care is received? (5) How will the potential language barrier be accommodated and will an integrated health clinic employ interpreters or push for increased language fluency among students? Additional questions related to concerns in terms of programmatic concerns included the following: (1) How will supervision be conducted for an interdisciplinary team? (2) Do the independent professional programs have different calendar years and, if so, how will that impact triaged patient care and inter-program communication? (3) What are the various ethical and legal liabilities inherent in multiple professional programs triaging one patient? (4) How varied or similar are the various governing/accrediting bodies for each discipline?
Additional Benefits

Finally, the Additional Benefits section was utilized to cluster items identified as potentially beneficial to the development of an interdisciplinary health clinic and not already included in other content areas. Themes were further grouped into benefits related to the development of shared knowledge, advocacy, and opportunities for individual programs as well as for the College of Health Professions as a whole.

Knowledge

An interdisciplinary health clinic would provide holistic understanding and knowledge regarding referral systems and services provided by other professions. Students and faculty would become better providers as they contemplate and understand different dimensions of patient care. By knowing additional options that are available, students and faculty would be better able to advocate for services consistent with client needs and cultural perspective.

Advocacy

Some of the deans and directors interviewed discussed the influential power of professional advocacy. Specifically, they said it would be enhanced through understanding of integrated health care models. It was believed the professional health programs would be in a position to highlight similar professional issues and address the issues with a unified position (e.g., managed care). Also, an interdisciplinary health clinic would provide the Washington County population an opportunity to actively participate in the creation of a health/wellness service system available to all members of the
community and provide positive role models for community members. All interviewees agreed it is an opportunity to “push the envelope” on what health care can be and the positive impact it can have on an entire community.

Program/College Developmental Opportunities

Most deans and directors agreed that prospective and incoming professional health care students would find the opportunity of gaining experience in an interdisciplinary health clinic very attractive; it would be a wonderful selling point for all College of Health Professions programs. In addition, the creation of a College of Health Professions Campus and an interdisciplinary health clinic would increase undergraduate exposure opportunities and provide a direct link of experience for the Pathway programs. The Pathways programs establishes a link between the College of Arts and Sciences and the professional schools, whereby undergraduate students interested in entering professional graduate programs can gain exposure to their desired professional field prior to application (i.e. during their undergraduate education).

Again, most of those interviewed expressed interest in the potential for Pacific University sponsored professional seminars or lectures focused on interdisciplinary health care research, academic, and clinical applications. It was believed that prospective faculty would be attracted to Pacific University because of an interdisciplinary health clinic and resulting clinical, academic and research opportunities. Finally, current faculty interest in integrated research, academic, and clinical application opportunities would likely attract investment in an interdisciplinary health clinic, not an administrative initiative.

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Recommendations

The following recommendations are based on the results obtained during the consultation process. They are not intended to be inclusive of all potential developmental process concerns and issues, as they are time dependent, but instead might serve as essential starting points for developing and maintaining a successful integrated health clinic on the College of Health Professions Campus. For these reasons, they are briefly described and identify general areas for consideration of focus or investment:

1. Allow additional time for all participating programs to provide input and to assist in devising a planned course of action for the following: (1) increased investment in future College of Health Professions endeavors; (2) increased creativity in problem solving; (3) increased collaboration to meet the community’s current and future needs; (4) increased collaborative learning among programs; and (5) increased potential for cutting edge discussion and implementation of ideas.

2. Conceptualize the development process as a means of initially establishing the desired culture of an interdisciplinary health clinic. Open and respectful communication of expectations, wants, needs, and room for negotiation will likely translate over to an interdisciplinary health clinic and College of Health Professions Campus at large.

3. Attempt to establish a culture where an interdisciplinary health clinic design is developed as a team rather than asserted by programs with existing clinics. It will be important for programs with existing clinics to be flexible regarding design and procedures. It is improbable that an interdisciplinary health clinic will function effectively within the clinic conceptualizations currently being implemented by Pacific University programs.

4. Develop a multi-disciplinary task force with representatives from each program to discuss and devise action plans for future interdisciplinary health clinic development and practice. Emphasis of the task force should be the concrete planning of an interdisciplinary health clinic (i.e. documentation, referral system, intake assessment procedure, staffing, shared resources, etc.).

5. Consider preventative health within a cutting edge health and wellness clinic. Many interviewees expressed their program’s interest in this vision. Strive to
develop a unified, collective vision or strategic plan specific to an interdisciplinary health clinic.

6. Design a flexible system or develop a task force that can account for and adapt to the evolutionary changes that will occur in non-static disciplines. This preventative measure will likely prove useful in achieving the end goal of an interdisciplinary health clinic. Additionally, the creation of a budget and discussion about funding sources will be beneficial for the College of Health Professions as a whole.

7. Consider placing emphasis on developing systems and environmental support to encourage interaction and cross-fertilization. Space and proximity do not equal integration or even interaction.

8. Consider the following when designing space: (1) need for a large auditorium able to accommodate interdisciplinary conferences, (2) need for design focused on interdisciplinary health clinic patient needs, (3) need for sufficient space for students to interact from all programs, and (4) needs identified by specific programs. Consideration could be given to the overall floor design. Many interviewees expressed an interest in the general design of an interdisciplinary health clinic on the first floor, classrooms on the second floor, labs on the third, faculty offices on the fourth, and administration on the fifth.

9. Create the foundation and infrastructure for an interdisciplinary health clinic prior to the opening of Phase 2.

10. Consider implementing a professional development/growth program for current staff, and recruitment practices for future staff (i.e. research, clinical, supervision, and academic roles) focused on interdisciplinary skills and training. Additional training will also be needed regarding an interdisciplinary health clinic’s target populations and cultural concept of health care.

11. Schedule gatherings where those involved could express and channel their energy and excitement for an interdisciplinary health clinic concept. Energy was high during the interview process and many interviewees expressed dissatisfaction with an inability to utilize or apply their energy. Interdisciplinary group meetings may alleviate some interviewees’ dissatisfaction by allowing a venue through which they can express ideas and mobilize energy.

12. Continue to pursue cutting edge academics, research, and health care as a core value shared by all programs. Re-evaluate current program curricula and resources available to achieve this goal. Incorporating these systems place the College of Health Professions at the forefront in research and development in the related fields and makes Pacific University desirable to both prospective staff and students.
DISCUSSION

Due to the varied and complex nature of the findings, discussion of the results will be organized into developmental process themes. These themes identify both common organizational dynamics when change is involved, as well as organizational dynamics specific to Pacific University’s College of Health Professions’ culture. The latter of these organizational dynamics was identified and labeled based on the language used by deans, directors, and faculty members during the course of the interviewing process. The organizational dynamics to be discussed include implicit organizational resistance to change, developmental stages of individual programs, and varied administrative experience of the deans and directors of these programs, and Pacific University’s College of Health Professions' culture of the “Big Dogs” as reflected in the language used by the deans and directors during the interview process. Following the discussion of organizational dynamics is a brief caveat on the pacing of an interdisciplinary health clinic development process and organizational change. Finally, a description of limitations related to the validity of results and recommendations are identified.

Resistance to change is an implicit aspect when dealing with individuals and groups of individuals when organizational change is needed during a transitional period. While there are a wide variety of reasons an individual or group of individuals may be resistant to change, elements of anticipation and fear of the unknown, comfort with how things are currently, and feelings of not being able to influence or control the change are likely present. When approaching organizational change it is easy to perceive resistance as a barrier to the desired goal and, therefore, that resistance needs to be eliminated (or
ignored) as it interferes with the task-oriented goal of change. A process-oriented perspective, consistent with the gestalt conceptualization of resistance, would seek to incorporate individual and group resistance as an important component of the developmental process. Contained in their resistance are messages of hesitation, concern, and potential for loss based on core values of the individual, group, and profession. Individual and group resistance is not only worth understanding but can be a foundation from which long-term change and collaborative process can begin and be fostered. Contained in their resistance are messages of hesitation, concern, and potential for loss based on core values of the individual, group, and profession.

Each program’s values and developmental goals were heavily influenced by that program’s developmental stage and that dean or director’s personal experience with organizational change. Pacific University’s professional programs within the College of Health Professions represent different developmental stages, especially in relation to participation in an interdisciplinary health clinic. Some programs are well established while others are in the process of becoming established. While some have fully operating clinics, other programs are in the process of opening a clinic or have no interest in operating a direct service clinic. In addition, program deans and directors appear varied in their experience and level of comfort related to the organizational shift required to operate an interdisciplinary health clinic.

Due to the varied developmental stages of the programs and the varied leadership experience, a unique opportunity exists. There is an opportunity to not only invest in the development of an interdisciplinary health clinic, but also in the development of the leaders who will be depended upon for the establishment, operation, and maintenance of
an interdisciplinary health clinic. For those deans and directors with clinics in existence there is the opportunity to discuss procedures and provide rationale for existing systems and culture. For programs without a functioning clinic, there is an opportunity to learn from existing clinics. Core to the success of this process is for programs with existing clinics to be willing to change aspects of their clinics and for programs currently without clinics to find ways in which existing systems and organizational structures can be adapted to meet their educational and professional practice needs.

Finally, Pacific University's College of Health Professions appears to have an established culture where the "big dogs" or the "800-pound gorillas" are perceived as receiving substantial financial and other resource support, while the smaller professional programs receive minimal financial and resource support. This perception of the culture was reflected in the language used by the deans and directors during the interview process; this perception appeared to create substantial concern and worry in the smaller programs. Limited resources create competition among professional programs and increase compartmental thinking. Fostering integration and a cooperative learning environment requires sharing of resources to include: physical, academic, cultural, clinical, personal experience, and financial.

Based on the organizational dynamics discussed thus far, a brief discussion regarding the pacing of an interdisciplinary health clinic development process is warranted. The issue of pacing was identified as a concern on both individual and programmatic levels. In relation to both levels, it appears the College of Health Professions as an organization, and the professional programs specifically, experience the current pace as not allowing significant time to plan, process, and be deliberate in the
execution of the development of an interdisciplinary health clinic. Increased balance between task-oriented and process-oriented values will likely alleviate this experience of being rushed and will increase commitment and investment in the organizational change required for the developmental process of creating an integrated health clinic.

Implicit organizational resistance to change, the varying developmental stages of individual programs and of the deans and directors of these programs, and Pacific University's College of Health Professions' culture of the "Big Dogs" as it is reflected in the language of the deans and directors appear to present substantial barriers to the development of an integrated health clinic. Increased attention to the pacing of the process and focus on balancing task-oriented activities with process-oriented values will likely enhance commitment and willingness to engage in the opportunity of a collaborative process. Investing in the collaborative process will, in itself, create opportunities and develop relationships required for a successful interdisciplinary health clinic.

Of several potential limiting factors related to the validity of the results and recommendations, the nature of consulting work and the power differential that existed in this consultation study were most noticeable. I identified these limitations based on their relevance to the field of consulting research and organizational consulting learning opportunities present for the clinical psychology field. Due to their impact on the generalizability and validity of the results, a brief description of limitations common to organizational process consulting work is followed by a discussion of the inherent power differential present in this study.
Consulting psychologists consistently rank conversations with colleagues as the most useful means of improving skills. As a result, research is usually limited to applied problems that may at first appear to have little to no consulting value (Blanton, 2000). The nature of consulting work is that it is time sensitive and project specific. This study is likely to be described in a similar fashion in that it is most salient, relevant, and has the highest utility to individuals and/or groups of individuals invested in the development of an interdisciplinary health clinic. While time and project specific limitations exist, it is suggested that the methodological process of this study can be generalized and applied to a variety of organizational development activities focused on providing process consultation or when a group of individuals is required to engage in a transformative process.

Another significant limitation of this study was the inherent power differential that existed between student consultants and the deans or directors who participated in the developmental process of forming an integrated health clinic. Common to the executive development literature, it was difficult to coordinate individual interviews and executive group meetings due to scheduling limitations and time constraints (Ellingson, Kochenour, & Weitzman, 1999). Although this limitation appeared to exist and impacted the developmental process, having student consultants may have increased some resistance from the deans and directors of the professional programs in terms of responsiveness, flexibility with scheduling, and willingness to be candid during interviews. To assume any and all resistance was due to the role of student consultants would be a false assumption. Additional reasons for resistance may include reluctance to participate in the formation of an interdisciplinary health clinic, hesitancy to lose
established funding for professional programs, or not conceptualizing an interdisciplinary health clinic as an essential aspect of the interviewee’s professional training program. Regardless of other factors, it appears evident that the multiple roles and inherent power differential which existed between study participants (i.e. deans and directors) and the student consultants likely impacted the interactions and, therefore, the information gathered during the study.
NEED FOR ADDITIONAL STUDY AND CONSULTATION

Additional opportunities for student study projects include both academic and applied research. These research opportunities would expand the current study and allow for other projects to utilize the existing framework. Information from this study can be applied to the early developmental process of creating an interdisciplinary health clinic and the study design can serve as a template for other organizational consulting research. Specific areas of possible research I identified included evaluating the implementation of recommendations provided in this study, a retrospective survey regarding effective developmental processes, ongoing process consultation with the executive group regarding the formation of an interdisciplinary health clinic, and other consultation projects within Pacific University’s organization.

In order to evaluate the implementation of recommendations provided in this study, one possibility is a retrospective survey designed to assess the effectiveness of the initial phase of process consultation for an integrated health clinic. Topics might include what worked and what did not work during the developmental process, how could the process have been improved, what remains to be resolved, and who should be involved during future developmental processes. More specifically, a critical incident approach to the retrospective interview may provide additional information regarding potential "pitfalls" while identifying themes that are likely to be currently reflected in the established culture of the College of Health Professions and an integrated health clinic.

Another opportunity to enhance early development of an interdisciplinary health clinic at Pacific University’s Health Professions Campus is ongoing process consultation with the executive group (i.e. deans and directors of professional health programs) related
to the operations of an interdisciplinary health clinic. Students from the Organizational Consulting track within the Clinical Psychology program could offer consulting services regarding an interdisciplinary health clinic and cultural development of the College of Health Professions. These students could assist with facilitation of meetings, system assessment and design, and monitor ongoing developmental aspects of maintaining an interdisciplinary health clinic with an emphasis on client care and training.

Finally, a variety of consultation projects beyond the College of Health Professions’ establishment of an interdisciplinary health clinic appear possible within Pacific University’s academic institution. Consultation services could be provided to offices with an undergraduate emphasis, to other professional programs, and to the administrative levels of the organization. These offices would likely benefit from increased information and understanding of how they relate with other components of the university and how they could better facilitate communication, coordination, and collaboration.

As Pacific University, and specifically the College of Health Professions, evolves toward integrated and comprehensive education, the need for the role of organizational consultant will increase. Based on the clinical training and interpersonal skills required by the School of Professional Psychology, and the Organizational Consulting track in particular, student consultants can fulfill certain aspects of the consultation process. Utilization of student consultants will not only provide valuable experience for the participating students, but will also fulfill an administrative need for improved communication, coordination, and collaboration among all professional programs and academic schools at Pacific University.
REFERENCES


APPENDIX A

Suggested Interview Questions
These questions are provided to you for consideration prior to our interview. Thank you.

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

3. What is your program’s vision for a clinic on the new health professions campus?

4. How does the health professions clinic goal correlate with your program’s vision?

5. What potential roadblocks do you envision occurring as you work toward the goal?

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice (e.g., potential prescriptive privileges for psychologists)?

7. Describe the culture of an integrated clinic on the new health professions campus?

8. Is there anything we have failed to cover that you believe is important to this process?
APPENDIX B

Attached you will find the results we obtained from the interview we held with you a few weeks ago concerning the future development of an interdisciplinary health clinic on the Health Professions Campus. Your results have been kept confidential. Per our discussion during the interview, we request you review the information to ensure accuracy and to make addendums as needed. We realize this information is sensitive and want to give you the opportunity to expand or censor responses with consideration for the rest of the development process. Results have not been shared with anyone else, including our supervisor Jay Thomas, Ph.D., ABPP, at this point in the process. Please feel free to contact either of us via email or phone to confirm accuracy, make addendums, or ask questions regarding this stage of the consulting process. Thank you in advance for your time. We look forward to integrating all our data and providing you with the results within the next few weeks.
APPENDIX C

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

- **PH1**
  - More efficient if they deans and directors are brought together to allocate space in the two new buildings
  - The dental program is not included in funding of building
  - The process was compartmentalized and limited planning – each program met individually with the architect. Would be better if the programs worked together, ex. – The clinics should all be on the first floor
  - Not very clear how the dental program will fit – push to get all programs into Phase 1
  - Space was designated first, then materials
  - Lack of focus on the faculty and students
  - Use end of PH1 for problem solving to avoid future problems in PH2
  - Hersen had a role conflict, of which all were aware
  - Able to see connection with OT, PT, Pharm, PA... not sure regarding OPT – based on OPT organizational structure

- **PH2**
  - Would like weekly or bi-monthly meetings to ensure each program is included in the decision process – increased communication
  - Team approach
  - Need to include the addition of an auditorium
  - Interdisciplinary clinic clearly defined – believes preventative, “total health care” model to avoid psycho, social, cultural barriers

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

- Current impression is that the programs, particularly the new programs, will be placed in close proximity with each other in the new building with little interaction
- Definite benefits if the clinic is interdisciplinary – ex. – Dental students could gain awareness of the psychosocial aspects of dentistry
- Dental students could work in conjunction with psychology students on anxiety or phobias in dental care, etc. for their capstone project

3. What is your program’s vision for a clinic on the new health professions campus?

- Opportunities and potential – then design space
- The ability to triage care
- Can create boards to change and improve patient care – providing services to underserved populations
• Budget = create internal source of funds, ex. - Sliding scale fee for service and supplement the internal fund source with external funding
• An actual dental clinic on site treating patients
• Integrated case presentations open to all faculty and students
• Some integrated coursework – difficult due to scheduling, but should be considered
• Club meetings or social gatherings between students
• Limited grades for interdisciplinary classes outside of core curriculum, more of an enhancement
• Equal not paternal management

4. How does the health professions clinic goal correlate with your program’s vision?

• Integrated seminars – supplemental, not graded, considered enhancement of education
• Cross fertilization
• Increased use of each other’s skills, ex. – OT students could observe dental students to assess positioning to help posture and decrease lower back pain, provide exercises to increase strength; ex. – Dental student brought in on stroke case to help patient re-learn to brush his or her teeth
• Consultation role for all programs to assist the other programs when indicated
• Input on developmental process fosters support
• Capstone projects could be interdisciplinary
• Meetings with all directors/deans have been very beneficial
• The dental program is a hybrid program because it is an undergraduate program that is also listed as a professional program, first B.S. in Health Professions – will have established identity and cross fertilization will provide increased awareness of other programs functions
• Provide interdisciplinary culture – how to work with professionals from other fields
• Will have a clinic on site but also will rotate students through outside rotations, ex. – Duality
• Supervision is vague – depends on the setting, the school setting will need to hire 1 dentist and 3 practicing hygienists or can get a limited access permit (LAP) so can provide care without dentist if the patient is low SES; consultation is ok as is, but must clarify own legal limits

5. What potential roadblocks do you envision occurring as you work toward the goal?

• Impression is that PH2 is already sold
• Underserved population probably not able to pay, so how cover expenses?
• How do some of the programs actually work together?
• Growing pains could be a big problem if individuals do not work together and communicate – “unwilling to cross the street”
• Fear of group process, fear it will create animosity and disrupt the process
• Funding – budget, especially being tuition based and ethical concerns this raises regarding the caliber of student admitted
• Specific funding for a dental clinic (i.e. cost of initial and on-going cost of providing direct care experiences) – some have been donated, but need consistent funding - $200,000 or more for x-rays etc.
• Rumors that the new building’s space is already allocated
• Identity development of the Health Professions vs. Art and Sciences
• Scheduling
• Degree requirements
• Community relationships
• Parking
• Time – involving all deans and directors in the planning process

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?

• Cost to maintain dental schools is prohibitive so some schools have been forced to shut down – this indicates that fewer dentists will graduate into the system requiring increased need for dental hygienists, most are housed within a 2-year community college
• The decrease in available dentists will initiate a move to increase access to care which may force the establishment of mid-level practices primarily staffed with hygienists (Advanced Dental Hygienist – Independent Practice)
• Current training educates hygienists to work in a dental office, but Pacific has the opportunity to increase the standard of care and train hygienists to work independently – an advanced dental hygiene model = advanced triage, diagnostic skills that would stress more preventative measures and less clinical, include skills in business, cultural, and health policy
• Political advocacy at this level will lead to new “power base”

7. Describe the culture of an integrated clinic on the new health professions campus.

• The students from each program know each other and the faculty from each program meet often (professional and social).
• Combined classes – HIPPA, risk management, etc.
• Pacific sponsored professional association seminars
• Students would graduate with a more holistic perspective on health and the role of health providers – understand the issues of other professions (e.g., HIPPA, board exams, etc.), then change the standards together, collectively – an example is the impact of insurance coverage on all the health professions
• Collaboration, liaison, and networking between programs
• Overall collegial
• Encountered barriers could lead to new opportunities and collaboration

55
• The culture will be defined from the top down, would prefer equal collaboration
• Each program considered a member of a team – non-hierarchical
• The establishment of the interdisciplinary clinic in Hillsboro will establish an identity for the Health College – possibly decrease any current animosity between the Health College and the Arts & Sciences College

8. Is there anything we have failed to cover that you believe is important to the process?

• Why is optometry an independent college? Create 2 colleges with a VP over each – fold optometry into Health College and education into Arts & Sciences
• Impressed with the new dean that was hired, good skills and style, confident in her expertise – it is okay that she will come and shake things up and attend to the cultural aspects of the School of Health Professions
• What will the new organization of the interdisciplinary clinic look like with the new dean?
• What was the vision of the individual who first used the term interdisciplinary in conjunction with the project?
• In PH2 for whom is the building intended for? Nursing – where will they be placed?
• Will PT get a cadaver lab in PH2 if it is not included in PH1?
• Each program has an established individual identity – they have not yet come together to discuss what future integration will look like
• Possibly have OHSU involved in steering committee
APPENDIX D

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

- **PH1:**
  - Architecture and design to enhance the functionality of interdisciplinary activities
    - We appear to have “given up” significant opportunities during the first stage (e.g., student lounge located near patient care) placing non-clinical elements within the clinical areas.
  - Infrastructure considerations
    - Due to “fast-track” nature of the project this elements feels lacking
  - Phase Three: Implementation of design and construction
    - Underway
  - Phase Four: Implementation and utilization
    - We will see how it works

- **PH2:**
  - Phase One: Architecture and advanced planning to maximize functionality and minimize “turf wars”
    - Need a large space mutually planned by the involved programs to create a true interdisciplinary clinic. Logistics of scheduling and use can overcome “ownership” issues
    - Total required space for Optometry clinical program is 23,000 square feet
    - Academic educational design to optimize program strengths and cooperation
    - Consideration of current and future needs
  - Two: Infrastructure Considerations
    - Clinical management for the clinical operations should move to be 100% paperless, electronic system for all programs – Optometry has a specific program suggestion with all health care providers options. Must maintain own program’s accreditation first but this does not preclude cooperative interactions and joint clinical programs.
    - Suggest model interdisciplinary clinic after a “Specialty Clinics Model” - to include referral and consultation systems designed to serve the needs of each involved clinical program.
  - Phase Three: Implementation of design and construction
  - Phase Four: Implementation and utilization
    - Place students and programs into full operations
    - Requires dedicated public relations department for all programs. Unified message and promotion
2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

- Phase I currently appears that so far they have only taken a model that already existed and just brought it closer together – not intuitively obvious as an interdisciplinary design in PH1, by proxy only. Currently the programs appear to exist in basic silo isolation
- Suggest development of specialty clinics vs. primary care (e.g., low vision and psych services integrated, or neuro rehab clinic integrating PT, OT, OPT, and SPP) – OPT has models for many of the suggested specialty clinics
- Additional idea: community outreach with migrant populations – all disciplines apply and delivery services to untapped patient populations
- Interdisciplinary specialty group or clinic is the stated goal – have not seen much action creating the motivation or incentive of investing in the vision and bring it to reality.

3. What is your program’s vision for a clinic on the new health professions campus?

- Increased awareness of what the other programs can provide and increased interaction will increase the level of respect and collegiality among faculty and students – shared classes, research, meeting areas, conferences, etc
- Integrated learning experiences (i.e. share resources, foster understanding and cross-pollination, students learn more and increased potential for education, knowledge, and client care – current is silos of understanding and close only by proximity
- A referral clinic for multiple professions working together to render quality patient care
- Can consult with professors from other disciplines on specific patient cases for development of enhanced management and treatment options
- Students can provide consultation services to enhance their learning experiences and would provide a vital service to the other departments.
- Focus on clinical care delivery models that may be currently non-traditional. The possibility of an integrated health care delivery model offers exciting opportunities and challenges

4. How does the health professions clinic goal correlate with your program’s vision?

- Integrated learning experience is not only possible – it has a huge potential for significantly enhancing education and patient care
- Sharing resources could decrease operational cost
- Work primarily with OT, PT and Psych
• Potentially have specialty clinic – neuro rehab, diabetic patients, etc. that combines services from all programs. This offers greater student education opportunities and enhances the delivery of a more comprehensive patient care. This is part of the core mission of the College.
• Increased standard/level of care for the patients again core to the mission of the College.

5. What potential roadblocks do you envision occurring as you work toward the goal?

• Architecture is critical to creating the outcome goals – rough desired design is clinic at base floor, classes on second, classes and library on third, labs on fourth, and faculty on fifth – class spaces to include a large space option(s).
• Breaking referral patterns out of our own individual programs. OPT has services that can be used by patients in OT and OPT has patients that would benefit from OT evaluations. We must start with education/training and reinforce what each program can offer to the other.
• Turf war – battling for limited resources could significantly hinder development.
• Different theories and approaches to patient care and educational curriculum deliveries. This may hinder integration of programs.
• Differing philosophical mission: patient vs. student centered clinics. Patient care and physician teaching clinics are not teaching labs. Should be based on productivity model.
• Silos of knowledge can limit sharing of information.
• Scheduling issues with shared classes.
• No auditorium or large meeting space. Needed to bring large multiple program education together.
• Liability insurance and responsibility for patient care and student education.
• Billing – who establishes billing? Does each program currently have different billing methods? What insurance panels will individual programs and their respective providers will be eligible to enroll?
• Education – what type of training will be provided and by whom so that student in one program will know when to refer to other program if patient can benefit? Education on available services and understanding on how the different programs expertise can impact the patient.
• Education – the faculty from each program must be trained on the scope of practice for all the other programs.
• Must be a simple system – a complex system will kill the concept.
• Feedback loop – how will feedback be handled (behavior modification) to let all participants in the system know of success or failures?

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?
• Desire to change curriculum to increase the amount of clinical work and take advantage of interdisciplinary opportunities – to do this OPT requires 45-47K square feet of TOTAL clinic space, OPT currently has 25K (PowerPoint available regarding these changes).
• The optometry program intends to move the clinical program to a paperless clinical management system as of May 15, 2006 (Has been delayed to August of 2006 due to technology issues).
• HIPAA guidelines have changed many things in terms of patient access, record security and data transmission. All programs involved in a joint clinical program must be fully compliant with all aspects of HIPAA.
• The scope of optometric practice was expanded in Oregon recently and will probably remain relatively stable for the near future.

7. Describe the culture of an integrated clinic on the new health professions campus.

• Dependent on the new Dean and University administration to bring together – what are the motives, incentives to cross-pollinate? Mutual ground will help.
• The clinic is not a teaching lab, it must be a health care clinic where the first priority is patient care – health care model.
• Open minded deans, directors, and faculty willing to look at new and different delivery models that may be different than the current way of providing patient care and student education – current isolationist culture must change in order for this to succeed. Must be willing to invest time, resources and money to develop the programs.
• This integrated clinic concept is a good goal because leads to increased respect for all professions, currently I do not believe that much is known regarding specifics of other professions and the services that they provide to patients.
• OPT program has watched other programs grow and interact. Historically we have been like a “dysfunctional family” by battling for limited resources. The culture must shift to a family that communicates trusts and shares information.

8. Is there anything we have failed to cover that you believe is important to the process?

• Preventative vs. Acute orientation to patient care are not mutually exclusive, can provide both functions within an interdisciplinary health clinic.
• Optometry in PH1 went from a requested 10,000 square feet to ultimately only 2700 square feet – It will be critical to the mission of the program that OPT has 23,000 square feet in PH2 which must include the majority of the clinical space located on the first floor.
• Optometry offers free student services – this is a large drain on our program’s resources. It is important that all health programs develop a consistent and universal plan for student treatment services, service discounts and access to health-related services. Optometry may be forced to discontinue its program if we are unable to reach a consensus.

• Must have a dress code for the entire building covering students, faculty and staff – not only for professional appearance, but also for security purposes.

• HIPAA concerns on patient policies and protocols. New HIPAA administrative rules have been released and we need to insure compliance by all programs.

• Mandatory and uniform IDs – if in PH2 the architecture not well planned – intermingling patients and students due to floor plan and access can create security and safety issues. This should be easy to remediate with carefully designed architecture in planning for the function of the space. (Separate entranceways, etc.)

• ONCHIT is mandating electronic medical records system (CMS website). All programs involved in the management of patients will need to be aware and compliant.

• Cost and staff resources are needed to manage the various aspects of clinical operations. Managed care requires a huge amount of time to process applications and billing statements for patients. Solution could be to outsource billing for continuity of all programs.

• Revenue for patient care needs to be a production-based model. In a shared integrated clinic the program that earns the money keeps the money –

• A production-based clinic model could allow faculty pay on clinical performance to include incentive-based pay.

• Faculty and clinic needs to be moved from a teaching lab model to a patient care and production model because I believe it will lead to increased levels of care for the patients.

• The HPC clinical programs need to operate under a separate umbrella (503C) for liability protection, managed care policy and plan administration and simplified revenue and expense management. Need to consider making HPC a separate non-profit organization with a unique board of directors still within the global umbrella of the main University – Currently all programs operate under a single University definition.

• Who can bill insurance companies? Optometry professors are required to be on managed care panels – distinction between lab for training and a clinic for patient care to bill insurance services rendered.

• Standard of care issues for care delivery and requires a minimum core elements to bill for Medicare and each managed care plan. This may vary from teaching lab requirements.

• Emphasis should be placed on the business aspect of the professions –

• Must provide a professional clinic image consistent with the mission and goals of the programs.
- Fund raising done by the interdisciplinary clinic should stay with the clinic for the benefit of patient care, student education and programmatic development.
APPENDIX E

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

   • PH1
     - All programs move into one new building – large classes & labs, but less overall space + less autonomy of space
     - Mixed blessings, less physical freedom – but close to state of the art equipment
     - Sacrifice program space for clinic/classroom space
     - 3-5 yr. plan in PH1 – less in clinic but develop relationships with practitioners in the community
     - Appears very collaborative
     - OT students likely to experience culture shift away from university to professional setting
     - Develop consultation rotation
     - Currently working with VA Garcia – hope on limited basis can work with them in the new building
     - Focus on work in context – in community vs. clinic
     - Proximity of space does not equal interdisciplinary
     - OT was ok with removal of clinical aspect in Phase 1
     - Building design does not separate clients and students (“walk the gauntlet to treatment”)

   • PH2
     - Starting from scratch for OT program – would like to look at other programs to see what they did
     - Interested in motivation or impetus from new dean to engage in development process
     - Best chance of IDHC is when doors first open because the space can be designed for that purpose
     - Large, flexible space needed

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

   • Want interdisciplinary
   • Ideal is triage but not authority over other professions
   • Probably more comfort with the multidisciplinary – all the programs have established practicums/indep. Clinics – multidisciplinary a stepping stone for interdisciplinary; large gap exists between current and interdisciplinary
   • Make absolutely clear that proximity is not interdisciplinary – currently alluding to interdisciplinary because of proximity
   • Select people (faculty/students) likely to emerge as interdisciplinary team – not forced by system design; start at faculty level, develop better understanding of other professions, reinforce those faculty invested in the
process, and allow faculty not interested to continue to pursue research, teaching, etc... this needs more work.

3. What is your program’s vision for a clinic on the new health professions campus?
   
   • “Example of what cutting-edge health care can be”
   • Interdisciplinary – more collaborative
   • Maybe triage patient
   • Co-consultation model – possibly create a team composed of different programs
   • Chance to develop interest in how different programs can fit with specific program in real world context – good learning experience
   • Chance for a new culture at Pacific – between programs
   • Practice development is secondary to the relationships with practitioners in the area for direct experience (i.e. “emerging practice projects”)

4. How does the health professions clinic goal correlate with your program’s vision?
   
   • Opportunity to push agenda towards health promotion/wellness
   • PH2 about 50% practicum students in clinic, other 50% sent to satellite practicum’s in community – in actual context
   • Become more interdisciplinary – simultaneous health and wellness promotion and work with disability concurrently
   • Interdisciplinary clinic/team only meets small portion practicum need – consultation
   • Proximity – jump easily from class to clinic
   • Identified psych as professional program with most compatible conceptualization regarding reactive vs. proactive care
   • Educational mission is based on a modeling philosophy (“walk the talk”), direct service as a means for direct education with education as the focus

5. What potential roadblocks do you envision occurring as you work toward the goal?
   
   • Most programs not well-equipped to deal with the target populations (i.e. Spanish speaking); concerned regarding the fit and questions having the required resources to provide required training
   • Complacency if go into multidisciplinary clinic in PH1 – comfortable and stay
   • Political – not all programs will be interested
   • Physical design, opportunity to develop an ideal space but pragmatics may constrain this
   • Concern to not compete with Tuality or local practitioners, but offer service so valuable will come to us because of high quality care – provide good example of what health care should be like – potential for animosity if create competition; “need to follow the relationship”
Interdisciplinary clinic needs a particular draw – e.g. Low cost, leading edge care, etc.
Pragmatic – how educational pieces fit in PH2 – not large enough to accommodate both educational needs and clinical needs
Would only fill a small portion of OT’s clinical needs (3-4 rotation max)
Philosophy – clinic focus = training vs. care
OT focus is on context in the community, experience is in connection with other organizations, does not translate to an interdisciplinary clinic where care is provided
What is the expectation of the clinic – need awareness for confirmation
Potential burn-out and split of focus – can we make it a break-even proposition – intangible success/profit
Financial concerns – for-profit clinics demand more on staff, desired is to run a break-even operation
Time to appropriately develop the space and integrated systems
Willingness to commit resources up front
Location – city location; small population to pull from – demographics does not indicate 19. pull of paying or insured clients – underinsured more likely
Physical location in the building potential hindrance – design how physical space supports what we do
Billing
Administrative expertise and staff – all deans and directors have 2.5 years or less except Michel; can be a benefit because we are all in this together and can learn how to do our respective jobs better from each other, can encourage alliances and negotiations because it leads to a new way of offering education and client care
Liability?
Dress code – dress code established prior to completion of building = less resistance
Parking
Impact of all the students in one location on clients – building design should separate students flow from client flow
Tension between VA Garcia clients and students
Attitude – buy-in of programs
Buy-in from faculty – difference between teaching and clinical work – possibly shifting towards hiring more clinical professors – possibly hire recent graduates (minimum 5 years in practice); possibly develop two groups of professors (1) teach/research (2) clinical – supervision, low on teaching responsibilities
Communication – when and how changes are going to be implemented
Culture demand – not well equipped to deal with Spanish speaking population
Neighborhood complaints
No MAX from FG
• Establish clear boundaries about separation students and clients – parking, congregation areas, etc.

6. Do you expect any changes to occur in your profession’s scope of practice or, standards of practice?

• Movement towards clinical doctorate (OTD)
• Possible change in scope PT could decrease clients for OT but not likely in next 5 years
• Philosophical pushes (e.g., service provided in client’s context/setting); Pacific is pushing that edge between acute care and rehabilitative

7. Describe the culture of an integrated clinic on the new health professions campus.

• New dean can bring in positive culture – currently high level of skepticism, need something concrete and deliverable – affirmation that past has not worked, but looks toward possibility of future
• History of programs being promised new space, if does not happen may be problematic – “not believe until they see it”
• Support going after the vision
• Need proactive, positive people
• Interaction between deans that can build trust between the programs because many are new deans – current is mistrust and potential for withdrawal; want to believe other people will follow through
• Fully respect other programs contributions and abilities – cross-referral
• Optimism for future and boldness for the future—promote the development of an interdisciplinary clinic
• Fosters the idea of interacting with other health professionals from an early stage in the students’ career
• Clients expect and receive high quality care that taps each programs group wisdom
• Integration of classes – if not applied at clinic from integrated perspective, why do it?
• Not willing to accept ‘no’ or conform to current institutional blocks - ex. Not see a client because no insurance, go beyond the usual – not attitude of you owe us – create different model of health care; this is sorely needed in society
• Auditorium needed for integrated classes, conferences, etc.

8. Is there anything we have failed to cover that you believe is important to the process?

• New administration for College of Health Professions – good opportunity to help each other work together – collaboration will potentially increase job skills
• Administrative staff concerns (i.e. reception staff, billing, insurance, liabilities, etc.)
• OT requires a lab in phase 2
• Different emphasis between programs regarding health professional all the time vs. when working in the clinic (wide range of professional attire based on occupation)
• Incoming students will not expect different than what is establish (e.g., dress code)
• Potential for hiring a consultant with experience with the design and set-up of interdisciplinary health clinics – financial limitations possible
APPENDIX F

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?
   • PH1
     o Entry level referral source – see VA Garcia patients
     o Help design/devise referral process through VA Garcia
     o Who/how patient billing – what will the system look like
     o See self as primary source of referrals for other programs
     o 2 students full-time with VA Garcia
   • PH2
     o How will the schools link up? This needs a lot of thought on how will occur
     o How integrate medical records/scheduling/billing - in conjunction with VA Garcia or own entity? Very expensive, maybe link up with VA Garcia
     o I don't see us moving our clinical activities into that new facility – remain with VA Garcia infrastructure because it is already established and integrated in PH1
     o Create a “wellness clinic” as potential integrated clinic – want to be part if preventative services are offered – total patient focus

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?
   • An integrated clinic with an emphasis on health and wellness, preventative services
   • Continue relationship with VA Garcia

3. What is your program’s vision for a clinic on the new health professions campus?
   • Exam rooms included
   • 100% support preventative clinic
   • Component of rotation – not stand alone rotation
   • Couple of weeks in the clinic – 2-3 weeks
   • 1-2 students at a time – possibly didactic
   • Possible for student to use this for their final project – to see clinical outcomes – broad topic – emphasis on quality improvement

4. How does the health professions clinic goal correlate with your program’s vision?
   • Increased interaction between students and faculty
   • Each program will learn more about the other programs – more in depth knowledge
   • Movement towards integrated medical teams
• Increased interaction between programs – common areas, shared educational process, etc.
• Provide increased service to those in need
• Opportunity to integrate classes (ethics, diversity seminars, shadowing across disciplines) if structure is provided
• Continue interdisciplinary case consultation – possibly integrate shadowing between programs – see how they work and actually function
• Applicant students find it a desirable experience, directors ok with the idea, faculty are harder to convince

5. What potential roadblocks do you envision occurring as you work toward the goal?

• Optometry will not relinquish their billing system – probably their record system also
• Language barrier – estimated that 60% population will have Spanish as their first language – issue for both phases – potential for students sent to PCC for interpretation training – become trainers
• VA Garcia does not provide interpreters
• PH1: may be employees of VA Garcia – how will this work?
• OT/PT not experienced at running clinical practices
• Medical records, referral system, and compensation
• Do not want to compete or be perceived as competing with Tuality for patients – both PT & OT currently working relationship with Tuality
• Program administration
• How faculty work together after being stand alone programs for so long – how to integrate?
• Common goal, mission, or vision?
• Will only be as real as the commitment invested in project
• Will the faculty number enough with clinical experience and interest to supervise students?
• Struggle between the programs to establish culture that reflects their current culture – culture may end up reflecting one or two established cultures
• PH2 will be more difficult to establish equitable system for students from different programs

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?

• No – but increasing incoming class size over next 5 years (now 40, 42 next year, 48 incoming class size is 5 year goal)
• Size increase helped by link with Hawaiian students, difficulty is in finding clinical site placements which allow them to integrate into their own communities
7. Describe the culture of an integrated clinic on the new health professions campus.

- 2 cultures – clinic will mirror Health Professions Campus
- Inclusiveness of faculty and students
- Commitment to help
- Services and opportunities to serve divided equally
- Real inclusion of Washington Co. community
- Fairness and equity in programs – in the students and faculties eyes
- Equity in money and equipment provided to each program – allotment of physical space
- Health Professions as separate financial entity from Pacific University’s Arts and Sciences
- Commitment to values and philosophy
- Integrated philosophy that fits with programs, yet maintains autonomy
- Not a hierarchical faculty, currently some are
- A collaborative culture can identify opportunities for each program

8. Is there anything we have failed to cover that you believe is important to the process?

- Grant opportunities are phenomenal
- Needs to be a budget for clinic not each individual program with equitable distribution of revenue between University/CHP and clinic
- Phase 1 was easier, Phase 2 will be harder – thoughtful planning is good
- Good to build foundation first – easier to change in the beginning than to go back – increase awareness and collaboration prior to moving into the new building
- Provides positive role models for the population served
- Enthusiasm for much needed services in Washington Co. – “If we miss this opportunity, we screwed it up”
- Opportunity to learn about other professions, get students and faculty to interact and see what happens, have formal sharing of educational practices in the clinical and classroom arenas, and create integrated teams with understanding or knowledge of other health professions
APPENDIX G

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

   • PH1
     o Case conferences have started
     o Envision role as consultants or advising/counseling
     o Fills a void in rural Washington Co., established partnership with Providence
     o Desire increased communication among professional schools (e.g., scheduling issues to design, room logistics, # of students participating in an interdisciplinary health clinic, etc.)
     o Having to lease outside research space and equipment, ideally would like it located onsite to increase student exposure and faculty opportunities

   • PH2
     o Expect to have issues over space demands of professional programs – Pharm will require double the amount of space currently allotted in Phase 1 or assume vacated space from the Phase 1 building when programs relocate during Phase 2
     o Best to have research facilities onsite, will require wet labs for Professional Accreditation and to support faculty research
     o Design in Phase 1 was not well planned, ideal to have ambulatory care for Tuality on the First floor – should we rebuild Phase 1 during Phase 2 to accommodate program design requirements (e.g., labs)

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

   • Definitely in the same space, but Pharm will not be operating a pharmacy
   • Do not want to compete with the other pharmacies in community
   • Could provide consultation services and may be able to bill for those services
   • Student services require working under a licensed pharmacist
   • Increased interaction beneficial to education for all programs

3. What is your program's vision for a clinic on the new health professions campus?

   • Pharm will not have an in-house pharmacy clinic to train students because not interested in offending existing community providers
   • Also not interested in dealing with the business and financial sustainability aspects of operating a pharmacy
   • Pharm class time would be during 8am-3pm, and interdisciplinary or lab time from 3pm-5pm
• Has a vision late afternoons of interdisciplinary conferences, small group interaction, and shared issues around ethics, professionalism, business, etc.
• Modified block design allows for mastery of content and remediation when indicated – creates difficulty coordinating with programs on different schedule

4. How does the health professions clinic goal correlate with your program’s vision?
• Use of the strategic initiative as the vision or ultimate goal
• Allows for autonomy and individual functioning of each professional school, but patients could really benefit from an interdisciplinary approach to health delivery
• Could provide patient counsel or advise
• Great opportunity for research and publication from integrated Health Professions academic specialties – this is a major benefit
• Provide electives that are open to all health profession students (e.g., drug abuse)
• Could have guest lecture component (e.g., ethics) and then have break-out sessions from that

5. What potential roadblocks do you envision occurring as you work toward the goal?
• Balancing faculty responsibilities and interests, research vs. education/academics
• Difficult to schedule around the programs different structures (e.g., blocks, rotations, or terms) – this will complicate integration and cross teaching opportunities
• Student culture – requires more professionalism, in the clinic and in the classroom; may require some formality, but more professionalism and respect
• Must be student focused – not profit driven
• Phase 1 has gone too fast and was driven by upper administration, directors had insufficient time and request for input
• Providing information is good, but there is value in the collaborative exchange of information
• Lab space and financial support
• Some professional programs made significant concessions that were unfair (e.g., no lab space and OT and Dental have shared class space – OPT could have made more and been more accommodating
• Space is a major issue – Phase 1 and 2
• Not all deans and directors are fully supportive of the effort
• Pharm has half the space needed and minimal space compared to other programs
• Not moving OPT into Phase 1 would have been good, feel OPT muscled way into Phase 1 and displaced other programs
Likely to have the same problems which occurred in Phase 1 – OPT will demand substantial space, student space will be lacking, parking will be lacking, etc.

Process was rapid and increased involvement will improve the outcome

Process will benefit from the planning process, which should be more open and allow more go between time

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?

- OSU is competing program, designed to fill rural void
- Increasing pull away from dispensing and draw toward patient care and consultation
- Increasing interest in applied application of pharmaceutical skills
- Technician replacing traditional pharmacist role
- Professional role is expanding – includes drug delivery, prescription recommendations, consulting professionals, etc.
- Shortage of pharmacists in institutional settings predicted, strengthens connection between the pharmacist and the provider
- Do not expect expansion of Pharm program beyond additional rotational sites
- No curriculum changes expected
- Would like to see the addition of a Master’s in Health Care Administration – this program could be housed under Pharm or, more appropriately, under the School of Health Professions

7. Describe the culture of an integrated clinic on the new health professions campus.

- Mutual value of social and professional interactions
- Provides life to the College of Health Professions
- Each program has their own identity, but invested in an interdisciplinary health clinic as a means to educate

8. Is there anything we have failed to cover that you believe is important to the process?

- None at this time
APPENDIX H

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

- PH1
  - The details have never been articulated how this process will work
  - What is the strategic plan?
  - What is the structure of an interdisciplinary clinic?
  - How will the clinic be administered?
  - Present how this process will move from concept to reality
  - How will the clinic be advertised? Why come to a clinic such as this? Where will referrals come from?
  - The concept of the interdisciplinary clinic needs to be concretized in such a way that (1) first determines who is primary provider for the client, (2) explains how the other disciplines will be involved in treatment, (3) how each discipline will be reimbursed, (4) how this process will be carried out
  - Currently have interdisciplinary case conferences
  - Proximity provides for cross-fertilization and collaborative projects — a natural consequence (e.g., compliance with dental care and psych, student lounges are shared, faculty consultation, and small scale team teaching like ethics or research)

- PH2
  - Grow faculty to improve faculty to student ratio
  - Need auditorium—mistake if not included, will limit symposia and impede cross-disciplinary fertilization
  - Architecture is important
  - More clarity on how interdisciplinary clinic would work
  - Unclear as to who moves in — SPP will retain PSC as primary training facility and moral commitment to population services
  - Increased number of lounges or size (consider location) to facilitate integration between different program students
  - What is the time line? 2008-2011?

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

- Interdisciplinary is the goal, but is only a concept which may not come to fruition
- The concept is based on the strategic plan from 2004
- Concept is unclear, does not specify what it means regarding structure — abstract idea is interesting
- Phase 1 of the process included independent initiatives from some programs to establish a clinic (psych, dental, optometry, PT?)
• Medical facility ultimately wants control of the integration (e.g., Virginia Garcia, Kaiser, Tuality, etc.)

3. What is your program’s vision for a clinic on the new health professions campus?

• Preventative care focus (psychoeducation, healthy living, medication consultation)
• More collaborative – proximity will facilitate the exchange of ideas and the potential for collaboration on projects, ex. – Dental and psych = psych can help to increase compliance
• If provided the proper structure faculty collegiality will increase
• Enriched experiences for students
• Increased knowledge of other professions can help increase the incidence of referrals for additional patient care
• The students will be better clinicians because will begin to think about and understand other dimensions of the patients life – until the clinician works in the medical field they may not understand the additional options available to the patient to increase quality of life
• The new clinic will not supplant existing clinics or rotations, but instead will provide additional practicum placements
• One rotation can be consultative in nature – provide preventative care, ex. – Skills training, parent training

4. How does the health professions clinic goal correlate with your program’s vision?

• Professionals operate in a large world and the interdisciplinary clinic can provide the opportunity to interact with other professionals and to observe pathology as it relates to other fields
• Provides stimulating work for the students
• Consultation role for each program – improve overall care for the client
• Allows care for those who can not typically get help
• Must translate the concept to an actual thing, skeptical this will occur

5. What potential roadblocks do you envision occurring as you work toward the goal?

• Individuality according to accrediting bodies
• Who owns the client?
• Budget? Reimbursement?
• Documentation
• Administration – mission? Suggest preventative or must defer to medical doctor model
• Staffing issues
• Overkill of services – will the clients be willing to go through full assessment?
• Architecture – how do you get the client from A to B to C
• Will clients be willing to go from one clinic to another
• How formal will the students be in non-clinical settings, ex? – Going between classes or in the lounges
• How to get the different disciplines to agree on one vision
• Funding source
• How will the relationship with VA Garcia be maintained? Could be a very complex relationship
• The training models vary in each program – other programs often have specialty rotations rather than a practicum placement
• “Devil is in the details”

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?

• SPP program will continue to grow in faculty to improve the student to faculty ratio – over 3-4 years by 25
• Program size will not likely grow much, PsyD is capped

7. Describe the culture of an integrated clinic on the new health professions campus.

• Collaborative
• Proximity will facilitate exchange of ideas and cooperation if provided with appropriate structures
• Programs must be allowed to maintain independence while fostering integration – up to the new dean
• Individual programs are driven by accrediting programs and not all programs are independent practices
• Enhanced learning environment
• Possibly multi-class faculty – teach in several of the programs; each program context specific, so some difficulty could be encountered in establishing
• Interdisciplinary case conferences open to all programs
• Cross-fertilization
• Often affiliated with hospitals and Dean of Medical School administers

8. Is there anything we have failed to cover that you believe is important to the process?

• Recommend look at models of already established clinics, plus those that failed
• What is the aim of the interdisciplinary clinic – proactive approach to treatment as opposed to reactive? Preventative vs. curative? The concept has a better chance as a proactive clinic.
• What is affiliation with hospital? PA not independent practice – will be under the supervision of MD. What will relationship be between medical profession and Pacific programs? Who controls what?
• Factor in new deans agenda – (1) develop new programs, (2) work with existing programs - maintain individuality and at the same time foster interaction among all of the programs
• Architecture is important – large auditorium required in Phase 2, should have happened in Phase 1
APPENDIX I

1. What do you see as the stages or phases involved in the development of an interdisciplinary health clinic?

   • PH1:
     o Disappointed not an interdisciplinary clinic until PH2; thought interdisciplinary clinic was main reason for move
     o Current mixed lab and classes not the best fit; no anatomy lab space – combined in 1 room is not ergonomic; new facility allows us to upgrade curriculum with spine manipulation – unsafe previously, now will have proper rooms to provide the training; currently barely OSHA standards
     o All deans and directors on the same page – must believe in interdisciplinary project for successful PH2
     o Good preparation for PH2
     o Start the planning for PH2 now using the knowledge of what worked and what did not work in PH1 – considering which programs did not receive adequate space originally or will grow in the future
   
   • PH2:
     o Architect – the faculty needs to be involved in this process prior to any decisions about space allocation, the faculty were involved much too late in PH1 and had to explain why allocated space would not work
     o Questions if enough student “green space” was allotted, loss of university benefits
     o Want to avoid “here is what you have to work with”
     o Interested in making the vision a reality
     o Architect does not have specific knowledge of the needs of every program placed in building – consult with deans and directors
     o Larger facilities with a fitness center (educational support provided) and anatomy lab
     o Addition of OPT

2. Is a multidisciplinary or an interdisciplinary health clinic the goal at the health professions campus?

   • Interdisciplinary
   • Could include team meetings, cross appointments among faculty (hybrid professions), course sharing (e.g., evidence based practices)

3. What is your program’s vision for a clinic on the new health professions campus?

   • Initial vision is not represented by current circumstances
   • Interdisciplinary case conferences
• Not typical PT services, health and wellness/preventative care emphasis — fitness center for community and students (e.g., diabetes, high blood pressure, etc.)

• Contributes to the educational process
• Cross-fertilization
• Closer proximity will hopefully promote better interaction, not necessarily though
• Increased interaction between faculty and students
• No change in clinical practice for majority of rotations, but one to two students would work in interdisciplinary clinic — consultation, preventative care, nutrition, etc. — currently Tuality takes students on rotations
• Shared classes (e.g., empirically based treatments, ethics, pharmacology)

4. How does the health professions clinic goal correlate with your program’s vision?

• Students see how other services can benefit patient
• Become more attuned to population that does not typically receive services — through VA Garcia and community
• Faculty could teach multiple classes to varied programs — promotes idea that we are all in this together, ex. — Ethics, enrich discussion and provide insight into other programs
• Provide services that are not typical PT — more involved in preventative care — must provide something different than Tuality which just down the street
• Holist care and prevention located in one building — health and awareness center created for an underserved population is not the usual focus
• If faculty involved in clinical work it can provide observational learning
• Tuition based now and an interdisciplinary health clinic would increase opportunities for grants

5. What potential roadblocks do you envision occurring as you work toward the goal?

• College will have to have a budget — each program supply portion of individual budget? Difficult equity because there is more money associated with pharmacy and dental practices
• Adding an additional layer of staff and faculty — consider expense
• Any delays in PH2 based on changes in participation, etc.
• Finances, cost of administrative staff
• Courses focused on integrated practice must be provided prior to opening an interdisciplinary health clinic
• PH1 not planned well — potential for lack of room to expand in PH2 which could create competition between the programs; good rapport now that could easily deteriorate in competitive atmosphere — “anticipate battle”;
able to avoid conflict in Phase 1 because some programs made significant accommodations

- Some faculty feel alienated due to the speed of PH1
- Lack of space/planning in building
- A program unwilling to budge on sense of total autonomy – can remain autonomous while participating as part of whole
- Most programs are used to having their own building and must either give up or share resources/space with other programs (i.e. flexibility)
- Difficult already due to scheduling and accommodations
- Not all faculty are required to maintain clinical practice – supervision interdisciplinary clinic
- Concerned programs will not interact without focus, scheduling, etc.
- Will PT contract directly with VA Garcia – not sure how will work

6. Do you expect any changes to occur in your profession’s scope of practice or standards of practice?

- 1993 OR granted direct access to PT which was the reason to move the program to a doctorate program – previously a patient needed a referral from an MD
- Access still limited due to insurance companies – still require MD referral despite law granting direct service
- Medicare considering paying for direct access to PT
- Direct access will have impact on the current curriculum – additional classes will have to be added that focus on increasing screening skills, evaluation methods, medical techniques, and the recognition on when to refer out
- Additionally, the Balanced Budget Act of 1998 (moratorium placed on $1,500 limit for PT work) may be rescinded, creating economic hardship for many PTs
- By 2020 all states will have direct access to PT
- The new facilities will allow the program to include spine manipulation to the curriculum
- Incoming class projected to rise to 36-40 students, minimal growth

7. Describe the culture of an integrated clinic on the new health professions campus.

- Team meetings for faculty
- Stronger collegiality
- Strong student interaction – between programs in comfortable settings
- People belong to college and not individual programs – part of something larger than just an isolated program
- Use of other program’s faculty; cross fertilization

8. Is there anything we have failed to cover that you believe is important to the process?
• Great opportunity for grant writing – could move clinic away from tuition dependence
• Phase 1 pace was too fast, Phase 2 should include more planning
• Allow more “buy-in” time, Phase 1 alienated some faculty – due to pace of Phase 1 many decisions were left to the directors without time to consult their staff
• The faculty should be included in almost every aspect of the project
• Cadaver room/anatomy lab a must in PH2, current cadaver room on the Pacific campus will not be OSHA compliant in a few short years – ventilation system, even though a must have for program anticipating a fight
• Need a fitness center in PH2 to provide some preventative care