

MADLY OFF IN DIFFERENT DIRECTIONS

HOW DO WE DECIDE ON AN INTEGRATED, SHARED CARE PLAN IN HYPERTONICITY MANAGEMENT?

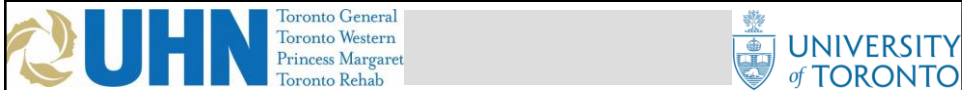
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Collaborating Across Borders V 30 September 2015



Multiple . . .



Patient
presentations



Health care
providers



Treatment
options

“Collaborative Practice is an . . .

**interprofessional process of communication
and decision making**
that enables the separate and shared
knowledge and skills
of care providers to
synergistically influence
the **client/patient care provided.**”

(Way, Jones & Busing, 2000)

Knowledge Base

- **Group decision making**
 - Social Psychology (Hogg, 2001)
 - Cognitive Psychology (Sniezak, 2001)
- **Naturalistic decision making**
 - Behavioural & social sciences (Klein 2008; 1993; Lipshitz 2001)
- **Organizational literature**
 - Team performance (Cohen & Bailey, 1997; Lemieux-Charles & McGuire, 2006; West, et al. 1998)

Knowledge Gap

- Patient-MD shared decision making

(Charles, et al., 1997; Legare, et al., 2008a)

- Uni-professional group decision making

(Christensen, et al., 2000)

- Patient decision aids

(O'Conner et al., 2007)

- Models & frameworks

(Dunn et al., 2013 ;Legare, et al., 2011, 2008b; Packard, et al. 2012)

Master's Thesis: Primary research questions

For healthcare providers (HCPs) working with people living with hypertonicity,

1. How do they **make decisions** to create an interprofessional (shared and integrated) care plan?
2. What are their **perceptions of the outcomes** of this decision making process?



- Qualitative, exploratory research design
- Constructivist grounded theory methodology
- Rigour & Quality
 - (e.g., memoing, triangulation, member checking)
- Ethics Approval-University of Toronto

- 11 participants from across Canada
- Publically-funded sector
- 4 professions:
 - Occupational Therapy
 - Psychiatry
 - Physical Therapy
 - Nursing



Data Collection & Analysis

- In-depth telephone interviews
 - Constant comparison
 - 3 coding stages
 - Open
 - Focused
 - Theoretical
- Demographic & practice context survey

Perceptions of the outcomes

Takes more time, however it is worth it:

- quality of decision making
- all team members are on the same page
- patient achieves anticipated outcomes
- work satisfaction

beneficial to patient's rehabilitation

"It's drawing on the individuals in the team and really pulling together and collaborating towards one common goal...that's what provides the optimal outcomes for our patients."

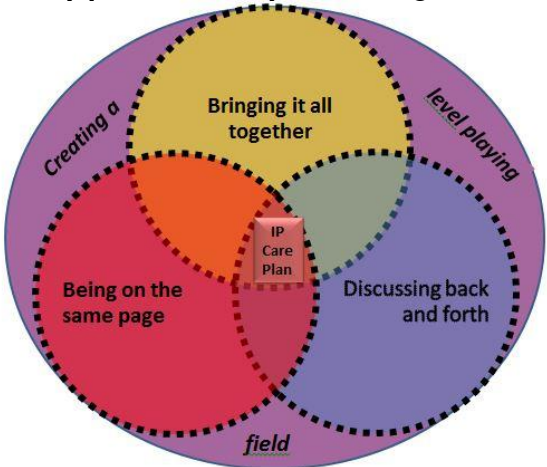
"There was consistency across the board. We could really evaluate whether our interventions were being effective or not."

"It does take more time communicating and consulting, but ultimately that time is well invested [that is,] a team that seems to really know what's going on and be working together."

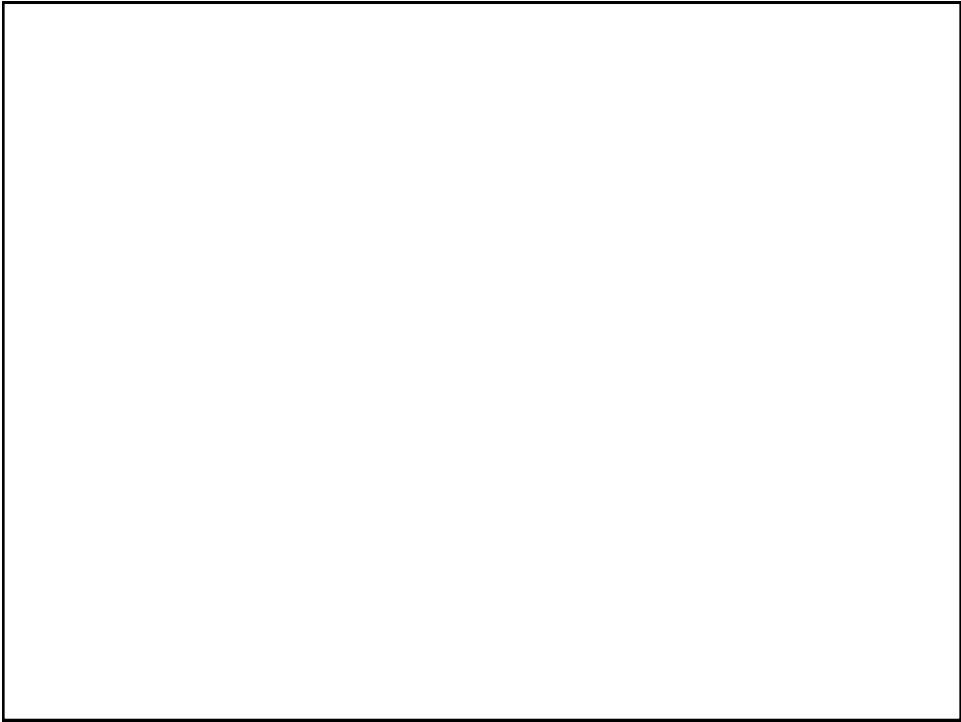
Themes

- Creating a level playing field
- Bringing it all together
- Being on the same page
- Discussing back and forth
- Evolving as new evidence arises

Provisional model of the interprofessional decision making process in hypertonicity management



----- = Evolving as new information arises



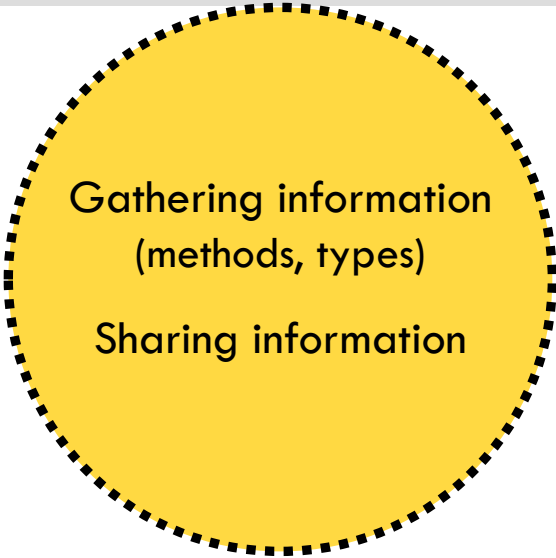
Creating a level playing field

- Willingness to work together
- Knowing each others roles
- Creating a safe environment
(trust, respect, equality)

Creating a level playing field

“I think that [the] people who are collaborating on [the] plan need to be able to trust each other, respect each other, communicate openly with each other, but also that...each of the clinicians feel responsible...but also accountable to the whole overall plan.”

Bringing it all together



Gathering information
(methods, types)

Sharing information

Bringing it all together

“[Therapists] depend a lot on video taking and reviewing of the motion video. The physiatrist will do their own appointment with them. Then we come together and we review the data together as a team, look at our written or clinical data as well as the video data [and] the [patient’s] goals.”

Being on the same page

Identifying critical impairments

Defining a realistic goal

Outcome accountability

Being on the same page

“At the impairment level, we see all kinds of things. You have to talk, think about the [patient] and their goal. What is the actual problem that we see? They are tripping and fallen three times. They’d like to decrease tripping. With that in mind, let’s review the video. There are lots of other things, but what is the primary reason this [patient] is catching their toe?

So we would try to problem solve it that way. [Be]cause there’s so many things that come up . . . probably a list of 12 problems, you [have] to narrow it down and say well this is problematic for the client at this point.”

Discussing back & forth

Engaging relevant voices

Having frank, open discussions

Resolving opinion differences

Accepting uncertainty

Discussing back & forth

“You know, three or four heads are much better than one and we have people who have expertise in physio and occupational therapy, and so we’re all putting our heads together.”

Engaging relevant voices

“...the physician, the physical therapist, occupational therapist predominantly and to a certain extent... the pharmacist.”

“Having the families be key players in the whole decision making process is so important for them following through with any recommendations that you’re going to make.”

Having frank, open discussions

“[It] involves hearing both the positive and the negative. It has to be an environment that’s both open [and] accepting of both sides of each participant’s argument.

So one of the things that has to be clear is that if you are firmly against what another person is saying, you have to put that on the table and let that be discussed by the whole team.”

Resolving differences of opinion

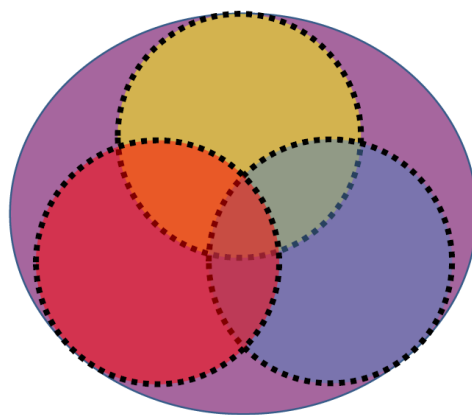
“If we are in disagreement, waiting and collecting more information, further investigations or try alternate therapies first. It would be based on things like the gait analysis or a change. It wouldn’t be just I want to go and talk to the people. It would be objective results.”

Accepting uncertainty

“I think rehab’s tough, rehab is gray. The evidence is certainly strong in certain areas at the impairment level with botulinum toxin and serial casting. There are many ways to do the same thing. You have to be a flexible thinker and realize that rehab isn’t always black and white.

So I think sometimes you don’t always know. I think that sometimes you think you do. You have to say well actually if I’d looked at the evidence this is not as clear, as strong as I’m hoping it is. So maybe it’s okay, it’s safe, it’s reasonable to try something else first.”

Decision making evolves as new evidence arises: — — —



- An evolving plan
- Engagement of new team members

Decision making evolves as new evidence arises

“This goes back to a cyclical way of thinking. You bring the patient back for reassessment. Is there anything that we did before that we could have done better or in a slightly different way?”

...we look at what we could do in the future if this [treatment] plan is not ..giv[ing] us the result that either the patient or we expect.

...the management of hypertonicity is not easy, and is for a lot of people [a] moving target. So, there’s a lot [of] adaptation to the plan and in some cases complete changes.”

Practice Implications

Guidance for educators, managers, health care providers regarding key *skills and behaviours*

- knowing each others roles and contributions in hypertonicity management
- gathering and sharing information
- eliciting different perspectives to develop shared understanding
- openly communicating, being flexible and gathering further evidence to resolve opinion differences

References

- Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, California: Sage.
- Christensen, C., Larson, J. R., Abbott, Z., Ardolino, A., Franz, T. & Pfeiffer, C. (2000). Decision Making of Clinical Teams: Communication Patterns and Diagnostic Error, *Medical Decision Making*, 20, 45-50.
- Dunn, S., Cragg, B. Graham, I.D., Medves, J., Gaboury, I. (2013). Interprofessional Shared Decision Making in the NICU: A Survey of an Interprofessional Healthcare Team *Journal of Research in Interprofessional Practice and Education*, 3(1), 62-77.
- Hogg, M. A. (2001). Social Psychology of Group Decision Making. In N. J. Smelser & P. B. Baltes (Eds.), *International Encyclopedia of the Social & Behavioral Sciences* (pp. 6403-6407). Oxford: Pergamon.
- Legare, F., Ratte, S., Gravel, K. & Graham, I.D. (2008a). Barriers and facilitators to implementing shared decision-making in clinical practice: Update of a systematic review of health professionals' perceptions. *Patient Education and Counselling*, 73(3), 526-535
- Legare, F., Stacey, D., Graham, I., Elwyn, G., Pluye, P., Gagnon, M. P. et al. (2008b). Advancing theories, models and measurement for an interprofessional approach to shared decision making in primary care: a study protocol. *BMC Health Services Research*, 8, 2.
- Legare, F., Stacey, D., Pouliot, S., Gauvin, F-P., Desroches, S., Kryworuchko, J., Dunn, S., Elwyn, G., Frosch, D., Gagnon, M-P, Harrison, M. B., Pluye, P. & Graham, I. D (2011). Interprofessionalism and shared decision-making in primary care: a stepwise approach towards a new model. *Journal of Interprofessional Care* 25(1), 18-25
- Lemieux-Charles, I., & McGuire, W. L. (2006). What Do We Know About Health Care Team Effectiveness? A Review Of The Literature. *Medical Care Research and Review*, 63(3), 263-300.

References (continued)

Mays, N., & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, 320(7226).

O'Connor, A.M., Bennett, C., Stacey, D., Barry, M.J., Col, N.F., Eden, K.B., Entwistle, V., Fiset, V., Holmes-Rovner, M., Khangura, S., Llewellyn-Thomas, H. & Rovner, D.R. (2007). Do Patient Decision Aids Meet Effectiveness Criteria of the International Patient Decision Aid Standards Collaboration? A Systematic Review and Meta-analysis. *Medical Decision Making*, 27, 554–574

Packard, K., Chehal, H., Maio, A., Doll, J., Furze, J., Huggett, K., Jensen, G., Jorgensen, D., Wilken, M., Qi, Y. (2012). Interprofessional Team Reasoning Framework a Tool for Case Study Analysis with Health Professions Students: A Randomized Study, *Journal of Research in Interprofessional Practice and Education*, 2(3), 250-263.

Sniezak, J.A. (2001). Cognitive Psychology of Group Decision Making. In N. J. Smelser & P. B. Baltes (Eds.), *International Encyclopedia of the Social & Behavioral Sciences* (pp. 6399-6403). Oxford: Pergamon.

West, M. A., Borril, C. S. & Unsworth, K. L. (1998). Team effectiveness in organizations. *International Review of Industrial and Organizational Psychology*, 13, 1 - 48.

Way, D., Jones, L. & Busing, N. (2000). *Implementation Strategies: "Collaboration in Primary Care-Family doctors and Nurse Practitioners Delivering Shared Care"*: Discussion Paper written for The Ontario College of Family Physician.

World Health Organization. (2001). International Classification of functioning, disability and health.