Navigating Cultural Differences in Interprofessional, International Service-Learning

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Abstract

Interprofessional international service projects provide the opportunity for health professional students to explore cultural and interprofessional differences while working collaboratively in a community setting outside of ones' familiar environment. Discussion of this topic highlights the importance of cultural competency on multiple levels. In addition to understanding differences related to health service delivery systems and health beliefs in an alternative culture, recognizing the diversity of values among professions with different expertise can create a more client-centered approach to care and effective rapport building among colleagues. Student performance of interprofessional service-learning in Nicaragua and review of the literature on cultural differences provide the opportunity to explore dissimilarities in professional values among American interprofessional health teams and the local beliefs and expectations of the Nicaraguan health care system. The purpose of this article is to enhance professionals' understanding of cultural considerations of health care delivery systems and to offer insights and suggestions to navigate cultural differences among health professions with the aim of providing culturally sensitive team-oriented and client-centered care in alternative environments.

Introduction

There is growing acceptance and a proliferation of the combination of service-learning and interdisciplinary learning in higher education (Connors & Seifer, 2005). The Pacific University Nicaragua initiative utilizes an interprofessional international service-learning approach through the collaboration of five professions; dental hygiene, pharmacy, physician assistant, physical therapy, and occupational therapy. Each year, a team of 20-25 students and faculty travel to Nicaragua for 10 days to provide healthcare to older adults living in community residential homes (i.e. hogares). The Pacific University interprofessional team works to create a sustainable impact through caregiver training and social capacity building while providing much needed healthcare, using a community-based rehabilitation approach endorsed by the World Health Organization (WHO, 2003, 2004, 2010).

In 2012 the team of five professions served 90 residents within two hogares in Nicaragua. Students and faculty provided assessments, interventions, workshops for community members, and caregiver education and training, as well as donating supplies. The health care delivery system, religious and social values, and differences in caregiver and health provider education were important aspects of Nicaraguan culture to be mindful of while providing competent client-centered care. Additionally, within the interprofessional team, personal and professional backgrounds and experiences influenced interactions and priorities of each discipline when providing client-centered care. Based on the experiences of the authors, literature review, and knowledge gained from the Nicaragua initiative over the past seven years, cultural themes have emerged and are explored regarding international and interprofessional differences and values to be considered in the development and implementation of interprofessional international service-learning initiatives within the health professions.

International Interprofessional Service Learning

Review of the literature found that students who participate in volunteer interdisciplinary work value working together and receive benefit from other professionals during their educational experiences by learning about the roles, resources, and services available (Cusack & O'Donaghue, 2012; Gallaher, Cooper, & Durand, 2010; Pettigrew, Lee, O'Sullivan, Henn, & O'Flynn, 2008). Additionally, international and interprofessional educational work has shown to increase student cultural awareness, ability to work on a team and gain a greater understanding of global healthcare systems (Haloburdo & Thompson, 1998; Solomon, 2010). There are benefits of international service-oriented healthcare work, as well as a need for more interprofessional practice in the educational setting due to the increasing multidisciplinary approach used in U.S. medical facilities and multicultural makeup of the U.S (Pahor & Rasmussen, 2009). Barriers to interprofessional practice have been identified in literature, such as turf wars and power struggles, concerns around liability, and inability to collaborate due to lacking communication habits or misunderstandings (Beales, 2011; Rice, Zwarenstein, Conn, Kenaszchuk, Russell, & Reeves, 2010; Solomon, 2010).

As shown above, current research addresses the importance of interdisciplinary and cross cultural work, the value of the team approach, and potential interprofessional barriers. Organizations and professionals have suggested team based models of practice to provide client-centered services in an interprofessional setting (Mann, 2009; WHO, 2010). However, there is little in the literature about using team based models to overcome the challenges internationally that arise by virtue of cultural differences experienced among health professions. The current gap in literature is in addressing culture between health care delivery systems and beliefs while working between disciplines within interprofessional educational programs. Resources exploring the value of experiencing the culture and understanding the local barriers to health care access in Nicaragua are also limited. This article explores the various aspects of culture in Nicaragua, and within the interprofessional team when viewed through the experiences and insights gained during the Nicaragua Initiative. From the available research and this gathered knowledge, strategies are offered that have shown to build effective interprofessional educational programs that address the many layers of cultural differences while working in Nicaragua.

The Nicaragua Initiative

The Pacific University Nicaragua Initiative has had a

presence in Nicaragua for seven years. The program engages in interprofessional care with the goal of providing services to indigent older adults living in hogares, due to lack of family to care for them or lack of financial support. Hogares are community residential homes that rely on charity and municipal support to provide social and basic medical support for older adults. While providing specific health care services, interprofessional team members are guided by the Community Based Rehabilitation (CBR) model of health care (WHO, 2010), which is sustainable within the existing community and uses the enthusiasm of the local caregivers and medical personnel. "Several principles of CBR include partnership building, education, and the eventual transfer of responsibility for provision of health care services to host communities" (Reisch, Boggis, Shaffer, Brown, & Black, 2011). The CBR model is best used in communities that do not have the infrastructure to support expensive medical institutions with highly trained or costly staff. The model works within the community to positively change the perception of disability, and identify solutions that could improve the lives, accessibility, and participation of all individuals. All health care disciplines can use this model by training and educating the client, caregiver and community at large on preventative health care techniques, teaching ongoing maintenance and self care methods, while addressing adaptation, advocacy or accessibility issues. This model is used in the Nicaragua Initiative as a platform for overcoming interprofessional and cultural barriers to deliver unified, community focused client-centered care.

Cultural Differences in Nicaraguan Health Care Delivery Systems

Socio–cultural, economic and political differences play a key role in how health care is delivered in any given environment. It is critical for health care students and professionals undertaking an international service-learning project to understand these differences in order to offer culturally sensitive interventions. In both the United States and Nicaragua, most health care services are delivered through one-on-one interactions with the doctor. There are only 3.7 physicians per 10,000 residents in Nicaragua compared to 27 in the United States (CIA, 2003). In Nicaragua, brigadistas are community volunteers or leaders that help deliver care primarily in rural areas to help overcome manpower shortages. Brigadistas have limited formal training and

rely on local nurses for guidance. Administrators of the hogares are frequently nuns within varying diocese of the Catholic faith, the major religion in Nicaragua. The nuns may have a nursing background, but no national standard of expectation is set. This is a stark contrast to the United States policies, which mandate a large hierarchy of administration and medical personnel in a nursing home (Centers for Medicare and Medicaid Services, 2012).

By implementing a Community Based Rehabilitation model to health care, the Nicaragua Initiative emphasizes community cohesion and training community members so they are able to work more effectively within a specific population. In the United States, health care students are not traditionally taught to use a Community Based Rehabilitation approach to treatment, instead focusing on the one-on-one delivery of care from the provider. For sustainability to be achieved in Nicaragua, the community members play a vital role. Although community members are not able to provide the complete healthcare that a physician does, they can learn to provide assistance with the daily lives and needs of the older adults. Knowledge of the differences in how care is delivered and who delivers that care in Nicaragua facilitates the team's ability to identify key community members and providers to guide educational efforts towards those who can make the greatest impact.

Geriatric Care in Nicaragua

The Nicaraguan health care system has found that 58 percent of the population is unable to access adequate health care services and treatment due to poverty and social exclusion, and 90 percent of the older adult population are without any social security benefits (CIA, 2003). Though older adults are highly respected in Nicaragua there is limited understanding or health professional training that supports their rehabilitative care. There are few geriatric physicians tending to all 24 of the country's hogares, which are largely in rural areas and receive little or no government funding. Residents rely on infrequent visits from only a few doctors for major health concerns, and the nuns for any minor concerns. Physicians who specialize in geriatrics must obtain their education outside of the country. Scarce resources in a poor country are understandably directed to child and maternal care. The majority of physicians and physical therapy students are educated

to serve this sector where government employment can be expected upon graduation. The Pacific team, in collaboration with Nicaraguan health professional educational programs, offers didactic and community work with hogar residents for Nicaraguan students. This has resulted in an increased awareness of the needs of the geriatric population by students enrolled in health professional programs in Nicaragua and their faculty. One nursing program at a major Nicaraguan university recently incorporated older adult education into their curriculum as a result of this collaborative effort.

Caregiver Education

Caregivers in the hogares have limited education or training in their area of work resulting in safety concerns while working with this population. A high school diploma is not required for a caregiver position; and employees receive minimal on-site training before beginning to work with the older adults. This creates room for error; as many of the caregivers have not worked with older adults previously, they do not understand many precautionary or handling techniques of working with a frail individual, which may lead to fractures, dislocations and pressure sores. Dislocation of the shoulder is a one example observed in the hogares; it can occur if the resident is pulled from sit to stand solely by their arms. Older adults living in the hogares are an at-risk population and are more susceptible to injuries if mishandled by improperly trained caregivers. As part of the community based rehabilitation perspective of care, the Nicaragua Initiative provides information and resources that are sensitive and mindful of the limited educational background of caregivers.

Participation in leisure, social, and physical activities can provide older adults with a sense of identity and meaning, which in turn promotes increased health and well-being (Stevens-Rathchford, 2008). Within the hogar, residents are permitted to move throughout the common facility as freely as physically possible, but much of their day is spent without structure, sitting quietly along the corridors or sometimes visiting with those around them. Recreational items such as television, reading material, and music are frequently unavailable which is in stark contrast to the abundance of resources in United States facilities. Caregivers in the hogares are not focused on participation in leisure, social, or physical activities for the older adults or engaging the residents in activities beyond their daily

hygiene. This is due to a large ratio of residents to each caregiver, the lack of education on the importance of activity, and lack of supplies.

Preventative care is not a traditional concept in the Latino culture, which tends to gravitate towards values of fatalism or an external locus of control. Preventative services for older adults are highly inadequate or inaccessible in Nicaragua. The Community Based Rehabilitation model is appropriate to spread awareness about the importance of providing preventative and maintenance health care to the older adult population. Education and modeling encourages the community to become more involved, teaching others to participate and engage with the residents. Education to caregivers on the value of activity participation and its influence on health and well-being for older adults is an additional focus of the Pacific health care team.

Religious Affiliation

Due to religious affiliation of the hogares, it is not always acceptable to provide care to the opposite sex when not family related. Within the culture of the hogares in Nicaragua, men and women are separated into different sections, and do not reside together. There are both men and women caregivers providing assistance most generally to the same gender residents, especially when it comes to more intimate tasks, such as showering, dressing and toileting. The religious norms can create a challenge, as much of the Nicaragua Initiative team is comprised of female providers and many of the male residents need interventions that involve close contact. To navigate this challenge, in line with a Community Based Rehabilitation approach, the team consults with a local gerontologist, known and respected by the hogar administration, who has paved the way for the team to proceed in a culturally sensitive manner. Care is provided to residents with proper supervision and education to the appropriate gender caregivers which allow sustained quality care within cultural norms after the Pacific team's departure.

Interprofessional Cultural Differences

Professionals within the United States culture have many variables to overcome when working on an interprofessional team. Differences in education, professional values, beliefs about health care models and treatments, as well as personal egos and personality

differences all impact team cohesion and productivity (Solomon, 2010). To be successful in spite of these variables takes a delicate balance of compromise and acceptance of differences, as well as recognition of the value of individuality. Working internationally as an interprofessional team requires navigation of local cultural norms; but also necessitates an understanding of the perspective from which each profession operates. In the case of the Nicaragua initiative, the Community Based Rehabilitation approach is used as a foundation for all professionals to focus on the community as a resource and the importance of sustainability after the team's departure. The professions are then unified in their purpose and goals while providing treatment in the hogares.

A major educational difference that can be seen among United States healthcare professionals is in their model of practice. Historically, professions that work with the body, and physical nature of the person practice from a "Medical Model" or "Curative" approach. A medical model focuses on the individual as having a problem, fixing it, and considering the situation solved when the person is "cured" (Collins, 1996).

In contrast, a "Social Model" looks at the outside factors that are affecting the person mentally, emotionally and physically (Collins, 1996). The social models consider what needs to be fixed about the society and environment, along with the people who care for them. Social models provide education for the person and community that may improve the individual's situation. There is a challenge when working across professions due to the differing perspectives and training of each profession when looking at a medical condition. To help avoid the problems of diverse goals and priorities, the community based rehabilitation approach is established by the team integrating a medical and social model approach.

The professional culture and challenges while working in Nicaragua must be considered when collaborating as a team. Individuals interpret the needs and priorities of any client through the lens of their specific profession. Each profession's scope of practice must mold to meet the needs of the environment, culture and available resources. For example, dental hygiene has a very specific scope of practice, and rarely works with rehabilitation professionals in United States settings. Working alongside physical and occupational therapy

is a unique opportunity to explore new perspectives of building rapport and trust with their client. Additionally, on the Pacific team, physician assistants are consulted to recognize acute needs and play a much more autonomous role from the doctor then they may be accustomed to in the U.S. They must communicate needs with physical and occupational therapy to assist in ways they may usually only discuss with nursing. Occupational and physical therapy work jointly on their goals to provide interventions, train caregivers, and facilitate groups that engage the older adults in leisure and social participation without the typical equipment, time or resources. In collaboration with a local physician, pharmacy takes a hands-on role with both patients and caregivers, recommending which medications a resident should take, without the structure and availability to accurate medical records that they are accustomed to, while educating and monitoring for contraindication and adverse side effects. Many of the team members from other professions are rarely given the opportunity to work side by side with each other, so the opportunity to ask questions and learn can be valuable. These multiple perspectives are very complementary to one another when working in an interdisciplinary setting. For example, when treating a patient with numerous cavities, the medical model may be focused solely on extracting the teeth, while the social model will be focused on educating the caregiver on appropriate foods and utensils to provide to someone suffering extreme mouth pain. "Medical education needs to be restructured to reduce its almost exclusive focus on the acquisition of scientific and clinical facts and to emphasize the development of skills, behaviors, and attitudes" (Leape et al. 2009, p. 427). A professional who understands the complementary power of the medical and social approaches will find them to be beneficial; working on an interprofessional team with novice students promotes understanding and accepting these two very different approaches. The Community Based Rehabilitation approach used in the Nicaragua Initiative created a unified understanding between the professions, allowing each professional's scope to be broadened and value to be placed on teamwork during the limited time available.

Prior to departure, educational programs are provided for participating students that focus on the Community Based Rehabilitation approach, on sustainable collaboration, and on exploring the various professions. Practice case scenarios and participation in team

building events are also used to prepare students in how to best face and overcome challenges that may arise from individual and professional differences while working in Nicaragua. The various professions involved have all completed their fall semester of school, but are in very different points of their education. Some students are in their first year of schooling and others are in their final semester. Some have been outside of the country many times, worked with older adults previously and completed their didactic training, while others have never left the United States nor begun their educational rotations at all. Each student comes with unique personal and experiential circumstances that influence their values and agendas while working on a team. Many have initial opinions of the other professions as being more or less hierarchical than their own, or stereotypes about the personalities that they may encounter among the various professions. These initial opinions are gradually changed as each professional becomes a person with a name and story. For example, for students on the most recent trip, the unique ways of the occupational therapy student became viewed as interesting and important aspects of discovering the value of quality of life for the individual. Physical therapy students had opportunities to ask questions of the pharmacy student about tremors and medications, and dental hygiene students requested advice from the physician assistants about their stomach ache after eating a strange pastry. Upon return from the Nicaragua Initiative 2012, students shared positive emotions around this interprofessional experience, preparation they received despite the difficulties they faced while delivering health care to this indigent population. For students, themes emerged of both the benefits of working together, and the value of this network for their long-term careers. They learned to educate one another and gained confidence to ask about what they didn't understand so a fuller perspective could be achieved.

Discussion

The interdisciplinary team that comes to work in hogares each December is focused on providing education and creating sustainable change, using the interest, excitement, and resources of the community and hogar residents. Where the United States system is strongly dependent on professionals that have been educated in medical schools and deliver services in medical facilities, Nicaraguans avoid medical facilities

and professionals due to the cost and barriers to access. Providers from the United States need to be conscientious of how they are educating both the caregivers and the community members to avoid overwhelming them with tactics that ultimately won't be beneficial to them. The focus should be on what the most important areas are in which to educate and train caregivers on methods that they are able to apply during care provision for all residents.

Students visiting the hogares know they may be the only access to dental or rehabilitative care that the older adults receive annually and to maximize their effect, put efforts and education towards practical and sustainable change. This expectation within the student community is driven by the Community Based Rehabilitation model. Interactions between the professions are non-traditional, with each student being required to step out of their typical role for the sake of practical service delivery. This results in pharmacy students joining physical and occupational therapy groups, learning how to guide an individual with hemiplegia to give attention to their weaker side. This brings physician assistants into the dental clinic, helping to problem-solve how to best care for a client with anxiety about receiving a tooth cleaning. Occupational therapy students learn to clean ears and pressure sores from the physician assistant student, while teaching proper bed and chair positioning to their colleagues. The community-based approach is interwoven all around, as the students become resources and teachers for one another and for the caregivers with whom they will leave their information and impact.

The benefits gained in working as a member of a community-based interprofessional team including the opportunity for peer education and brainstorming, were noted by student participants.

Student Feedback

> While the skills and experience gained through this project could be developed in a classroom or clinical setting over time, the international setting provided detachment from everyday life, and immersion in the Community Based Model, resulting in our dependence on one another. These factors accelerated the trust and familiarity in the team dynamic, allowing each student to quickly

appreciate hard work, individual expertise and the pooling of ideas.

Megan Kelly, student participant

The ability to work on an interdisciplinary team in an educational setting allowed for greater peer teaching in the moment of each others roles in an individuals health care. As well as the ability to build professional competency in brainstorming, especially when this is what tends to happen on a team in the work setting.

Katie Schumacher, student participant

An additional benefit perceived by students is the acquisition of new knowledge and the opportunity to expand learning outside of one's profession.

The experience in a culture outside of the United States specialized medical model provided a team of student professionals the opportunity to step outside the constructs of their profession and look at the larger of picture of what needed to be done, and the best way to accomplish it. That may look like an OT, PT, and PA students cutting walker legs, or OT and pharmacy students labeling medication bottles. There are many situations that expand the students' creativity and educational boundaries. This has the potential to result in breakthroughs of new learning. It also has the potential to put students in situations beyond their scope of knowledge.

Nicole Randt, student participant

Further, student team members build on-going relationships and valuable skills that will serve them well as they pursue their future career paths.

I returned from this experience having several colleagues to keep in my professional network as a sounding board and trusted expert while pursuing my own practice. Through our international service learning, I have seen them work in tough situations as both resourceful and valuable team players and know that will continue into their future careers.

Megan Kelly, student participant

Despite focused preparation prior to travel, and the perceived value of the educational experience post-travel, participants experience unforeseen challenges in navigating ethnic and interprofessional cultural differences while in-country. Student participants identify the importance of language study, consideration of the local history and culture, and the experience of prior work within interprofessional teams as means to more successfully navigate and discuss diversity and interprofessional issues. Megan Kelly, student participant notes, "One does not realize before travel how important this knowledge or these skills are until you actually get there. The information provided prior to travel has a tendency to go in one ear and out the other." An ideal candidate for participation in an international interprofessional endeavor includes "adequate education in ones individual profession so that ones personal role is clear," states student participant, Nicole Randt. She adds, "Previous international travel experience to provide diverse perspective on lifestyles, customs, and expectations of other countries is valuable." Given that it is not possible to fully prepare beforehand for all of the challenges involved in an international interprofessional experience, Dana Erickson, student participant, points out that

the ability to be extremely flexible and go into it with more curiosity than ego is of upmost importance. If everyone is more interested in learning what the other professions and culture have to offer rather than trying to focus and highlight their own profession or culture they will be able to work together cohesively and provide culturally relevant services.

Conclusion

Reviewing all the differences—in perspective, education, experience and personal beliefs and values—how can one team ever be on the same page? For the Nicaragua Initiative the answer is found in the Community Based Rehabilitation model. The Community Based Rehabilitation model is the framework upon which the Nicaragua Initiative is designed. It helps meet the needs of the facility despite the differences in culture when it comes to health care resources and access, while fostering commonality in philosophy and goals to promote effective teamwork across diverse professions and community entities.

Ultimately, working across cultures is about collaboration. It involves knowing the needs of the

culture being visited, and the cultural expectations of each team member as a professional and as a person. "Collaboration isn't about 'winning,' and we may have to choose our battles from time to time. Collaboration is about coordinating our unique skill sets with others as we work together to find the best solutions" (Solomon, 2010, p. 49). To best serve patients with multiple health care needs, it is important to understand the scope of practice of each profession to collaborate appropriately with interdisciplinary team members. Preparatory activities to educate the interprofessional team of students on the approach, international culture, and interprofessional cultures are all important strategies for team cohesion. In the Nicaragua Initiative the CBR model creates sustainable and unified intervention delivery among professionals giving care. This model provides a foundation from which all students can collaborate effectively. Interactions with one another, the hogar residents, their caregivers, and the community at large all benefit from this unified approach.

References

Beales, J., Walji, R., Papoushek, C., & Austin, Z. (2011). Exploring professional culture in the context of family health team interprofessional collaboration. *Health and Interprofessional Practice*, *1*(1), eP1004. http://dx.doi.org/10.7772/2159-1253.1012

CIA. (2003). The world factbook. https://www.cia.gov/library/publications/the-worldfactbook/geos/nu.html

Collins, C. (1996). Medical model vs. social model of care. *Canadian Nursing Home*, *7*(3), 17-19.

Connors, K. & Seifer, S. D. (2005). Interdisciplinary models of service-learning in higher education. Community-Campus Partnerships for Health [Fact Sheet]. Learn and Serve America's National Service-Learning Clearinghouse. Retrieved from http://www.servicelearning.org/instant_info/fact_sheets/he_facts/interdisciplinary

Cusack, T., & O'Donoghue, G. (2012). The introduction of an interprofessional education module: students' perceptions. *Quality In Primary Care*, *20*(3), 231-238.

Gallagher, H. C., Cooper, M. and Durand, C. (2010). Effects of an interdisciplinary volunteer experience on student's knowledge of and attitudes toward the health care team. *The Journal of Physician Assistance Education*, *21*(3), 27-30.

Haloburdo, E. and Thompson, M. (1998). A comparison of international learning experiences for baccalaureate nursing students: Developed and developing countries. *International Learning Experiences*, *37*(1), 13-23.

Leape, L., Berwick, D., Clancy., Gluck, P., Guest, J., Lawerence, D., Morath, J., et.al. (2009). Transforming healthcare: A safety imperative. *Quality and Safety Healthcare*, *18*(6), 424-428. http://dx.doi.org/10.1136/qshc.2009.036954

Mann, K., McFetridge-Durdle, J., Martin-Misener, R., Clovis, J., Rowe, R., Beanlands, H., & Sarria, M. (2009). Interprofessional education for students of the health professions: The "Seamless Care" model. Journal Of Interprofessional Care, *23*(3), 224-233. http://dx.doi.org/10.1080/13561820802697735

Centers for Medicare and Medicaid Services. (2012, August 3). Nursing Homes Overview. Retrieved from http://www.medicare.gov/nursing/overview.asp

Pahor, M., & Rasmussen, B. (2009). How does culture show? A case study of an international and interprofessional course in palliative care. *Journal Of Interprofessional Care*, *23*(5), 474-485. http://dx.doi.org/10.1080/13561820903163512

Pettigrew, C. M., Lee, A., O'Sullivan, C., Henn, P., & O'Flynn, S. (2008). Strategies for interprofessional education in health and social care-a teaching and learning model. *Physical Therapy Reviews*, *13*(3).

Reich, R., Boggis, T., Shaffer, K., Brown, S., Black, A. (2011). Description of a model of interprofessional global education for allied health students. *Health and Interprofessional Practice*, 1(1), eP1001. http://dx.doi.org/10.7772/2159-1253.1000

Rice, K., Zwarenstein, M., Conn, L., Kenaszchuk, C., Russell, A., & Reeves, S. (2010). An intervention to improve interprofessional collaboration and communications: A comparative qualitative study. *Journal Of Interprofessional Care*, *24*(4), 350-361. http://dx.doi.org/10.3109/13561820903550713

Sims, D. (2011). Reconstructing professional identity for professional and interprofessional practice: A mixed methods study of joint training programmes in learning disability nursing and social work. *Journal Of Interprofessional Care*, *25*(4), 265-271. http://dx.doi.org/10.3109/13561820.2011.571352

Solomon, P. (2010). Inter-professional collaboration: Passing fad or way of the future? *Physiotherapy Canada*, *62*(1), 47-55. http://dx.doi.org/10.3138/physio.62.1.47

Stevens-Rathchford, R. (2008). Aging well through long-standing social occupation: A close look at social participation and quality of life in a sample of community dwelling older adults. *A Forum on Public Policy*. Retrieved from http://forumonpublicpolicy.com/archivespring08/stevens-Ratchford.pdf

Van Nice, A., Potter, A. Johnson, D., & Hursey-King, P. (2011). Nicaragua Project. Innovative Practice Projects. Paper 16. Retrieved from http://commons.pacificu.edu/ipp/16

World Health Organization. (2003). *International consultation to review community-based rehabilitation*. Geneva, Switzerland: WHO Document Production Services. Retrieved from http://whqlibdoc.who.int/hq/2003/ WHO_DAR_03.2.pdf

World Health Organization. (2004). *CBR: A strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities. A joint position paper*. Geneva Switzerland: WHO Document Production Services. Retrieved from http://www.who.int/disabilities/publications/cbr/en/index.html

World Health Organization. (2010). *Community-based rehabilitation: CBR guidelines*. Geneva, Switzerland: WHO Press. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241548052_introductory_eng.pdf

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