A Qualitative Investigation into Behavioral Health Providers Attitudes Toward Interprofessional Clinical Collaboration

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Abstract

Interprofessional clinical collaboration (IPC) is an approach in which healthcare providers from different professions work to collaboratively improve health outcomes for patients. Limited research exists on behavioral health provider's attitudes toward IPC. This qualitative study included 32 participants with results highlighting two major themes: (1) benefits (to the profession and client) and (2) collaboration (collaboration experience and consultation). Finally, a strengths, weaknesses, opportunities, and threats analysis was used to operationalize the findings and develop implications.

Introduction

Interprofessional collaboration (IPC) is defined as "a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues" [1].(p.58) The core concept of interprofessional collaboration is the construction of a respectful and trusting team of professionals that integrate the perspectives of each discipline into a collective action that addresses the complexity of client needs [2]. The interprofessional model focuses on measurable outcomes, best practices, and cost containment [3]. Since the late 1990s, there have been many studies addressing how healthcare providers feel about interprofessional collaboration, because their attitudes and perceptions have been found to be important in whether or not IPC is successful [2]. Amongst these many studies, missing is information on the attitudes and perceptions of behavioral health providers. With the

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increasing call for mental health providers to be included on interprofessional teams, it is imperative that these missing voices are included in the research on IPC [4, 5].

Behavioral Health Providers and Interprofessionalism

Since 1974, teamwork has been the recommended approach for providing care and has had political movement toward making this approach the standard of care [6, 7]. In 1981, the Harding Report established interprofessionalism as the most effective way to provide quality and complete patient care [8]. When teamwork was first recognized as an effective method, mental health specialists were included, theoretically on these teams [9]; however, in practice, this did not occur frequently. With renewed interest in mental healthcare and improving the quality of care to patients, there is a call for behavioral health providers and other mental health professionals to join interprofessional teams [4].

Healthcare professionals, including behavioral health providers (BHP), recognize that interprofessional collaboration is the best and most comprehensive strategy to address major issues, such as chronic diseases and co-occurring medical and mental health issues [10–13, 7]. It has proven to be difficult and expensive to attempt to address such complex health issues in silos; thus, IPC has become a favorable approach [10]. Currently, behavioral health providers are collaborating with families, communities, and healthcare professionals in an effort to increase service availability and to provide more extensive care and services [14–16]. By collaborating with healthcare professionals, behavioral health providers are a part of a team ensuring that clients are provided better quality and more holistic care. In addition, behavioral health providers are also helping minority clients by addressing discrepancies within the healthcare system and in working toward healthcare equity [17]. Ultimately, BHP are actively expanding the scope of their services and furthering their professional competency [5]. One of the major advantages in the behavioral health profession is the training and comfort level with diverse populations. Interprofessional teams are typically diverse, made up of professionals from various disciplines with different roles and responsibilities, requiring high-level communication skills. IPC is a natural fit for behavioral health providers and an ideal care environment that will utilize their default training and skill to improve the quality of care for clients [18].

Benefits to Providers

According to the research, embracing interprofessionalism has several benefits for behavioral health providers. It will help them to become well rounded, acquire new skills, broaden their scope of work, and increase their competency [19]. Collectively, interprofessional education (IPE), which is the act of educating health professionals out of silos and providing opportunities for them to learn, collaborates together while in training programs, and IPC produces similar beneficial outcomes, such as intra-professional communication, mutual respect, increased levels of confidence, improved psychological well-being, enhanced job satisfaction, increased knowledge, more professional opportunities, and increased awareness [20, 21]. In terms of professional identity, it has been highlighted that IPC strengthens professional identity [22], perspectives on mental health are broadened, and more optimistic views are supported [23].

Benefits to Patients

In addition to the benefits experienced by the professionals, the patients benefit tremendously from receiving collaborative care. One of the most apparent benefits of interprofessional collaboration is that the patients receive holistic care [24]. The patients are able to receive holistic care because the professionals involved in IPC are able to gain more information about the patient and can better help them with multiple complex health concerns. IPC increases the efficacy and accuracy of the professionals' case conceptualization, treatment plan, and the provided services

[24]. In including behavioral health providers on interprofessional teams, access to mental healthcare is expanded, quality of life for patients is increased, and a reduction in mental and physical symptoms have been noted [24].

The purpose of the current study was to conduct a preliminary investigation focusing on behavioral health providers' attitudes toward interprofessional collaboration in clinical settings. Recent healthcare trends are leading to an increased call for behavioral health providers to collaborate on interprofessional teams; however, to date, there is limited knowledge on behavioral health providers' attitudes toward interprofessional clinical collaboration. This qualitative investigation sought to add to the limited research on behavioral health providers and interprofessionalism by answering the following research question: What are the attitudes of behavioral health providers who are engaged in interprofessional clinical collaboration?

Methods

Research Design

As an exploratory study, a qualitative design was employed to gain an understanding of the attitudes toward interprofessional clinical collaboration from behavioral health providers. A qualitative methodological approach is appropriate for this research question because limited information exists in this area of interprofessionalism with behavioral health providers [26]. The institutional human subjects review board approved this study in the summer of 2016 and recruitment began shortly after for 30 days. The detailed procedures will be further explained below.

Sample

Recruitment specifically entailed posting on a multidisciplinary professional behavioral health listserv in an attempt to seek out participants with a strong professional identity. A flyer describing the study was posted on the listservs twice within the 30-day period. Thirty-two out of forty-two participants who indicated an interest, completed the study, which is a 76% response rate. Demographically the participants included women ($n = 21$), White American ($n = 16$), Black American ($n = 14$), and mixed race ($n = 2$). Ages ranged 21–31 ($n = 14$), 32–42 ($n = 15$), and 43–60 ($n = 3$). All participants held a master's degree or higher and practiced for 3 years or more in the fields of social work/medical social work ($n = 12$), professional counseling ($n = 9$), psychology (educational psych, clinical, and school; $n = 5$), behavioral health provider ($n = 2$), child and youth interventionist/ABA ($n = 2$), alternative therapy provider ($n = 1$), and director of behavioral health ($n = 1$) in the USA.

Data Analysis

Data analysis was conducted using a qualitative methodology approach, a software program to organize the responses, and the six-phase method of inductive analysis [25] to guide the data coding and reporting process. The research team consisted of an associate professor and three doctoral students. The six step process for data analysis is described below:

Step 1: familiarization with the data. The process of familiarization took 45–60 days and included collecting responses from the survey, organizing the responses into separate documents, reading and re-reading the separate transcripts; step 2: generating initial codes. Initial codes were generated through open coding, simultaneously with using a computer software program for organizing the transcripts and generating additional initial codes; step 3: searching for themes. The computer software program MAXDQ was used for step three. This software allows the user to sort through initial codes, digitally place initial codes into categories, and manually generate themes; step 4: reviewing themes. After the themes were generated using MAXDQ, the research team

reviewed the themes and collaborated to refine the themes. A thematic map was developed (Fig. 1), which portrays the development of initial ideas into codes, patterns and then subsequent themes. Step 5: defining and naming. The research team collaborated on defining and naming the themes, through discussion, and three rounds of refinement. Step 6: producing the report. The final step in the process led to all researchers agreeing on the themes and patterns, which answered the research question and highlighted two major themes: (1) benefits and (2) collaboration. The auditor was consulted during steps 4–6 as needed.

SWOT Analysis

Upon completion of the data analysis, it was apparent that the emerging themes provided sufficient implications for behavioral health providers utilizing IPC. In an effort to organize these themes and provide practical implications, an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) [29] was facilitated. This is a tool that helps the researcher focus in on key elements of the study. This tool is well known for its practicality and for being a powerful and successful technique [30, 31]. It not only lists desirable and undesirable descriptions in the four quadrants; it also helps the researchers better understand how strengths can be capitalized to create new opportunities and how weaknesses can be prevented to further eliminate threats and confinement in the field [32]. The researchers developed a table that presents the SWOT analysis (Table 1).

Trustworthiness and Rigor

Trustworthiness and rigor are essential for quality research; several steps were used to enhance trustworthiness and rigor throughout the data analysis process. First, potential biases prior to data collection were identified by bracketing assumptions about the research study topic. Member checks were used in the data collection process by inviting participants to review their typed responses and to make any changes for accuracy or change of thought; however, no participants responded with changes. An outside auditor uninvolved in the project agreed to review reflective journals and themes as they were generated. The auditor is an associate professor of social work at a research one university. The consensus coding meetings also served as a form of investigator triangulation [27]. Finally, using thick descriptions and representative quotes from participants [28] allows the readers to make decisions about the transferability of the findings.

Results

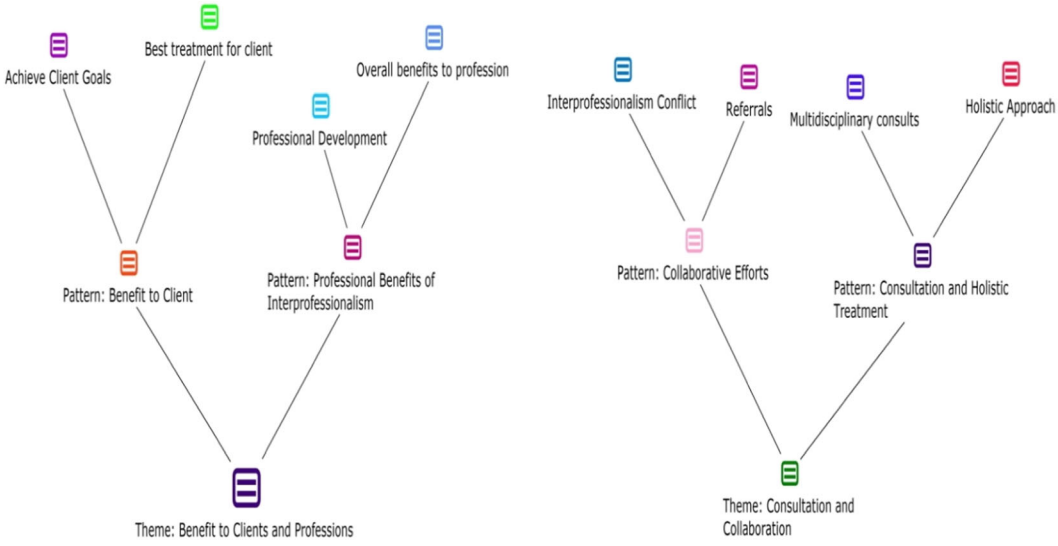
Upon analyzing the data, the qualitative software identified common patterns and assisted in naming the themes regarding behavioral health provider's attitudes toward interprofessional clinical collaboration. The following is the description of the two major themes: (1) benefits (subthemes: to the profession and client) and (2) collaboration (subthemes: collaboration experience and consultation). The thematic map is helpful in visualizing the data and the pathways to themes (see Fig. 1).

Theme 1: Benefits

Behavioral health providers (BHP) describe interprofessionalism as being a benefit to the clients they serve as well as the profession. This theme was supported by 81% of surveyed participants within two patterns: (1) benefits to clients and (2) benefits to the profession.

Benefits to Clients BHP noted the increased ability to provide holistic care, improved quality of care, address mental health concerns completely, and the cost savings for clients with bundle

Figure 1
Emerged themes



payments and other incentives. Overwhelmingly, BHP reflected on collaboration being the pathway to providing the best quality of care which is reflected in outcomes for patients. Noted by a BHP,

> It contributes to the success of our patients outcome from treatment; if we do not collaborate interprofessionally we set our patients and clinic up for failure. We have weekly meetings that soley revolve around interprofessional collaboration and successful treatment practices that ensures a great outcome for the patient (p 32).

That sentiment was reiterated by several others, "Collaborating with other professionals allows clients to receive the best treatment" (Participant (p) 31), and "Through collaboration, I am able to provide more adequate treatment to my clients" (p 93). Another BHP, focused on cost and time savings for the client and for the staff at the clinic,

> We have a service now where you can almost pay one fee, and you get a team to help concerning mental health, chronic pain, and other members, etc; it turns out cheaper for the client and the doctor can move quickly to the next patient while I sort out other needs, maybe mental health maybe not (p 21).

Above the BHP focused on the benefits based on clinic setting, others conceptualized benefits based on the population served, placing an emphasis on engaging in interprofessional collaboration to coordinate care and maximize effectiveness for children and their families. A few participants mentioned this through statements such as "Interprofessional collaboration is essential for our child and adolescent populations" (p 14) and "We work together to coordinate care for children to maximize the effect of all providers" (p 8).

Benefits to the Profession Most noted the ability to learn from different professionals which assisted in their growth professionally, strengthening professional identity, and confidence. Some examples of reflections in this area include, "I grow tremendously when working with other mental health professionals" (p 5), "working with other professionals adds to my tool belt" (19), and "It also provided more information about the clients to allow for a better conceptualization of the case" (p 23). Professional growth and how it impacts clients were noted frequently with BHP discussing how working in interprofessional environments assisted in the development, enhancement, and refining of specific counseling skills (i.e., CBT, solution focused), clinical skills (i.e., assessment, diagnosis), or in acquiring

new skills like increased general medical knowledge, specific mental health knowledge, and better case conceptualization skills and practice.

Others noted benefits including building mutual respect, increased salary when working in hospital settings, elevated prestige of the profession of "counseling," decreasing burn out, increased flexibility, excitement because of the variety of cases and exposure to different ailments, and a facilitation of inquisitiveness and renewed interest in the profession. In terms of prestige someone noted, "It felt prestigious being a part of that team. I had my license they had their license and we were all at the table finding answers to complicated issues" (p 21).

Noteworthy was this response on earning potential, "There is a potential to get paid an increased rate…. my position is at a hospital being at a hospital in that setting I was paid more than the CSB [community service board]" (p 27). Another noted respect and earning potential in one quote, "Even though they had white coats, we were all respected and paid well for the jobs and titles we earned" (p 1). In summarizing a professional journey to licensure and as the BHP notes, their "niche", they expressed how beneficial an interprofessional setting was even as a novice BHP and throughout their career span:

> Working in interprofessional settings as a qualified mental health professional with a bachelor's degree, I was encouraged by psychologist, psychiatrist, and others in mental health to seek a master's degree and become a licensed professional counselor; after ten years as a LPC I also sought a masters of public health. Supported and they helped me pay for it through a rural health program. I've built a specialty niche for myself and am telling people about the opportunity now (p 30).

The exposure to different professions for p 30 was instrumental in their professional development as a behavioral health provider. Having the support and combined knowledge of different specialty groups provided access normally only available in higher education settings. However, the interprofessional setting was the incubator for professional and educational development.

Theme 2: Collaboration

Collaboration theme was noted by 73% of surveyed participants and included two subthemes: (1) collaboration experience and (2) consultation. The theme is supported by quotes that describe the history of their experiences in interprofessional environments and motivation for consultation/collaboration.

Collaboration This included a lot of information related to BHP experiences with specific professionals in a broad range of areas, including school, judicial, hospital, and clinic settings with a diverse range of professionals that include family physician, internist, psychiatrists, counselors, social workers, psychologists, case managers, judges, chiropractors, yoga and meditation instructors, spiritual growth coaches, and probation officers. When discussing the professions they have collaborated with, the participants noted that within this collaboration, they would often meet to discuss their roles on the team, discuss their cases, and create and execute treatment plans. In reflecting on some of the barriers to collaboration participants noted a diverse set of issues they have encountered. Several participants noted financial barriers, "I believe they have [collaboration experiences] worked out well but money was more of an issue than our professional differences" (p 32); others noted their view on the differences which led to less collaboration, "As a counselor, my view on health and wellness differs somewhat from the psychologist, …As such, we don't really collaborate either" (p 17). A less noted barrier included issues at the national level,

> I wish the professions could get along better at the legislative and professional level. In-fighting amongst the professions is a complete waste of time. There is a false belief that if one profession advances, it is at the expense of the others. There are enough clients for everybody" (p 15).

Consultation Motivation for consultation efforts as well as the importance was the main focus of this subtheme. Some participants noted that they consult inter and intra professionally, as that allows them to provide holistic care and continuity of treatment. The idea of a holistic systemic approach was continuously mentioned and deemed favorable. In addition, treatment planning and treatment teams, in order to achieve the clients' goals and needs, were reflected throughout. One participant mentioned their belief in consultation and the importance of considering alternative treatment methods, "Because I believe in consultation and client autonomy and cultural competence, I feel it is important to consider "alternative" treatment methods but I also value psychopharm management when needed" (p 29). While many used the term "consultation," it was noted that only a few discussed the traditional triadic consultation relationship. One unique consultation relationship described a BHP working at a medically underserved clinic in a rural area,

> I engaged in consultation when needed. In rural clinics every specialty may not be readily available, this is a fact that I face every day. When this occurs I consult with people I need on site, or off site, using telehealth…… Most recently I had children from El Salvador who experienced a lot of trauma but they were initially there for asthma and one child had unmanaged diabetes. The entire family had trauma, I reached out to a child psychiatrist who specializes in the care of children from a lot of Spanish countries they were 400plus miles away and I set up meetings on the computer (p30), which helped tremendously in helping me form a broader treatment plan.

SWOT Analysis Results

The emerging themes create implications for interprofessional collaboration within the behavioral health profession. In order to organize implications for clinical practice, an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) was conducted [29] (see Table 1).

Table 1
SWOT analysis

Strengths	Weaknesses
• Provides opportunities for professional growth • Allows differing perspectives on client case • Enhances clinical care and increases access to community resources • Client needs that are beyond the scope of practice of one professional can be addressed by another. • Client outcomes are enhanced.	• Requires the willingness of other professionals to engage in the process • Requires knowledge of community-based resources in order to effective treatment plan or make referrals • Requires time and effort on the part of the professional
Opportunities	**Threats**
• Creates learning opportunities for professionals beyond post-secondary education • Professionals experience opportunities to better conceptualize cases. • Opportunities to develop professional relationships arise. • Holistic care provides opportunities for clients to maintain continuity of care from one service to the next.	• Interprofessional collaboration is not always supported on the legislative or political level. • Financial consequences of referring out to other professions can deter professionals from engaging in IPC. • Differing opinions on a client issue can discourage IPC.

Discussion

Some results of this study are consistent with prior studies, including behavioral health providers find value in interprofessional collaboration, they are engaging in these experiences in various roles, and they appreciate the experiences of working with diverse professionals with a shared goal of supporting clients [5, 7, 10, 12, 13]. While there were some points of contention, overwhelmingly, behavioral health providers in this study found interprofessional clinical collaboration as beneficial to their own professional development and to clients. This mutually beneficial theme is important because it can be motivation to engage in interprofessional collaboration even with underlying hesitancy or confusion [5]. Behavioral health providers were able to identify several benefits to the profession, and many of the benefits overlapped benefits to the profession that were previously identified, including enhanced communication, mutual respect, confidence, and increased knowledge [21]. However, benefits not readily found in other literature included personal incentives, such as financial benefits or perceived prestige, educational advancement opportunities with special programs (i.e., rural health provider development programs) and facilitation of inquisitiveness and a renewed interest in the profession. These findings are interesting in that the benefits are directly related to personal growth and development (i.e., financial or educational). In working to encourage behavioral health providers to be a part of interprofessional teams, it may be potentially important to mention not only the benefit to clients but also personal benefits such as increased earning opportunities or educational incentive programs. While apparent in less than 10% of the comments, interprofessional clinical collaboration is not fully understood, with many confusing co-location of multiple healthcare services, consultation, and true interprofessional collaboration; however, behavioral health providers were still able to identify and recognize the benefits of working collaboratively.

Another interesting finding in the current study was the variety of experiences behavioral health providers have had and who they have had contact with interprofessionally while practicing. Similar results were found in a quantitative study [5], specifically that some behavioral health providers identified working in some capacity every week with professionals from other healthcare disciplines; however, current findings expanded that finding with more detailed information on who the professionals are (i.e., psychiatrist, yoga instructors). In the current study, behavioral health providers highlighted working with other behavioral health specialists, alternative medicine professionals, and general medical health professionals (i.e., nurses and medical doctors). These experiences are interesting and have not been highlighted in other studies that look at behavioral health providers experience with interprofessional clinical collaboration. The current study also expounds what was conceptualized as collaborative relationships behavioral health providers could have, which was specifically conceptualized as collaboration in medical settings with physicians and nurses [26]; the current study has found that behavioral health providers have had experience with a variety of professionals in many different settings to include judicial settings.

While the findings were eye opening in terms of adding to the current research on who behavioral health providers collaborate with and their attitudes toward interprofessional clinical collaboration, it is clear that some clarification on what interprofessional collaboration is is still needed. Many respondents confused consultation with interprofessional collaboration, so much so that it became a theme supported by 70% of the participants surveyed. This is a small sample, but this confusion with consultation and collaboration is important to note. Understanding interprofessional collaboration is important in maintaining strong relationships with your healthcare counterparts and developing positive working relationships when engaged in interprofessional collaboration [33]. Consultation is distinctly different and includes a triadic relationship in which one person is the expert; interprofessional collaboration is distinctively different and posits that no one person on the team is the "expert" that instead everyone can contribute equally to treating the patient [34]. In real work settings, if behavioral health providers are confused as to their role on

interprofessional teams because they view this as a consultation relationship, that can cause behavioral health providers to role conform, not speak up, or not be valued on interprofessional teams [35]. If behavioral health providers do not understand their roles on these teams, it will be difficult for them to explain their roles on these teams to other professionals, who as another study found may not understand the role of behavioral health providers [19]. On interprofessional clinical teams, it would be imperative for behavioral health providers to not only understand interprofessional clinical collaboration but to also be aware and knowledgeable of the competencies that guide these teams [22, 26].

The SWOT Analysis

The SWOT analysis is used to provide clarity and to assist with the implications for clinical practice. The analysis found behavioral health providers identified strengths and opportunities related to interprofessional clinical collaboration including opportunities for professional growth, different perspectives, the enhancement of clinical care, increased access to resources, professionals working together to address all concerns, and enhanced client outcomes. The current literature consistently states that IPC is the most effective way to provide comprehensive care, in an effort to enhance clinical care, address all client concerns, and improve client outcomes [7, 11]. Implications for clinical practice based on the strengths and opportunities would include increasing access to continuing education in the area of interprofessional collaborative care [21]. There are several resources available that provide information on and training in the area of integrated behavioral healthcare and interprofessional collaboration, such as the substance abuse and mental health services administration (SAMHSA—https://www.samhsa.gov) and IPEC competencies discussed and explored in the context of mental health education [26].

While the literature has found similar benefits to the current study, there are also similar weaknesses and threats. The current study found that some of the weaknesses and threats that arise include the following: lack of willingness to engage, funding, time, and effort. The time required for interprofessional efforts is heavily noted as a major barrier to collaboration [18]. Many professionals are hesitant to engage in interprofessional efforts due to the amount of change, effort, and commitment it entails [14, 18]. Reimbursement was also noted as a threat to IPC, with many states trying out bundle payments for medical health providers and few with established protocols for all of the many different behavioral health providers. Although weakness and threats exist which cause barriers to IPC, it is noted in the literature that education and advocacy efforts related to how important collaborative care is and the impact on clients can help alleviate these barriers [26, 36].

Implications for Behavioral Health

Behavioral health providers have identified interprofessional clinical collaboration as important to clients, and they have demonstrated their knowledge in this area of healthcare. While a bit of confusion is present, overwhelmingly, the framework is understood along with the benefits and barriers. The current study has several implications for behavioral health providers; however, based on the findings, the two areas that resonate the most include education and advocacy. Interprofessional education (IPE) involves two or more disciplines being educated from and with each other during their graduate healthcare programs. Educationist have identified how to incorporate the interprofessional competencies in behavioral health education [26], and there have been a few studies with behavioral health providers in these interprofessional courses with positive outcomes [20, 37]. Therefore, a framework and examples exist for interprofessional education in behavioral health education. For behavioral health providers who have completed their education,

it will be important to seek out continuing education opportunities in the areas of interprofessional clinical collaboration.

Some of the other identified barriers including funding and advocacy are important implications, and it is recommended that behavioral health providers continue advocacy issues at the legislative, state, and regional levels. An assessment conducted indicated that collaboration and integration are accepted by healthcare providers, yet it is continuously influenced by structural barriers. [38] Some of the structural barriers have been noted in the current study and in the literature, with positive strides being made to minimize the structural barriers. Several advocacy efforts and changes in policy, such as the 1981 Harding Report and The Affordable Care Act, have already started to positively impact the behavioral health field [8]. These advocacy efforts have helped to establish interprofessionalism as an effective method, increased funding, developed integrated care programs, and help to change reimbursement. It is evident that progress has been steady and there is still work to do in the area of bundle payments, conceptualizing behavioral health providers' potential role in hospital settings and expansion of the role in one of the largest healthcare systems, which is the veteran health administration. The Veteran Health Administration is the largest integrated healthcare system serving 9 million enrolled veterans every year; however, many behavioral health providers are not recognized as mental health providers (i.e., professional counselors) [39].

Limitations

With all studies, there are limitations. The primary weakness included using an Internet-based survey. This format was used to allow respondents time to think and reflect on their experiences in interprofessional clinical collaboration. The approach to using Internet-based surveys in this way has been researched, and it was found to be beneficial for participants [40]. However, in using this method, there is an inability to assess nuances gained from live interviews, such as non-verbal's and inflections in voice [40].

Future Research

Based on the current findings, future research is suggested to expand and clarify findings. Namely, it will be important to investigate the confusion between consultation and interprofessional collaboration and whether or not this confusion interferes with behavioral health provider's ability to be successful on interprofessional clinical teams. Future research should look into how different professional groups conceptualize interprofessional collaboration and if the different conceptualizations have an impact on client outcomes or care. In addition, face-to-face qualitative interviews with behavioral health providers engaged in interprofessional collaboration are needed to explore some of the weaknesses and threats that were found in the current study. A phenomenological study exploring behavioral health providers' lived experiences with weaknesses and threats to IPC is important in understanding how these professionals overcome barriers to engage in IPC.

Conclusion

Although further research is required to gain a more complete understanding of the relationship between behavioral health providers and interprofessional collaboration, the current study identified new elements that could benefit BHP's and future engagement in IPC. The past and current literature on interprofessional collaboration suggests that behavioral health providers collaborate with other professionals in order to provide timely and holistic care to patients, and the current study found that while this is true, other motivations include personal and professional

growth [7, 11, 12]. Interprofessionalism is not without its challenges, as conflicts between the various professions can often create a barrier to interprofessional engagement. However, despite its challenges, many behavioral health providers within the current study noted that interprofessionalism has significant benefits and they were actively engaged in interprofessional collaboration.

Compliance with Ethical Standards

The institutional human subjects review board approved this study in the summer of 2016.

Conflict of Interest The authors declare that they have no conflict of interest.

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