Understanding Physiotherapists' Roles in Ontario Primary Health Care Teams

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ABSTRACT

Purpose: To understand physiotherapists' roles and how they are enacted within Ontario primary health care (PHC) teams. **Methods:** Following a pragmatic grounded theory approach, 12 physiotherapists practising within Ontario PHC teams participated in 18 semi-structured in-depth in-person interviews. All interviews were audiotaped and transcribed verbatim, then entered into NVIVO-8. Coding followed three progressive analytic stages and was iterative in nature, guided by grounded theory. An explanatory scheme was developed. **Results:** Physiotherapists negotiate their place within the PHC teams through five interrelated roles: (1) manager; (2) evaluator; (3) collaborator; (4) educator; and (5) advocate. These five roles are influenced by three contextual layers: (1) inter-professional team; (2) community and population served; and (3) organizational structure and funding. Canada's PHC mandate (access, teams, information, and healthy living) frame the contexts that influence role enactment. **Conclusions:** To fulfill the PHC mandate, physiotherapists carry out multiple roles that are based on a broad holistic perspective of health, within the context of a collaborative inter-professional team and the community, through an evidenced-informed approach to care. There appear to be multiple ways of successfully integrating physiotherapists within PHC teams, provided that role enactment is context sensitive and congruent with the mandate of PHC.

Key Words: inter-professional teams; primary health care.

RÉSUMÉ

Objectif : Comprendre les rôles des physiothérapeutes et comment ils sont appliqués au sein des équipes de fournisseurs de soins de santé primaires en Ontario. **Méthodes :** Suivant une méthode théorique à base empirique pratique, 12 physiothérapeutes pratiquant dans des équipes de soins de santé primaires de l'Ontario ont participé à 18 entrevues personnelles détaillées semi-structurées. Toutes les entrevues ont été enregistrées, transcrites verbatim et entrées ensuite dans NVIVO-8. Le codage a suivi trois stades analytiques progressifs et était de nature répétitive, guidé par une théorie à base empirique. On a créé un système explicatif. **Résultats :** Les physiothérapeutes négocient leur place au sein des équipes de soins de santé primaires en jouant cinq rôles interdépendants : (1) gestionnaire; (2) évaluateur; (3) collaborateur; (4) éducateur; (5) représentant. Ces cinq rôles subissent l'influence de trois strates contextuelles : (1) équipe interprofessionnelle; (2) communauté et population desservies; (3) structure organisationnelle et financement. Le mandat du Canada au niveau des soins de santé primaires (accès, équipe, information et vie saine) circonscrit les contextes qui agissent sur les rôles joués. **Conclusions :** Pour s'acquitter du mandat relatif aux soins de santé primaires, les physiothérapeutes jouent de multiples rôles qui reposent sur une perspective holistique générale de la santé dans le contexte d'une équipe interprofessionnelle basée sur la collaboration et de la communauté, en suivant une approche des soins éclairée par des éléments probants. Il semble y avoir de multiples façons d'intégrer avec succès les physiothérapeutes dans les équipes de soins de santé primaires, à condition que les rôles joués soient contextualisés et conformes au mandat relatif aux soins de santé primaires.

In Canada, primary health care (PHC) is generally understood as describing first-contact services, defined by four key features: (1) collaborative teams, (2) healthy living, (3) information, and (4) access.¹ These four features frame Canada's PHC mandate. In Ontario, physiotherapists are underrepresented within PHC teams;^{2,3} the

majority of community physiotherapy services in Ontario are available only through the private health care sector, which translates into limited or no access for many people.²⁻⁴ The Canadian Physiotherapy Association contends that inter-professional health care models that integrate physiotherapists ensure continuity of care and

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effective management, education, and care for all Canadians.⁵ Recent research demonstrates that PHC providers support embedding physiotherapists within PHC teams.² Further, exploring current PHC models as cost-effective options to expand publicly funded community physiotherapy service within Canada has been recommended.^{2–4} Thus, an understanding of how physiotherapists currently practise and what roles they are playing within these settings is needed.

Health care providers' roles are constantly evolving,⁶ partly because of the changing nature of practice environments, which can create uncertainty within inter-professional teams.⁷ Clearly defining provider roles and responsibilities enhances the positive elements of collaborative practice models.^{8,9} With respect to physiotherapists specifically, Canada's current competency profile for physiotherapists reflects the diversity of practice, is evidence-informed and needs-driven, and describes seven roles common across professions.¹⁰ These competencies ensure that physiotherapists have the skills needed to function on inter-professional teams. Currently, physiotherapists lack presence within Canadian PHC teams. Gaining an understanding of how physiotherapists practise and articulating the presently unknown factors that influence practice patterns within Ontario PHC teams are important steps toward expanding the integration of physiotherapists within these teams.

The purpose of this study was to understand physiotherapists' roles within Ontario PHC teams. Understanding the roles carried out by physiotherapists also involves gaining insight into how those roles are enacted. In the context of this study, role enactment was understood to encompass how health care providers carry out their roles as considered from a social process perspective,¹¹ specifically those involved in the formation and interaction of a group of persons, in this case the PHC team. We acknowledge that some scholars conceptualize "enactment" as a term relating to the mode in which various role components are carried out.¹²

METHODOLOGY

To understand how physiotherapists practise and to explicate role enactment within PHC teams, an interpretive, process-focused method of inquiry was required. We chose a grounded theory approach because it has the potential to reveal social processes^{13,14} and because it promotes "the act of constructing an explanatory scheme from data that systematically integrates concepts, their properties, and dimensions through statement of relationship."^{14(p.64)} We chose pragmatic grounded theory specifically because the first author (SPD) is an experienced physiotherapist and PHC researcher, and because this study represents a portion of a larger mixed-methods research project. Particularly important is that when the researcher is already well acquainted

with the topic being investigated, pragmatic grounded theory provides a means of dealing with pre-understandings.^{15,16} Professional experience can enhance the researcher's ability to understand and relate to participants' perceptions and experiences, increasing the "sensitivity" of the research team during the analysis process.¹⁴

METHODS

Ethics approval for this study was obtained through the University of Western Ontario's Research Ethics Board.

Participants

We identified potential participants through a database of providers who currently work within the two most common Ontario PHC models (Community Health Centres and Family Health Teams). From this database, a total of 19 physiotherapists from 15 PHC teams were identified, and one physiotherapist from each PHC team was purposively sampled. A second round of interviews was directed by theoretical sampling.¹⁴ Final participant demographics are summarized in Table 1.

Data collection

We contacted the selected participants by phone or email to confirm their interest in receiving information about the study. Those interested were sent an information letter describing the purpose of the study and the nature of the request for their involvement with an accompanying consent form. Data were collected in the form of 18 semi-structured, in-depth interviews; 17 of these took place in person at a location of the participant's choosing (typically the PHC setting in which they worked), while one follow-up interview was conducted by phone. We used an interview guide that included open-ended exploratory questions such as, *How do you negotiate your role as a physiotherapist within the PHC team you are a part of? Tell me about the process of care for a typical client from referral to discharge? How do you collaborate with other team members to provide service?* However, the interviewer kept the data-collection process open and flexible, deviating from the interview guide when necessary to enhance the richness of the data collected. All interviews were audiotaped. Memos of observations at the various interview sites and reflections during the analyses were maintained throughout all stages of the research process.

Data analysis

All interviews were transcribed verbatim, then checked by the original interviewer (SPD) for accuracy and entered into NVIVO-8 (QSR International Ltd., Cambridge, MA) to facilitate analysis. Data collection and analysis occurred simultaneously, following an inductive, iterative process. Coding was framed by three progressive stages: open, axial, and selective.¹⁴ *Open* coding consisted of a line-by-line analysis of the transcript to determine codes. As

Table 1 Demographics of Final Sample

Participant characteristics			Primary Health Care Site characteristics	
Identification no.	Sex	Years in Practice	Primary Health Care Model	Size Category
001	M	24	CHC	Small
002	F	18	CHC	Rural
003*	M	7	CHC	Rural
004*	F	8	CHC	Rural
005	F	16	CHC	Rural
006	F	1	CHC	Rural
007	F	17	FHT	Community
008*	F	12	CHC	Small
009*	F	10	FHT	Large
010*	F	15	CHC	Rural
011	F	4	CHC/FHT	Rural/Small
012†	F	7	FHT	Large

Rural = 0–4 physicians; Small = 5–10 physicians; Community = 11–20 physicians; Large = 21+ physicians; CHC = Community Health Centre; FHT = Family Health Team.

*Participants who were interviewed twice.

†Participant who was a physiotherapist by profession but functioning as a “Chronic Disease Management Facilitator.”

each new transcript was analyzed, data were compared with existing codes and either an existing code was assigned or a new code was created. This stage of analysis also involved writing reflective memos that would assist in the later analytic stages. *Axial* coding constituted the second stage of analysis, in which codes were compared with each other and with the reflective memos to form categories, representing similar codes brought together through the relating of concepts inherent in the codes. *Selective* coding was the final stage, in which categories were examined and compared with each other to develop themes. The main themes that emerged formed the basis of the developing theory. At this point, we undertook theoretical sampling to carry out a second round of interviews to explore and refine the emerging theory. In an effort to explore as many perspectives as possible, all analytic stages involved regular debriefing with the research team.

Credibility and trustworthiness

The credibility and trustworthiness of the data were enhanced through six principal means: (1) prolonged engagement with the data via in-person and multiple interviews; (2) purposive sampling followed by theoretical sampling; (3) verbatim transcription of interviews and rechecking of the transcripts by the original interviewer; (4) development and maintenance of an audit trail throughout the research process; (5) analysis of transcribed data followed by collaborative team discussions at all stages of analysis; and (6) use of a consistent school of grounded theory, in this case pragmatic, to enhance internal consistency.^{14–16}

RESULTS

Physiotherapists' roles within Ontario PHC teams were varied and carried out in a dynamic manner, as framed by Canada's PHC mandate. In their attempts to fulfill the evolved holistic perspective of health, physiotherapists were resourceful and pushed the boundaries of their practice as well as advocating for their place within the PHC team. Physiotherapists negotiated their place within the PHC teams through five interrelated roles: (1) manager; (2) evaluator; (3) collaborator; (4) educator; and (5) advocate. The manager role was the central and integrative role. Negotiating a balance between one-to-one and group-programming care emerged as a key feature of the manager role. This balancing act represented a tension negotiated in practice to fulfill the four pillars of the PHC mandate.

Three practice contexts influenced how physiotherapists enacted the five interrelated roles: (1) inter-professional team (core context); (2) community and population served; and (3) organizational structure and funding. These contexts were framed by Canada's PHC mandate (see Figure 1).

Physiotherapists' roles: The influence of contextual layers

Manager

The physiotherapists' roles were varied, and how these roles were enacted depended on the participants themselves as well as on their ability to negotiate with their team and community. Manager was the central role physiotherapists carried out. To implement management plans for their clients, physiotherapists demonstrated an understanding of the broader health care

Figure 1 Physiotherapists' roles within Ontario primary health care teams: factors that influence enactment.

system and their community. As managers, they considered the needs of clients in the context of the available human, physical, and financial resources. Given limited resources, a fundamental component of the manager role was the ongoing balancing act between one-to-one versus group-programming care, a process that changed in relation to the three practice contexts:

The ideal scenario would be that patients have access to direct one-to-one physio, in a time-limited fashion, but that the emphasis within that framework of care is to augment this little bit of individualized care with groups and community resources ... this is where the contribution of the team is so important.

The manager role overlapped with all other roles. For example, the interplay between providers and, in many cases, groups of providers (e.g., Allied Health) dictated to a large degree how physiotherapists went about their day-to-day work, highlighting collaboration as a feature of management. Physiotherapists described their collaboration with team members as enabling them to manage their clients in a comprehensive manner: "Having the network of providers here to provide comprehensive care I have seen to be so important, and you don't have that in private PT [physiotherapy] settings."

Linking the influences of two practice contexts, the "inter-professional team" and the "population served

and community,” participants explained how connecting their clients to community resources was also important to ensure that clients received the full complement of care required. “If we identify any other broader health needs we have the wonderful luxury of referring to a really diverse team.... we also have links within the community.”

Apart from a team complement perspective, physical structure also influenced how physiotherapists enacted their roles. In all cases, an emphasis on self-management emerged as an important management strategy: “Because of the way the FHT [family health team] is set up, I think really the emphasis on self-management is key in this setting.”

Evaluator

Many participants explained that conducting a comprehensive assessment was a primary duty within their teams. In the evaluator role, physiotherapists collected relevant assessment data and analyzed it to form an evaluation, which guided an intervention plan:

We would just take in referrals, do our assessments and then make recommendations as necessary or plan for interventions or referral to community resources... We primarily function as assessors...

As a component of the evaluator role, the concept of triage agents emerged. The potential role of physiotherapists functioning as triage agents highlights another example of pushing the boundaries of traditional practice as well as advocating for themselves within PHC teams:

I could definitely see where [a triaging role] would be a really helpful role in this setting and would help to free up some of the other practitioners time so they can deal with other issues... it would be better to have a second PT [physiotherapist] there within the primary care team doing that role.

Collaborator

Communication within the team was related to how physiotherapists (and other providers) were able to provide care. As collaborators, physiotherapists consulted with other health care providers, collaborating in such a way as to achieve optimal client care. The collaborator role was tightly connected to the context of the inter-professional team and a key component of overall client management:

Part of the beauty of this setting is that [team members] come to us for collaboration and consultation for anything regarding physical activity ... we are not always responsible in the end for running some of those programs, but certainly play a key role to ensure that the content of the program is safe and effective.

As collaborators, physiotherapists drew upon the skills of their team to provide comprehensive care that was continuously evolving. “We are looking at the person as a whole. The care cannot be provided in a

comprehensive way by just one practitioner. There are multiple needs, and people need choices and diversity.”

The collaborative approach to care from a variety of providers was considered to be very important in managing chronic conditions: “With the chronic conditions there is often a mindset that has developed over time or a sequence of behaviours that have developed that need to be addressed by multiple providers.”

Several participants explained a structure in which various smaller teams of providers worked within the context of the larger inter-professional team and how they “bridged” across these provider groups as collaborators. “The ‘teams within the team’ is definitely a prominent feature of our interdisciplinary work environment ... Essentially, as PTs we tend to connect all of the teams.” Physiotherapists’ professional training enabled them to “bridge” across providers and programmes. “Physiotherapists are really able to span all areas as we are trained to take a multi-system approach.”

Educator

Participants described how the limited human and fiscal resources of their PHC setting promoted an emphasis on client education and empowerment. Thus, physiotherapists enacted the role of the educator by providing client education and encouraging client empowerment. In this role, physiotherapists used effective communication to educate clients, team members, and other stakeholders in aspects of health related to their scope of practice. Client education related to the management of specific issues was described as a central aspect of the physiotherapist’s role, highlighting the crossover between the roles of educator and manager:

I really see a lot of my role is to identify what movement impairments people have and then to treat those accordingly the focus here is on self-management through patient education.

The emphasis on health promotion and chronic disease management in particular was related to physiotherapists enacting their role as educators. In this sense, education was often contrasted with “hands-on treatment”; participants used both, but emphasized education:

Some people just needed health promotion and education with respect to prevention ... even when it comes to chronic disease management, education is a big component ... so we educate and help facilitate rather than treat hands-on.

Physiotherapists described empowering patients as necessary and effective. Demonstrating crossover with the manager role, physiotherapists partnered with clients to assist them in becoming their own health managers:

I’m a big proponent of not making people reliant on us as providers, and I think that in terms of client empowerment ... really educating them in terms of their own role related to their health ... that is key ...

In many PHC teams, participants also directed their educator role toward their team: "The referral can come from any provider on the team, and they are aware of our scope of practice; we have communicated it to them [and] educated them on what physiotherapists do." The sometimes narrow or limited perspective of a physiotherapist's breadth of practice led several participants to explain the need for ongoing education and advocacy to the PHC team with respect to their scope of practice: "When I first got here, they thought that I was an exercise instructor ... that was very frustrating. I am still trying to tease things out and develop the role."

Beyond the domain of the team, participants extended their educator role into the community, again highlighting crossover between the educator and manager roles. "We have partnered with public health, and they are doing education sessions with our program and our senior groups."

Advocate

In addition to participants advocating for their place within PHC teams, a distinct advocacy role relative to both the client and the community also emerged. In this role, participants identified the broader social determinants of health as barriers for patients in accessing care and identified opportunities to develop strategies to optimize care for patients, communities, and populations:

So here we have a large centre and we have a dedicated health promotion team that look at everything from safety to food ... basically addressing the social determinants of health and develop a wide range of services to address these various areas.

Participants indicated that physiotherapists and other health care providers alike need to advocate for momentum within current systems to ensure that care provision evolves as necessary:

But also PTs [physiotherapists] do need to advocate vocally within the teams ... For both PTs and primary care professions ... slowly shifting our training and our mindsets away from traditional modes of delivering care ... we need to evolve how we do things given the changing landscape of health resources and health needs.

Further, participants acknowledged the need to advocate within the team to support the evolution of roles less traditionally enacted by physiotherapists: "I am always trying to push the boundaries and place a great emphasis on health promotion ... attempting to shift more of the team's energy in that domain."

DISCUSSION

Using a pragmatic grounded theory method, we developed a theoretical explanatory scheme to facilitate an understanding of physiotherapists' roles within Ontario PHC teams. Physiotherapists in this study carried out five interrelated roles—(1) manager, (2) evaluator, (3) collaborator, (4) educator, and (5) advocate—in a fluid

and dynamic manner. We did not seek to describe what tasks physiotherapists were doing within these roles. Notably, these five roles correlate with four of the seven roles outlined in the Essential Competency Profile for Physiotherapists in Canada.¹⁰ Thus, our study substantiates the depth and breadth of this profile as it relates to physiotherapists working within PHC.

In addition to exploring and articulating the roles currently enacted by physiotherapists, this study also uncovered three specific contextual layers: (1) the inter-professional team, (2) the community and population served, and (3) organizational structure and funding. Ways in which these contextual layers affected physiotherapists' role enactment within PHC teams also emerged. These findings constitute important new knowledge.

Understanding interrelated roles

The central and integrative role enacted by physiotherapists within Ontario PHC teams was the manager role. This role connected the other roles: the four other roles appeared to be necessary components of the overall management role. Mindful of limited resources, physiotherapists managed clients on a one-to-one basis, through group programming offered within their respective PHC teams, and through interfacing with and recommending programs available in the community. Thus, an ongoing balancing act emerged as an important feature of the manager role. This collection of roles is similar to the described roles of a care manager, recognized as an important player in PHC reform.¹⁷

Despite the heterogeneity of PHC teams, we consistently found that physiotherapists functioned collaboratively with both clients and providers. Inter-professional competencies are acknowledged in competency frameworks for most health provider groups, but only recently have national inter-professional competencies been developed. The six competency domains established within the National Inter-professional Competency Framework are (1) inter-professional communication, (2) client/family and community-centred care, (3) role clarification, (4) team functioning, (5) collaborative leadership, and (6) inter-professional conflict resolution.¹⁸ Our findings validate the first four competencies relative to physiotherapists working within PHC teams. The physiotherapists we interviewed functioned uniquely as a "bridge" between smaller teams within their larger PHC teams. As educators, participants incorporated client education into management plans, educated their teams on how their skills could be best used, and engaged in educational sessions within their respective communities. Finally, participants also advocated both for their clients and for their own place in the PHC team, through role clarification, in an effort to improve client care and community health.

The literature identifies potential challenges that may occur within health care teams as provider roles evolve, such as the blurring of provider roles.⁷ The blurring of

provider roles within PHC teams impedes collaboration⁹ and translates to role confusion.^{8,19} Our study participants unanimously described working with their respective inter-professional teams as a positive experience, which suggests that they may have worked in teams that promoted synergy among providers and fostered a climate of mutual respect. Both factors are linked to enhancing team function and client care as reported in the literature.^{20,21}

Impact of contextual layers

A central finding of this study is the fundamental importance of the inter-professional PHC team contextual layer in enabling physiotherapists to function optimally in their respective settings. Physiotherapists interface with individual providers, teams of providers, and existing community programs to develop and make recommendations for intervention plans and manage their caseloads with limited resources. Drawing on the diverse skills of providers, an inter-professional team is understood to facilitate a comprehensive approach to care.^{22–24}

Within the inter-professional team, physiotherapists enacted their educator role in multiple ways, including educating the team as to the most appropriate use of their unique skills and knowledge. As PHC teams continue to develop and scopes of practice evolve, team members need ongoing education on the optimal use of each provider to enhance the positive elements of collaborative inter-professional practice.^{8,9,25} Negotiating traditional and evolving roles is an important element of collaboration within Ontario PHC teams.²⁶

Physiotherapists in this study believed they were able to facilitate client self-management, moving beyond educating patients to empowering them, by applying evidenced-based self-management programming^{27,28} in their practice. People with chronic conditions need self-management skills to manage their health and prevent functional decline.^{29,30} Supporting clients' self-management is consistent with the population health approach adopted by Canada for health policy and program development.³¹ In this way, the roles enacted by our physiotherapist participants appear to be similar to roles enacted by home-care physiotherapists practising in the community,^{32,33} the primary difference being the central influencing role of the inter-professional team within PHC. This study highlights the congruence of physiotherapists' role as (client) educators, as well as managers, collaborators, and advocates in supporting clients in self-management and thus aligning with the PHC mandate.

Both the organizational structure of the teams and their funding constituted another contextual layer that affected the process of role enactment for physiotherapists practising in PHC teams. Consistent with previous findings,² physiotherapists noted financial constraints as a barrier to clients' accessing their service, both in PHC teams and in other community settings. The emergence

of these factors highlights an important interplay between structure and process that has not been captured in other studies. Some studies have contended that organizational factors, such as governance and provider complement, have minimal impact on team functioning, and that process within the team accounts for a higher proportion of the variance in the construct of 'effective team work.'^{34–36} Our findings demonstrate how funding limitations, in particular, challenge physiotherapists to be resourceful with their inter-professional teams and communities.

Our study highlights how some physiotherapists, specifically those working in emerging PHC roles, have transitioned from traditional providers who carry out health care plans to dynamic professionals able to carry out a variety of roles in an evolving health care environment. These physiotherapists constitute a niche group within the profession, who have sought out work in their respective teams and feel they are pushing the boundaries of traditional physiotherapy practice.

LIMITATIONS

Our study has several limitations. Our sample reflects only one province in Canada, and the views captured in the study are those of physiotherapists working within PHC teams. Given the inter-professional nature of PHC, the perspectives of other providers and stakeholders could further develop the emerging theory. While the number of physiotherapists practising within PHC teams in Ontario is limited, a strength of our study is that our sample included almost all of those practising in that context at the time of data collection.

CONCLUSIONS

Physiotherapists' roles within PHC teams in Ontario and the ways in which they enact these roles are variable and dynamic in nature, framed by the four pillars of Canada's PHC mandate. In their attempts to fulfill the evolving holistic perspective of health characterizing PHC, physiotherapists are resourceful and push the boundaries of their practice as well as advocating for their place within the PHC team. Physiotherapists negotiate their place in the PHC team within five interrelated roles, influenced by three contexts. This study highlights how physiotherapists working in emerging PHC roles operate from a broad holistic perspective of health within the context of a collaborative team and community. Thus, there appear to be multiple ways of successfully including physiotherapists within PHC teams, provided that role enactment is context sensitive and congruent with the mandate of PHC.

KEY MESSAGES

What is already known on this topic

The international literature describes several benefits related to integrating physiotherapists into PHC teams.

Although physiotherapists are well positioned to participate in PHC teams, in Canada they have been integrated only to a limited degree. Increasing physiotherapists' presence in PHC remains a priority for the profession.

What this study adds

This research begins to fill the gap in understanding how physiotherapists can expand their presence within PHC teams through insight gained into how they actually practise within these teams. Physiotherapists must recognize their roles in PHC as part of the collective evolutionary process and understand the importance of advocacy at multiple levels. Absent in the current literature is the notion that physiotherapists have multiple important and context-driven roles to enact within PHC. In addition to explaining the roles enacted by physiotherapists, this research also highlights the need to ensure that educational curricula for all health care providers include study of inter-professional collaborative practice.

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