Evaluation of Interprofessional Care (IPC) Behaviour and Perceptions following an Intensive Continuing Education Development Initiative in Arthritis Care

K Lundon[2,3], C Kennedy[1,2,3], L Rozmovits, L Sinclair, R Shupak[2,3], K Warmington[1], L Passalent[1,2], S Brooks[5], R Schneider[2,6], L Soever[2,4]

[1]Mobility Program Clinical Research Unit, Keenan Research Centre, Li Ka Shing Knowledge Institute, St. Michael's Hospital; [2]University of Toronto;
[3]Martin Family Centre for Arthritis Care and Research, St. Michael's Hospital; [4]Mount Sinai Hospital; [5]The Arthritis Society; [6]Hospital for Sick Children

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BACKGROUND

- As of June 2011, the Advanced Clinician Practitioner in Arthritis Care (ACPAC) program[1] has trained 37 experienced physical and occupational therapists to work as extended role practitioners (ERPs) in two identified streams of arthritis care that include ongoing management and triage.
- Graduates of the ACPAC program have received additional training with formal evaluation to establish competency in advanced knowledge and skills in management of select arthritis conditions. Their roles may require additional performance expectations of authorized activities which are currently achieved through delegation or medical directives.

Interprofessional Care (IPC)

- Interprofessional care (IPC) "occurs when multiple health workers from different professional backgrounds provide comprehensive health services by working with patients, their families, carers and communities to deliver the highest quality of care across settings" [2].
- There is evidence that patients with complex forms of arthritis benefit most from an interprofessional collaborative approach to their care[3].
- Evaluation of the ACPAC ERP in terms of IPC also requires consideration of the responsibility of other healthcare team members and environmental factors that may affect extended role implementation.

PURPOSE

The purpose of this study was to describe the practice behaviour and perceptions amongst ACPAC ERPs and relevant Clinical Team Members (CTMs) and Administrators in order to determine the extent to which this new human health resource in arthritis care is functioning in the context of IPC practice .

METHODS

- mixed-methods: quantitative (survey) and qualitative (focus groups /interviews) components.
- ethical approval was received from the Research Ethics Board at St. Michael's Hospital.

Recruitment-inclusion criteria:
ACPAC ERPs: Participants were graduates of the ACPAC program and had practised for at least one year following completion of training. **CTM:** Participants identified by an ACPAC ERP as a healthcare professional (e.g. physician) with whom the graduate worked regularly as an ERP. **Administrator**: Participants identified by an ACPAC ERP as a clinic administrator, department head, department chair, or hospital administrator responsible for the clinic, unit or area in which the graduate worked.

I. Quantitative Approach

- ACPAC graduates (n=30) completed a survey which addressed demographics on their primary team (# of team members, professions or roles).
- The ERP was asked to rate their primary team's "Readiness for Interprofessional Care Practice" based on a single item with 6 response options[4] .
- The Bruyère Clinical Team Self-Assessment on Interprofessional Practice was used to assess the ERP's perception of how well their primary team's current status related to IPC practice[5]. The scale consists of 2 parts: Part 1 Subjective evaluation [23 items, scored on 5-point scale: agree very little (1) to agree strongly (5)] evaluates a clinical team's perception of key team characteristics known to enable IPC, and Part 2 Objective evaluation (9 items, response yes/no) evaluates the level of actual team practices associated with IPC. Each part was scored and interpreted separately.

II. Qualitative Approach

- Focus groups and interviews were conducted by an independent, experienced qualitative research consultant.
- Focus groups captured details of ERPs' experiences including: moving into extended practice roles; barriers and enablers to achieving their full scope of practice; their experience of interprofessional care; and, perceived impact on patient care.
- One-on-one interviews for the ACPAC ERPs' CTMs and administrators captured details of their actual experience of working with an ACPAC ERP; perceptions of value added to their service by the presence of an ACPAC ERP; and, challenges associated with the role.

Analysis: Data were digitally audio-recorded for verbatim transcription and entered into HyperResearch software for textual data analysis. Transcripts were coded for anticipated and emergent themes using the constant comparison method, including searches for disconfirming evidence. Due to the heterogeneity of the ACPAC ERPs' practice settings, a modified organizational framework[6] was used to evaluate IPC broadly in terms of behavioural change, change in organizational practice, and benefit to patient from the perspectives of ACPAC ERPs and their colleagues.

RESULTS

I. Quantitative

The IPC survey was issued to 30 ERPS across one fiscal quarter. Twenty-five of the 29 respondents reported that they were working as an ERP. Of those working as an ERP, 24 (96%) responded to the IPC questionnaire.

Primary Team Demographics

Most respondents reported working on an interprofessional team, with a mean of 9 people comprising the team (range 2 to 25).

Readiness for IPC Practice

Seventy-five percent felt their team was actively working in an IPC practice model (Action stage) or making plans (Prepared for action stage) while 25% felt their team was in the Pre-contemplation (never thought about it) or Contemplation (thinking about it) stages.

Bruyère Clinical Team Self-Assessment on Interprofessional Practice

The mean subjective subscales (mean scores: range 3.66-4.26) and overall scores (mean score: 3.9) were high (scale range 1-5=better perception of teams IPC practice) (Figure 1a). However, the objective scale that evaluates the level of actual team practices associated with IPC was lower (mean 4.6, scale range 0-9=more team practices associated with IPC). Fewer than 50% of ERPs identify with actual IPC team practices in five of the nine items (Figure 1b).

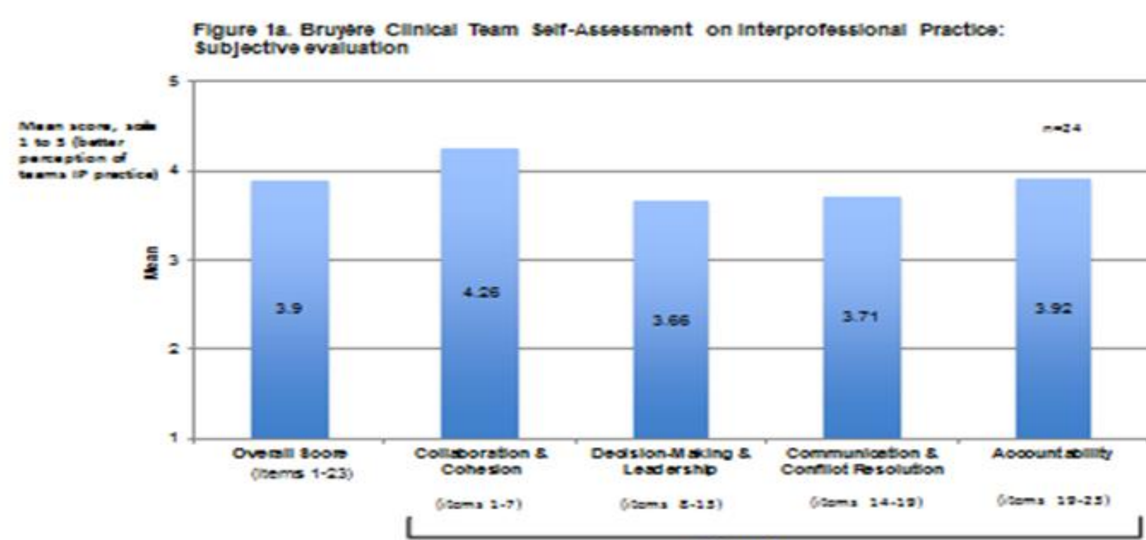

Figure 1b. Bruyère Team Self Assessment on Interprofessional Practice: Objective evaluation of team practices associated with IPC (% Yes response by item)

Mean score = 4.58, scale range 0 to 9 (higher level of actual team practices associated with IPC)

% YES response

Item	% YES response
Single integrated care plan for each patient	21.74
Integrated assessments among disciplines	12
Integrated interventions among disciplines	82.61
Team uses indicatorsto assess how well it works together	30.43
Flexibility in the roles for team members	95.45
Team regularly reviews specifics of how it goes about delivery care	33.33
Interprofessional approach to student training	69.57
Integrated charting practices	52.17
Collaborative decision-making regarding operations and care delivery	43.48

II. Qualitative

Participants

A total of 20 of 30 ACPAC graduates (67%) participated in one of three focus groups. Fifteen (75%) graduates were physiotherapists and five (25%) were occupational therapists. Sixteen (80%) graduates worked in urban areas while the rest (20%) worked in rural settings. Eleven participants (55%) worked in academic hospitals and nine (45%) worked in community hospitals or other community-based settings.

A total of 18 colleagues of ACPAC graduates participated in interviews and included a range of clinical (CTMs) and administrative team members. Seven (39%) were rheumatologists, four (22%) were other clinicians (orthopaedic surgeons, family physicians, nurse practitioners), and seven (39%) were administrators.

1. Behavioural Change

One of the most challenging aspects of working as an ERP was the issue that the new role was not consistently and/or readily recognized by other professions. It took time and external pressure to elicit behavioral change by other professions in terms of acceptance of the ERP role.

… I think there's a real circuit of transfer of knowledge and the patient's included in that… if you work in an interprofessional team you learn from each other..[ERP]

The reluctance of individual physicians to accept the ERP role was an ongoing challenge in a number of settings. For family physicians unfamiliar with the role it was perceived that the ERP was an additional gatekeeper rather than a professional expediting access to specialist care.

…our general family doctors were a little out of sorts at first saying, "well, I know they need to see a rheumatologist, I don't need them to be seen by a physiotherapist"…but when the rheumatologist said, "yes, but I'm not going to see them without that" then they backed down…now they love it. Because they saw that their truly inflammatory patients were seen by the rheumatologist immediately…because it works in terms of getting their patients the care they need right away… [CTM/Administrator]

2. Change in Organizational Practice

Integration and institutional support of the extended practice role varied. There was inadequate resourcing for the role and vulnerability to politically-driven changes in priority, thus straining IPC relationships at some sites.

…the role is supported by incremental funding every year … and so every year we're lobbying for funding and these people feel very unstable because they feel that their job year after year is dependent on funding… [CTM/Administrator]

Physician support for attaining medical directives was integral to broadening ERP roles and was linked to enhanced IPC. Most graduates, however, were routinely hampered to some degree by the lack of medical directives.

… it was "who are these non-nursing people asking for medical directives?" And the committee was made up of physicians and nurses and so it was a battle explaining who we are, why we were okay to have these directives, what our training was…[ERP]

3. Benefit to Patient: Improvements in health or well-being of patients

The ERP was perceived to have a substantial impact on patient-centred IPC via diminishing the often noted silo effect and providing a conduit for communication and collaboration between different departments, disciplines or professionals.

…I work across every MSK program in our hospital…and so I think the biggest difference that I've made is that I unite those silos…I'm the person who's a constant…so I think I'm improving efficiencies and I think I'm making them work together more than they ever did before... [ERP]

The ERPs were perceived to substantially improve patient care in the context of IPC by effectively triaging and directing patients to the most appropriate care provider, reducing wait times and allowing physicians to prioritize genuinely urgent cases.

…it's helping my practice, it's also helping patients to get in and be seen sooner who would benefit from earlier assessment and treatment that may make a difference in terms of their functioning and contribution to society in the short term…[CTM/Administrator]

DISCUSSION AND CONCLUSION

- ACPAC ERPs are generally effective participants in, and contributors to IPC as perceived by ERPs and their CTMs/administrators at select sites.
- Their presence appears to both promote organizational change and impart general benefit to the collaborative care of patients with arthritis.
- However, ACPAC ERPs are working on teams that are at varying stages of readiness for IPC practice, with 75% ERPs identifying their team as working in this context.
- Barriers such as institution-specific lack of medical directives, remuneration conflicts, and role recognition issues were identified to impede role implementation.

This study offers the opportunity to reflect on the introduction of a new human health resource in arthritis care and IPC practice. Interprofessional healthcare models will need to evolve given demographic and chronic disease trends. A shift in traditional roles and professional boundaries by a well-trained and competent new healthcare provider can narrow the gaps in healthcare to allow patients to receive appropriate and timely care.

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