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

K Lundon1,2, C Kennedy3,1,3, L Rozmovits, L Sinclair, R Shupak2,3, K Warrington1, L Passalent1,2, S Brooks2, R Schneider3,6, L Soever2,4
1Mobility Program Clinical Research Unit, Keenan Research Centre, Li Ka Shing Knowledge Institute. St. Michael's Hospital; 2University of Toronto; 3Martin Family Centre for Care Research and St. Michael's Hospital; 4Mount Sinai Hospital; 5The Arthritis Society; 6Hospital for Sick Children

BACKGROUND

As of June 2011, the Advanced Clinician Practitioner in Rheumatology (ACPAC) program2,3 has 10 experienced professional and occupational therapists who work as extended role practitioners (ERPs) in two identified streams of arthritis care that include: (a) ACPAC ERPs; and (b) physiotherapists and occupational therapists who work with patients, that families, carers and communities to deliver the highest quality of care across settings4.

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 resource in arthritis care is functioning in the context of IPC practice.

METHODS

Mixed methods: quantitative (survey) and qualitative (focus groups interviews)

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 practiced at least one year following completion of training. CTMs: Identified by an ACPAC ERP as a healthcare professional (e.g. physiotherapist) with whom the graduate worked regularly as an ERP. Administrators: Identified by an ACPAC ERP as a clinician, department head, director, 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 assessed demographics on their employment, training, and experience (n=25). The survey was developed in collaboration with the ACPAC program and the Toronto Rehabilitation Institute.
- The ERP was asked to rate their primary team’s “readiness for Interprofessional Care (IPC)” on a scale of 1 to 5.

The Burye Clinical Team Self-Assessment on Interprofessional Practice was used to assess the perceptions of how well their primary clinic’s current state related to IPC practice. The scale consists of 2 parts: Part I subjective evaluation (53 items, scored on a 5-point Likert scale). This part included questions about key team characteristics known to enable IPC, and Part II objective evaluation (8 items, response packet survey). The level of interprofessional team practices associated with IPC. Each part was scored independently.

II. Qualitative Approach

- Focus groups and interviews were conducted by an independent, experienced qualitative research consultant.
- One focus group comprised details of IPC experience including module extension-practice roles; barriers and enablers to achieving their full scope of practice, their experience of interprofessional care; and, perceived impact on patient care.
- One focus group focused on the ACPAC ERPs CTMs and administrators captured experiences 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.

The restructured ACPAC ERPs are generally effective participants in, and contributors to IPC as perceived by ERPs and their CTMs/administrator.

I. Results

1. Quantitative

The IPC survey was issued to 30 ERPs across one fiscal quarter. Twenty-five of the 29 respondents were working as an ERP. Of those working as an ERP, 24 (86%) responded to the IPC questionnaire.

Primary Team Groomhics

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.

Burye Clinical Team Self-Assessment on Interprofessional Practice

The mean subscale scores (mean scores: range 3.66 to 4.6) were as follows: mean score: range 3.66 (mean score: range 3.66 to 4.6) was used to evaluate the perceived level of IPC practice in five of the nine items (Figure 1).

II. Results

A total of 20 to 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 respondents (55%) worked in an Acute Care setting (e.g. emergency) and 12 (55%) in another community-based setting.

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 surgeon, family physician, nurse practitioners), and seven (39%) were administrators.

1. Behavioural Change

One of the most challenging aspects of working as an ERP was the new role that was not consistently and readily recognized by other professionals. They also acknowledged that the behavioural change by other professionals in terms of acceptance of the ERP role.

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 challenging for them to recognize the perceptive of the ERP role.

The ACPAC ERPs were seen as leaders in the interprofessional care and collaboration as perceived by their colleagues.

II. Integration and Institutional Support

ACPAC ERPs were generally seen as effective participants in, and contributors to IPC as perceived by ERPs and their CTMs/administrator. The restructured ACPAC ERPs were generally effective participants in, and contributors to IPC as perceived by ERPs and their CTMs/administrator.

CONCLUSION

The ACPAC ERPs were generally effective participants in, and contributors to IPC as perceived by ERPs and their CTMs/administrator at selected sites.

ACKNOWLEDGEMENTS

Canadian Initiative for Outcomes in Rheumatology Care: The Ministry of Health and Long-Term Care, HealthFutur(e)Ontario, Arthritis Health Research Initiative, CCA, ACPAC ERPs.

REFERENCES