Promoting Family Medicine Residents' Capacity For Interprofessional Collaboration: A Core CanMED Competency

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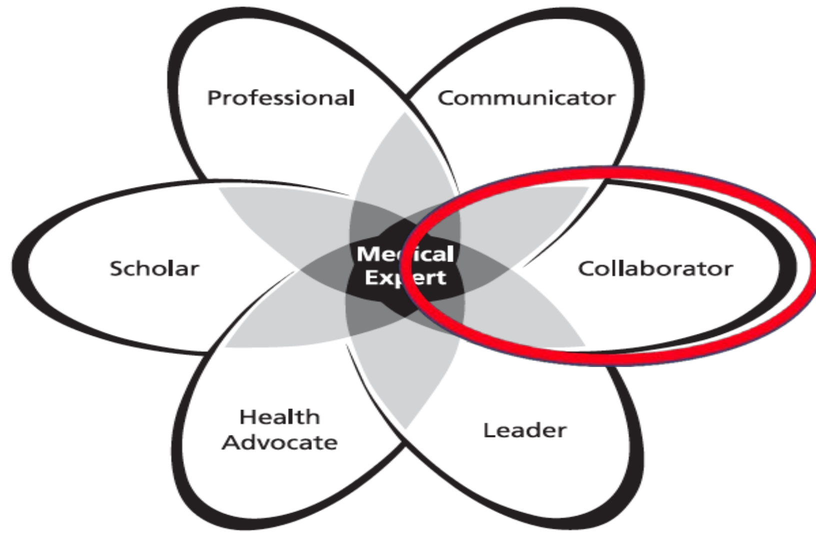
Declaration

This study was funded with a ReHabilitation Grant from the Faculty of Health Sciences, University of Manitoba.

The primary investigator worked in the study setting during the period of data collection and analysis.



Frank, 2015

Background

- In primary care, an interprofessional approach can improve access, cost-effectiveness, and health outcomes (Dahl-Popolizio et al., 2016; Fricke, 2005; Rexe, Lammi & Zwek, 2013Kamper et al., 2014, Mickan, 2005; Trivedi et al., 2013)
- OT and PT have expertise in preventative and supportive community care for mental and physical chronic health issues (Dahl-Popolizio, Manson, Muir & Rogers, 2016; Davis, MacKay & Badley, 2008; Fricke, 2005; Rexe et al., 2013).

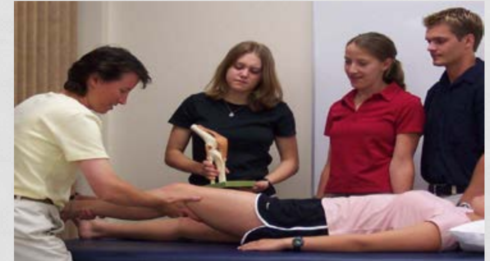
Background

Role clarity promotes integration of OT and PT into primary care teams (Donnelly, Benchley, Crawford & Letts, 2014; Paz-Lourido & Kuisma, 2013; Davis et al., 2008, Rexe et al., 2013).

No studies have focused on interprofessional education regarding rehabilitation professions for medical residents (Paré, Maziade, Pelletier, Houle & Iloko-Fundi, 2012; Weppner et al., 2016).

Setting

- Family medicine teaching clinic with an interprofessional primary care team in downtown Winnipeg, Canada.
- OT and PT provide education to residents using both didactic and experiential methods (0.4 EFT).
- Residents are in the clinic for ~ 24 weeks (usually 12 weeks x 2).



Research Objective

Explore first-year family medicine residents' understanding and value of OT and PT in a primary care clinic. Specifically:

- gain an understanding of family medicine residents' views of the OT and PT role;
- consider these resident views in conjunction with their referral patterns to OT and PT.

Quantitative | **Qualitative**

Data Collection

Data extraction of referrals written by 29 R1 residents

4 focus groups (total n=13)

Data Analysis

Descriptive and correlative statistics of:

- Referral frequencies
- Population referred
- Reason for referral
- Medical issues identified in referral

- Inductive analysis with open coding
- Categorizing of data guided by the Interprofessional Competency Framework
- Development of themes and categories

Results

- Frequencies
- Correlations

Themes

Discussion

Compare and contrast; Interpret

RESULTS

Qualitative Results from Focus Groups

Characteristics Of Participants (n=13)

Type of Learner	
First year resident	11
Medical student	2
Age	
21-30	8
31-40	3
41-50	2
Sex	
Male	8
Weeks of clinic exposure	
0-10	1
11-20	5
21+	3
Missing	3

THEMES

OT and PT Expertise

Shared Roles

Show Me

OT and PT Expertise

Occupational therapy examples

- environmental assessment and adaptation
- CBT

Physical therapy examples

- musculoskeletal diagnosis
- physical health programs

Examples for both professions

- functional assessment of impairment and/or disability
- non-pharmacological treatment of chronic pain
- specialized equipment
- patient-centred goal-setting.

Shared Roles

Shared roles include:

- general counseling
- early management of acute MSK injury.

Referring for shared roles:

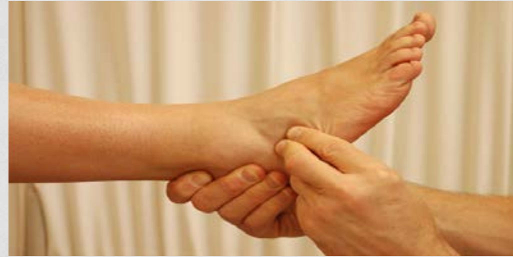
- **Advantages**: may have more expertise, visit length.
- **Disadvantages:** disruption continuity of care, limits capacity to develop own skillset.

Show Me

"But I think seeing firsthand is different than reading a report and seeing what people do. And actually working with them first-hand you kind of get more of an appreciation. And the mental and emotional aspect of it I wouldn't have thought of before." (P7)

"Like I know when we went and saw this lady and she had actually fallen just before we got there. So they showed her how to safely get up from her fall. And then right then did a cognitive assessment on her and then . . arranged for some equipment to be brought in so that she could be more safe . . . Like that was pretty cool." (P10)

Quantitative Results from Referral Analysis

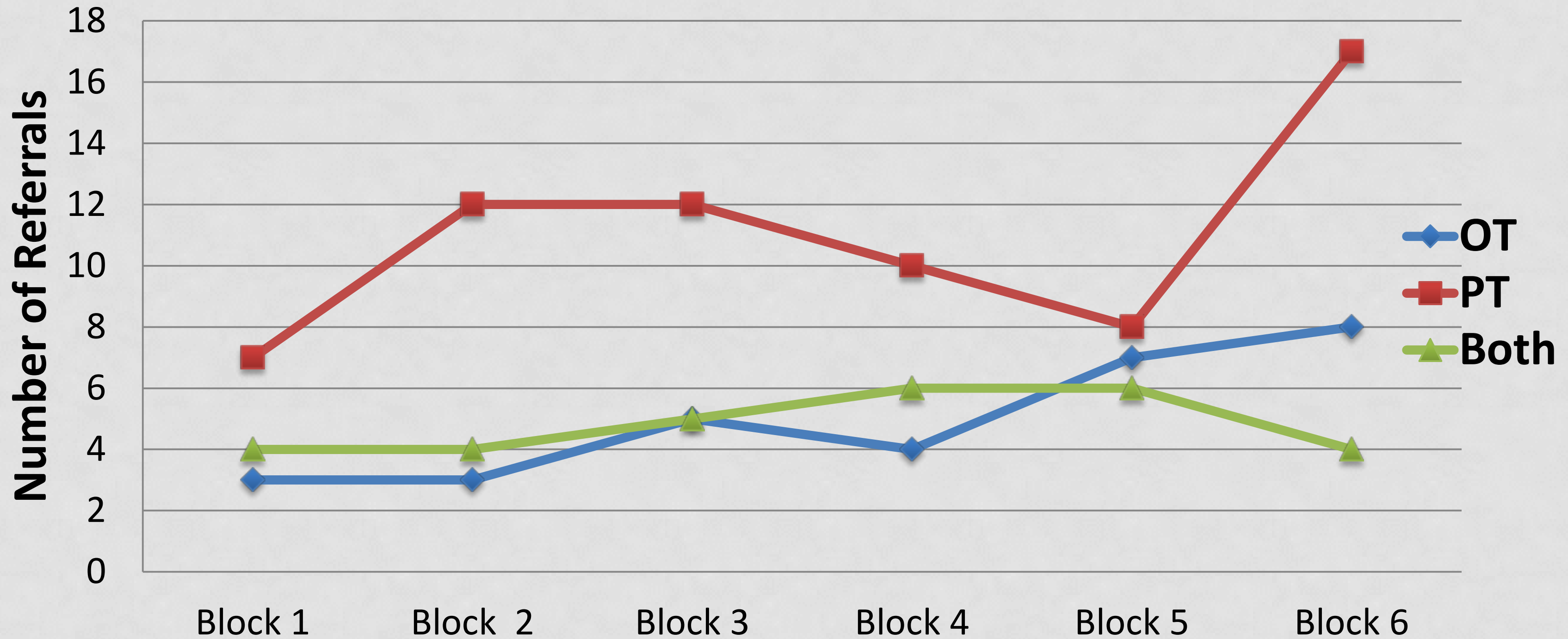


Referral Frequency

- 129 referrals written by two cohorts of R1s
- $\bar{X}$ = 4.5 referrals (per resident); range 0-12

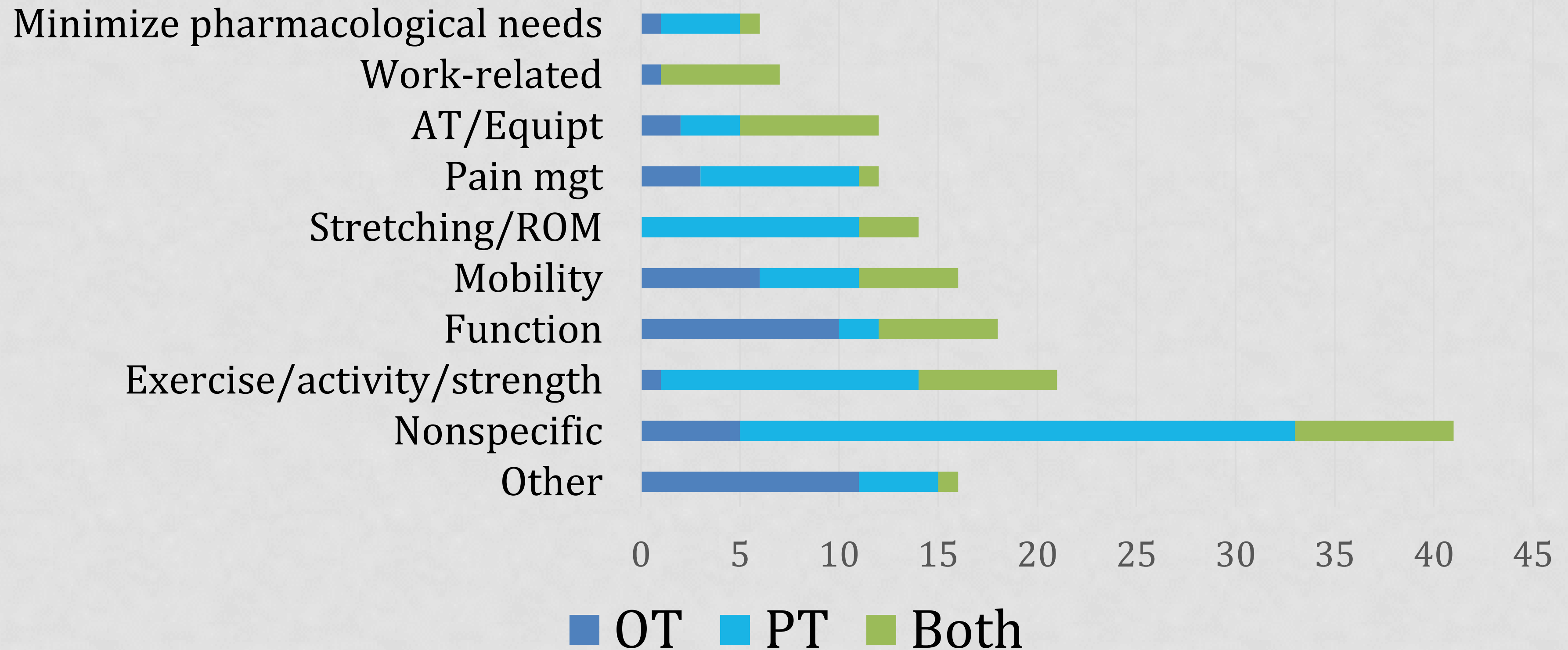
Proportion of Referrals per Discipline

Number Of Referrals Over The Education Year

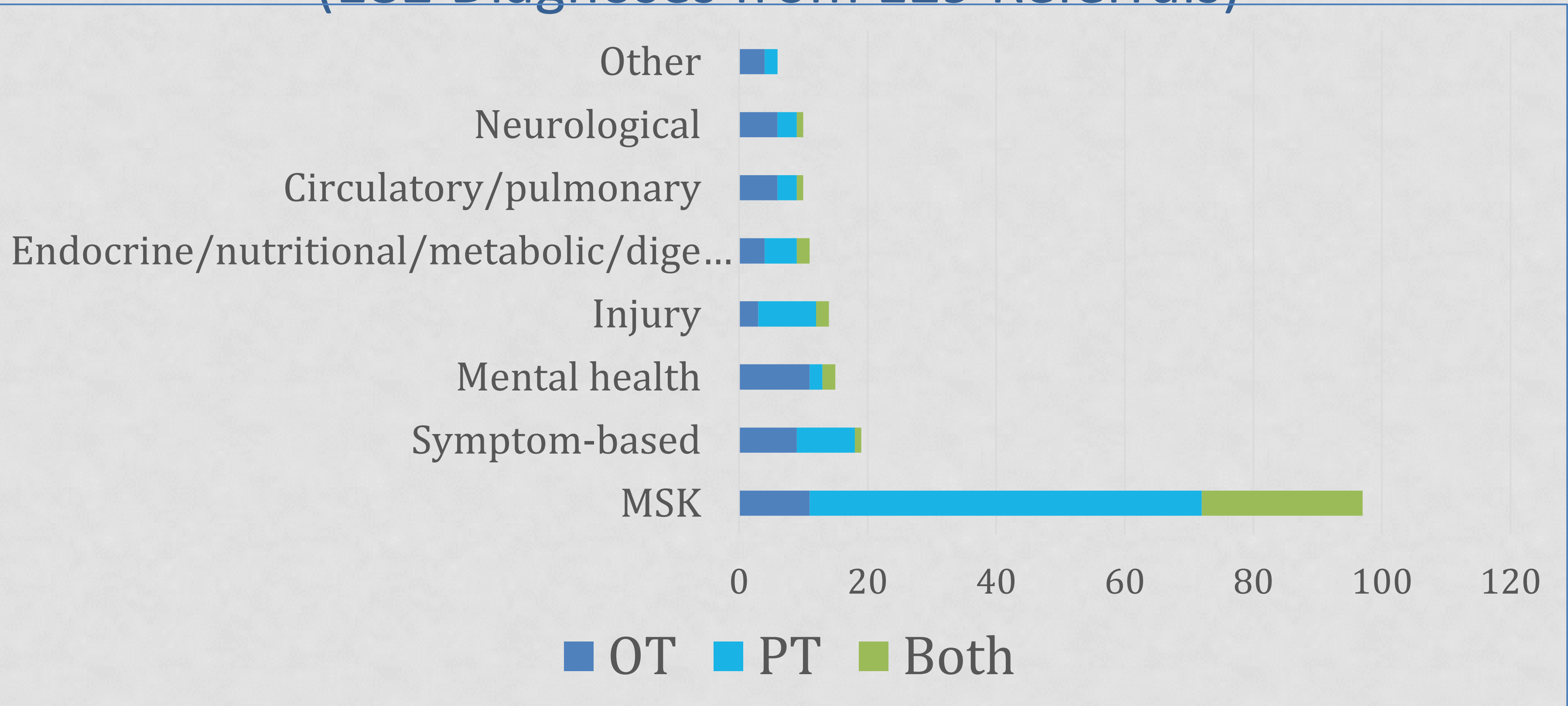


First block at clinic = 14 referrals Last block = 29 referrals (NS)

Reason For Referral
(156 Reasons from 129 referrals)



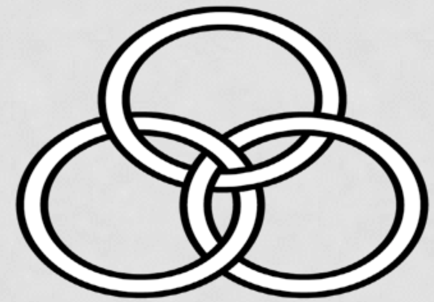
Diagnostic Referral Pattern
(182 Diagnoses from 129 Referrals)



Discussion

- Interprofessional teaching approach valued by residents.
- Role clarity appeared to be enhanced when greater interaction with OT & PT during clinical encounters.
- Teaching approach was consistent with a small body of literature on resident learning (Flynn, Michalska, Han, Gupta, 2012; Soones, O'Brien & Julian 2015, Hauer et al., 2012).

Discussion



- Some residents expressed hesitancy in how to manage "shared roles".
- Lack of literature on this topic.
- Models of interprofessional collaboration suggest:

  -the use of formal tools for clarifying and negotiating responsibilities (D'Amour et al., 2008) .

  -the need for reciprocal relationship building (Wener & Woodgate, 2016).
- An area for future reflection and study, particularly in relation to medical education.

Key competencies	Enabling competencies
PHYSICIANS ARE ABLE TO:	
1. Work effectively with physicians and other colleagues in the health care professions	1.1 Establish and maintain positive relationships with physicians and other colleagues in the health care professions to support relationship-centred collaborative care
	1.2 Negotiate overlapping and shared responsibilities with physicians and other colleagues in the health care professions in episodic and ongoing care
	1.3 Engage in respectful shared decision-making with physicians and other colleagues in the health care professions
2. Work with physicians and other colleagues in the health care professions to promote understanding, manage differences, and resolve conflicts	2.1 Show respect toward collaborators
	2.2 Implement strategies to promote understanding, manage differences, and resolve conflicts in a manner that supports a collaborative culture
3. Hand over the care of a patient to another health care professional to facilitate continuity of safe patient care	3.1 Determine when care should be transferred to another physician or health care professional
	3.2 Demonstrate safe handover of care, using both verbal and written communication, during a patient transition to a different health care professional, setting, or stage of care

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