# Physiotherapy in Primary Care

**Module 8**

## PT Leadership in Team-Based Primary Care

**Please note:** This course was designed to be interacted and engaged with using the online modules. This **Module Companion Guide** is a resource created to complement the online slides. If there is a discrepancy between this guide and the online module, please refer to the module.

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## MODULE INTRODUCTION

*Please see the online learning module for the full experience of interactions within this document.*

When most people think about leadership, they think about formal leadership, administrative, or management positions. However, leadership does not require formal positions or titles. The purpose of this module is to discuss different ways physiotherapists can lead collaboratively as members of primary care teams to provide effective team-based care and help advance team-based primary care.

**Module Learning Outcomes**

By the end of this module, learners will be able to:

1. Describe collaborative leadership approaches within the interprofessional primary care team.
2. Identify leadership strategies for the advancement of physiotherapists' role within primary care.
    a. Contribute to quality improvement, evaluation, and research to advance team-based primary care.
    b. Contribute to mentorship and education of students and physiotherapists entering team-based primary care settings.
    c. Advocate for team-based models of care that meet the needs of patients by leveraging the expertise of all team members, including physiotherapists.
3. Identify personal learning needs related to leadership in team-based primary care and a plan to address those learning needs.

**Note:** A full reference list for topics discussed in this module can be found in the Conclusion section.

The goal of this module is to help you gain new knowledge related to leadership in team-based primary care, to help you identify your own learning needs, and to develop a plan to address those needs related to competencies 3.4, 3.5, 4.4, 4.5, 4.6, 5.2, 5.3, 5.4, 5.5, 6.1, 6.2, 6.3, and 6.4.

*Continue to access the competencies that are relevant to this module.*

**Module Competencies**

3.4 Apply evidence-informed approaches to enhance team collaboration and effective team functioning in primary care.

3.5 Collaboratively and constructively engage in addressing and seeking to resolve disagreements among interprofessional primary care team members.

4.4 Lead or actively participate in program evaluation and quality improvement activities in team-based primary care.

4.5 Supervise and/or mentor team members who participate in the delivery of physiotherapy services in primary care.

4.6 Safely manage data from persons seeking care in accordance with pertinent institutional and jurisdictional policies.

5.2 Identify, implement, and evaluate opportunities for innovation in delivering primary care services.

5.3 Provide leadership for the advancement of physiotherapist roles within primary care teams.

5.4 Mentor physiotherapists or physiotherapy students to prepare them for future primary care roles.

5.5 Participate in collaborative leadership within the primary care team.

6.1 Deliver evidence-based and person-centered approaches to team-based primary care.

6.2 Participate in research to advance the delivery of physiotherapy services within team-based primary care.

6.3 Engage in critical self-reflection, self-directed learning, and professional development to advance contributions to service delivery as a primary care team member.

6.4 Support the professional development of students and other interprofessional primary care team members.

**Continue to Section 01**

## SECTION 01: COLLABORATIVE LEADERSHIP

In this section, you will be introduced to collaborative leadership, including its definition, goals in practice, and examples in team-based primary care. You will also learn about the role of tasks and relationships in becoming an effective collaborative leader.

**What is Collaborative Leadership?**

Leadership is not limited to individuals in designated leadership or management positions. Every member of an interprofessional team can demonstrate leadership competencies and contribute to leadership within the team. **Collaborative leadership** is a term used to describe the sharing of leadership responsibilities amongst a team.

Collaborative leadership involves:

- Breaking down silos so that team members can work together and share responsibilities to reach common goals and health outcomes.
- Maintaining accountability through shared decision-making.
- Leveraging the diversity of opinions and strengths across all team members in order to generate strategies and solutions to problems.
- Valuing each other's knowledge, skills, expertise, and the different strengths and perspectives each practitioner brings to the table.[1]

**Note:** The Canadian Interprofessional Health Collaborative (CIHC)(opens in a new tab) has identified collaborative leadership as one of the six domains in the National Interprofessional Competency Framework (2023).[1]

To be a collaborative leader on a team, practitioners:[1]

- Advance interdependent working relationships among all team members.
- Facilitate effective team processes for shared decision-making.
- Develop and facilitate shared accountability mechanisms.
- Co-create a practice culture that values care partners and supports their physical and mental well-being.
- Apply collaborative decision-making principles to continuous quality improvement processes and outcomes.
- Promote interprofessional collaborative leadership development, including skills and knowledge for the critical role leaders have in supporting effective interprofessional team dynamics and collaborative practice.

**Tasks and Relationships**

Collaboration is a crucial element of effective leadership. Leaders who excel in collaboration have two primary focuses: **tasks** and **relationships**.2 By keeping team members focused on the tasks at hand, collaborative leaders facilitate progress toward a shared goal. At the same time, they build strong relationships among team members, encouraging effective teamwork. Furthermore, in a team environment, leaders may take on different roles, depending on the strengths of oneself and all team

members. While one leader may focus on building relationships with patients, families, or community services, another leader may focus on keeping the group on track to complete tasks.

**Note:** Leadership roles may also rotate between team members to build capacity and include a broader range of perspectives. Even people seeking care and learners can take up leadership roles in the team environment. The collaborative leadership model is rooted in the concepts of mentorship and inclusion.[2, 3]

Throughout this module, you will explore the key elements of collaborative leadership and how to apply them in primary care teams. With a focus on tasks and relationships, every member of the team can work together towards a shared goal, building strong relationships, and achieving success.

*Before looking into the elements of collaborative leadership in detail, continue to explore four examples of how physiotherapists demonstrate collaborative leadership in team-based primary care.*

**Example 1**

**Interdisciplinary Treatment Planning**

In a primary care clinic, a physiotherapist can lead by collaborating with other health care professionals, such as physicians, nurses, and occupational therapists, and lead the development of comprehensive treatment plans for people with chronic conditions. They initiate and actively participate in team meetings, share their physiotherapy expertise, seek out the perspectives and suggestions from other team members, and coordinate care to address peoples' health needs.

**Example 2**

**Community Wellness Programs**

A physiotherapist takes a leadership role in organizing community wellness programs in collaboration with local health care providers, community organizations, and public health agencies. They can identify community needs, initiate the development of relevant programs, and make the case to decision-makers to garner support for such programs. They collaborate with dietitians, fitness trainers, and mental health professionals to create holistic programs that address the diverse needs of the community. By fostering these collaborations and creating a program using the strengths of each team member, the physiotherapist contributes to preventive care and community well-being.

**Example 3**

**Person-Centred Care Teams**

In primary care practice, a physiotherapist can be a role model by demonstrating person-centred care and advocating for its importance among team members. They can collaborate closely with family physicians, nurses, and social workers to provide personalized care plans for people with complex health needs. By integrating physiotherapy into the overall care strategy, they contribute to a more holistic approach, ensuring that everyone receives comprehensive and coordinated health care services.

**Example 4**

**Promoting Equity, Diversity, Inclusion, and Indigeneity**

As you learned in **Module 03: Creating Safer and Braver Spaces for Clients, Support Networks, and Team Members**, it is essential to consider privilege and oppression to help build more equitable healthcare services. This work applies to providing services to communities, as well as in creating a physiotherapy profession and primary care teams that represent the diversity of the communities they serve. A physiotherapist can lead by example by taking steps to consciously recognize how privilege and oppression impact how people encounter the health system and the profession. They can advocate for more inclusive spaces and practices.

**Reflection Question:** How have you applied elements of collaborative leadership in practice? In what ways might you practice collaborative leadership in the future?

To further develop the collaborative leadership competencies introduced in this module, there are programs in healthcare leadership across Canada. One example is the **Centre for Advancing Collaborative Healthcare & Education (CACHE)**(opens in a new tab).

In this section you were introduced to collaborative leadership, through which practitioners support each other, share decision-making, and are accountable for reaching common goals. In the next section, you will be introduced to three leadership strategies for the advancement of the role of physiotherapists within primary care.

**Continue to Section 02**

**Page link:**

https://www.cihc-cpis.com/

https://ipe.utoronto.ca/

## SECTION 02: LEADERSHIP STRATEGIES FOR ROLE ADVANCEMENT

Considering that physiotherapy roles in primary care teams continue to develop and evolve, leadership strategies perform several important functions to grow this role.

As you will learn in this section, physiotherapists can demonstrate leadership by:

1. Working towards continuous improvement of health outcomes, programs, and evidence.
2. Supporting continuous learning and mentorship to enhance the capacity of physiotherapists in primary care.
3. Advocating for team-based primary care and roles for physiotherapy.

You will explore these three strategies throughout this section.

**Quality Improvement, Program Evaluation, and Research**

Continuous quality improvement and evidence-based practice play a vital role in delivering high-quality care, especially given the constantly evolving nature of health systems. This part of the section will provide you with the fundamental knowledge required to understand and measure quality improvement initiatives, evaluate program effectiveness, and contribute significantly to advancing patient care through research.

Quality improvement, program evaluation, and research are related but different ideas. Whether to use quality improvement, program evaluation, or research depends on the purpose.

*Continue to contrast the purposes of quality improvement, program evaluation, and research.*

**QUALITY IMPROVEMENT**

**Quality improvement (QI)** projects serve the purpose of enhancing internal processes, practices, or productivity related to a specific intervention. They aim to determine the impact of an intervention (not necessarily a health care intervention) on a specific group of participants in a given setting. Additionally, quality improvement is usually carried out to evaluate an already approved or literature-proven effective practice.[4]

**PROGRAM EVALUATION**

The purpose of **program evaluation** is to inform decisions, identify improvements (i.e., formative evaluation), and provide information about the success of programs (i.e., summative evaluation) according to predefined goals and objectives. Program evaluation involves the systematic collection and analysis of information about a program. It seeks multiple sources of information as a means to improve program implementation and to understand program effectiveness.[5]

**RESEARCH**

**Research** is defined as "an undertaking intended to extend knowledge through a disciplined inquiry and/or systematic investigation."[6] As reflected in this definition, the purpose of research is to generate new knowledge or expand on existing knowledge, often to produce knowledge that is generalizable to the wider population or transferrable to local contexts.

To help demonstrate the similarities and differences between quality improvement, program evaluation, and research, an example of the primary care physiotherapists' role in each of these processes will be provided.

**Physiotherapists' Role in Quality Improvement**

There are many frameworks for quality improvement. One example is the PDSA cycle, which stands for Plan, Do, Study, Act.[7] The steps of the cycle are to:

- **Plan** the test of change, which includes plans for collecting data.
- **Do** the test on a small scale.
- **Study** the results and compare them to your predictions.
- **Act** on what you learned to plan for the next iteration of the cycle.

For example, physiotherapists at the Hamilton Family Health Team used the PDSA cycle when integrating a group program into the services already provided. The group program is called Living Better with Pain, also known as COMMENCE in research literature, which was introduced in **Module 07: Supporting Self-Management.**8

*Continue to learn how the Hamilton Family Health Team used the PDSA model for quality improvement.*

**An Example of Quality Improvement**

Based on an environmental scan, a need for additional community resources for people experiencing chronic pain was identified. Opportunities to improve access to care for people living with pain were explored, and the Living Better with Pain program was identified as an opportunity to improve access and quality of care.

**Step 1**

**Plan**

Hamilton Family Health Team completed an environmental scan and identified a need for additional community resources to support people experiencing chronic pain who identified function and participation goals. Opportunities to improve access to care for people living with pain were explored, and the Living Better with Pain program was identified as an opportunity to improve access and quality of care.

The physiotherapists submitted a proposal to a planning committee for review. In addition to articulating evidence on the effectiveness of the Living Better with Pain program, the team compared the workload for the primary care team to deliver existing services for people with persistent pain, and the estimated workload of the proposed group program. In collaboration with the program creator, the team modified the program so that it would be delivered by one physiotherapist and one mental health counselor to leverage the expertise of the Hamilton Family Health Team.[8]

**Step 2**

**Do**

The Living Better with Pain group program was delivered on a pilot basis, with three iterations completed. Patient health outcomes were tracked, which included functional measures, pain scales, depression screening, rating of change, and patient satisfaction.[8]

**Step 3**

**Study**

Studying the outcomes of the pilot program demonstrated that patient health outcomes improved, and patients and providers were satisfied with the program. A need to train additional health professionals to deliver the program was identified.[8]

**Step 4**

**Act**

The team at Hamilton Family Health collaborated with the program creator to organize training for additional team members. The group program continued to be offered with additional providers involved.[8]

Future iterations of the PDSA cycle at the Hamilton Family Health Team included trying virtual delivery, and integration of expertise from pharmacists during one session.8

By identifying an appropriate framework for quality improvement, such as the PDSA cycle, physiotherapists can implement processes for continuous improvement in the quality of the services they provide.

***Access an additional resources to help you with planning and implementing quality improvement activities.***

**Physiotherapists' Role in Program Evaluation**

There are many approaches to program evaluation. One commonly used approach is the use of a **logic model.**

*Continue to learn how logic models can help with program evaluation.*

**Logic Models**

Logic models help define programs by providing a visual representation of relationships between program activities and intended outputs and outcomes. They can be helpful both for planning a program and evaluating a program. Logic models should help show why a program is expected to work and allow for the evaluation of whether it works as intended.

One great example of a resource to support you in the use of a logic model is the **Evaluation Guide for Older Adult Clinical Fall Prevention Programs.**[9] This resource is meant to support program evaluation for programs related to Stopping Elderly Accidents, Deaths, and Injuries (STEADI).

The STEADI logic model example depicts the common components of a logic model: inputs, actions, outputs, context for implementation, and outcomes.

*Continue to compare the different common components of a logic model.*

**Inputs**

The resources invested into a program (e.g., funding, staff, materials).[10]

**Actions**

The activities, events, strategies, or interventions completed as part of the program (e.g., testing and treatment, staff training, public service announcements, workshops).[10]

**Outputs**

The products of the planned actions (e.g., number of people treated, quality of training, number of workshops delivered).[10]

**Context for Implementation**

Information on the situational context that led to the creation of the program. May also include assumptions about the program that may impact delivery and external factors that could impact program success.[10]

**Outcomes**

Describe the intended effects of the program, often divided into short-term (e.g., changes in knowledge or skills) and long-term outcomes (e.g., changes in health outcomes).[10]

A framework often to frame the outcomes in a logic model is the **Quintuple Aim**(opens in a new tab). This provides a way to align the intended outcomes of a health service with the aims of the broader health system. The domains of Quintuple Aim are: to improve health outcomes, improve patient experiences, reduce costs, promote provider well-being, and promote health equity.[11, 12]

*Continue to access the STEADI Logic Model which can be found on page 14.*

**STEADI Logic Model**

**Note:** The Evaluation Guide for Older Adult Clinical Fall Prevention Programs uses a framework based on the Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health, which includes six steps:[5]

1. Engage stakeholders
2. Describe the program
3. Focus the evaluation design
4. Gather credible evidence
5. Justify conclusions
6. Ensure use and share lessons learned

The six steps are based on four standards: utility, feasibility, propriety, and accuracy.

**An Example of Program Evaluation**

A comprehensive example of program evaluation is when a group of Toronto area Community Health Centres integrated a number of new physiotherapists within their interprofessional teams. The integration of physiotherapy in primary care was planned with clear evaluation strategies using components of the Quintuple Aim as the targeted outcomes.

The program evaluation plan included: client satisfaction surveys, demographic information about the clients served, assessments of employee engagement, physiotherapy service parameters, patient and population outcomes, and indicators of equitable access to care.

Using data collected, the benefits to clients, populations, providers, and the health system have been clearly demonstrated, and the service delivery models has been expanded to include other primary care and rehabilitation sites outside the Community Health Centre system based on learnings from the evaluation process.[13]

This example provides a great example of the evaluator role of primary care physiotherapists. Physiotherapists played an important role in this program evaluation, providing leadership to a collaborative interdisciplinary team involved in the evaluation process who ensured that appropriate aspects of the evaluation were included.

**Physiotherapists' Participation in Research**

Because physiotherapy roles in team-based primary care models are still evolving, there are many evidence gaps to be addressed. Physiotherapists practicing in team-based primary care settings may not be experts at leading research like those in academic settings, but that doesn't mean that they don't play important roles within research teams aiming to produce new knowledge that can help advance team-based primary care.

**Integrated knowledge translation (iKT)** is a term used to refer to research that incorporates principles of knowledge translation throughout the entire research process. The central assumption underlying iKT is that involving knowledge users as equal partners alongside researchers will lead to research that is more relevant and useful for the knowledge users. For team-based primary care research, physiotherapists working in primary care teams are key knowledge users and therefore can play an important role throughout the entire research process.

*Explore some examples of how physiotherapists in primary care can play an important role in research as a knowledge user of a research team.*

**Identifying or Refining Research Questions**

As a physiotherapist in a primary care team, you may be in the best position to identify the research gaps that, if addressed, would have the biggest impact on the health of your patients. You could play an important role by bringing potential research questions forward in collaboration with primary care researchers. Similarly, physiotherapists with practice experience in primary care may be well positioned to help refine research questions brought forward by researchers.

**Development or Refinement of Research Methodology**

Physiotherapists in primary care can play an important role in developing or refining new assessment approaches or interventions to be tested through research. For example:

- Refining the research and data collection plan to ensure that it is feasible within the primary care setting
- Selecting meaningful outcome measures

**Interpreting Findings and Disseminating Results**

Understanding the context that research takes place in is critical to being able to interpret and apply the results, so health professionals in primary care can play an important role in supporting the interpretation of results. Effective end-of-study knowledge translation involves communicating research findings to knowledge users. As one of the knowledge users for primary care research, physiotherapists can help shape the communication of research results to facilitate implementation in practice.

Physiotherapists in primary care can also play important roles, even when they are not integrated within the research team.

*Brainstorm some ideas in response to the following question using your own professional experiences.*

**Question: What are some different ways that physiotherapists can be involved in research without being integrated into a research team directly.**

*Continue for four examples of roles that physiotherapists may take on to support the research process when they are not a member of the research team.*

**Supporting Recruitment**

For ethical reasons, clinical research often requires someone within the circle of care to invite people to share their contact information with the research team or to meet with research team members. In this way, physiotherapists in primary care can play a critical role in recruitment to make research possible.

**Carrying Out an Intervention**

Health professionals may be involved in carrying out an intervention and play a critical role in carrying out the protocol as intended.

**Collecting Data**

In practice-based or embedded research, data collection often happens within the primary care setting. Some data collection benefits from the expertise of a physiotherapist (e.g., performing a standardized test like the 6-Minute Walk Test or the Timed Up and Go) and other times, data collection is made feasible by pairing it with a visit to a health professional (e.g., completion of a patient-report outcome measure).

**Being a Research Participant**

Many research questions about physiotherapy in primary care require the involvement of physiotherapists as research participants. For example, to address a research objective to understand the experiences of physiotherapists who are added to existing primary care teams, interviews with physiotherapists who join existing teams would be needed. To assess barriers and facilitators to the

implementation of a new clinical practice guideline for physiotherapy in primary care, the physiotherapists would provide a critical perspective as research participants.

One current example of how physiotherapists working in primary care are contributing to research is within a cluster trial to evaluate the impact of integrating physiotherapists within primary care teams and making them available at the first point of contact for people with back pain. In this study, physiotherapists are taking on each of the roles highlighted in this section, and are part of knowledge translation efforts by helping to shape manuscripts and conference presentations to share their experiences with other potential knowledge users.[14]

This part of the section explored how physiotherapists take on leadership roles in improving primary care care through quality improvement practices, program evaluation, and participation in research.

**Mentorship and Education to Build Capacity for Physiotherapists in Primary Care**

**Mentorship**

As integration of physiotherapists in primary health care teams is at an early stage across much of Canada, people entering these roles frequently identify the need for mentorship, guidance on program development and role definition, and opportunities to hear from other physiotherapists in similar settings. One way to demonstrate leadership is to provide support to physiotherapists who are interested in, or new to, practicing in primary care settings.

Mentorship has been historically viewed as one more experienced mentor supporting one less experienced mentee. This unidirectional view of mentorship, often referred to as an apprenticeship model, can limit the benefits of mentorship. One limitation to the apprenticeship view of mentorship is that it does not adequately acknowledge the mentee's role in their mentoring experiences.[15]

Additionally, the apprenticeship view of mentorship does not acknowledge growing evidence that, in many cases, a single mentor will not likely be able to fulfill all of a mentee's needs and that there are more effective or efficient ways for mentees to develop new knowledge and expertise.16

The definition of mentoring has been expanded to emphasize the value of mentorship that goes beyond a dyadic relationship between two individuals to include a variety of potential mentorship relationships. A few examples of mentorship relationships include: 17, 18

- A single mentor working with a single mentee
- A group of mentors sharing their collective knowledge and experience with one mentee
- One mentor working with multiple mentees
- Peer to peer mentoring
- Online peer communities
- Programmatic mentoring, where feedback is provided at many stages throughout a training program

Moving beyond the "one mentor–one mentee" approach is particularly important in team-based primary care environments where there are relatively few mentors to meet the mentoring requirements of a growing number of people seeing themselves as mentees.

Consistent with the view that **mentorship is relational focused** and often extends beyond dyadic relationships, the following definition was proposed by the Committee of Effective Mentoring in STEMM:

**"Mentorship is a professional, working alliance in which individuals work together over time to support the personal and professional growth, development, and success of the relational partners through the provision of career and psychosocial support."**

**-National Academies of Sciences, Engineering, and Medicine, et al., 2019[18]**

Regardless of the structure of the mentorship relationship, there are a number of behaviours that facilitate a collaborative and positive mentorship relationship.19

*Continue to learn about some of the behaviours that contribute to positive mentorship.*

**Align Expectations**

Mentors set clear expectations and provide a safe space for mentees to share their expectations. Together they ensure expectations can be met.

**Assess Understanding**

Mentors and mentees work together to understand what mentees know, are capable of, and can improve upon.

**Communicate Effectively**

Mentors engage in active listening, provide timely and constructive feedback, and tailor communication to meet the mentee's needs.

**Address Equity and Inclusion**

Mentors reflect on biases and assumptions they bring to a mentoring relationship. They acknowledge and give consideration to how their background might differ from the background of their mentees.

**Foster Independence**

Mentors work to motivate mentees, build their self-efficacy, encourage creativity, and facilitate and acknowledge their contributions and path toward independence.

**Promote Professional Development**

Mentors help mentees set career goals, develop and refine professional development, develop a professional network, and access resources for professional development.

There are a growing number of resources available for mentorship and networking, including formal and informal mentorship programs, physiotherapy in primary care communities of practice, and networking events. For those looking to make connections, consider attending primary care conferences, reaching out to your physiotherapy association, and making connections with other physiotherapists working in primary care settings.

**Supporting the Learning of Physiotherapy Students**

Clinical education is a critical part of entry-level physiotherapy curriculum. Furthermore, clinical placements provide key learning opportunities for students to attain entry-level physiotherapy competencies while providing patient care. Low numbers of clinical education providers and increasing enrollment in entry-level physiotherapy programs have led many to question the sustainability of using one-to-one student-to-clinical instructor placement models that are most common in physiotherapy education. This is particularly true in primary care, where there is a limited number of physiotherapists currently practicing, but a projection for an increased need for the future. Physiotherapy leadership in primary care must include support for the education of future physiotherapists.

Innovative placement models may help create additional opportunities to prepare future physiotherapists for team-based primary care settings.

*Continue to compare two examples of placement models.*

**Collaborative Placement Models**

**Collaborative placements models**, in which more than one student is assigned to one registered health professional. Collaborative placement models have the opportunity to both increase the number of primary care placements available and also provide valuable learning opportunities for students whose experiences may be enhanced through peer learning.20, 21

**Emerging Role Placements**

**Emerging role placements** in physiotherapy are when physiotherapy students are placed in a setting that does not already have a physiotherapist. Emerging role placements have been shown to challenge students, leading to enhanced professional identity and clinical reasoning.[22, 23]

Founded in 2013, the MAC H$^2$OPE clinic (McMaster Helping Hamiltonians through Occupational Therapy and Physiotherapy Engagement) increased occupational therapy and physiotherapy access in the city, with a focus on opportunities for student involvement. MAC H$^2$OPE was an example of both an emerging role and a collaborative placement led by primary care physiotherapists and occupational therapists who provided support for students learning in a community-based setting.

*Explore the timeline to learn more about the MAC H$^2$OPE initiative.*

- **Opening the Clinic**

The need for physiotherapy and occupational therapy integration on primary care teams was identified in Hamilton by educators in rehabilitation sciences, and a student-led, free clinic was established in partnership with the local YMCA and clinicians who volunteered their time and expertise. The clinic was open when students from physiotherapy and occupational therapy programs were on placement, with the goal of creating access to services for people who would not otherwise have access, based on models of service delivery from primary care.

- **Creating Partnerships**

When physiotherapists and occupational therapists joined primary care teams in Hamilton, some former students from the MAC H$^2$OPE clinic were successful in being hired in those roles. Partnerships

were formed with those primary care teams whereby physiotherapy and occupational therapy services were provided at MAC H[2]OPE, in kind, not only when students had clinical placements, but year-round.

- **Lasting Impact**

After 10 years of service, this clinic has recently closed because primary care teams in the city have grown to include physiotherapy and occupational therapy, and are committed to providing access to people without family physicians.

The story of MAC H[2]OPE demonstrates how a commitment to providing learning opportunities increased the capacity of future physiotherapists and occupational therapists, and contributed directly to the growth of integration with primary health care teams.

**Advocate for Team-Based Models of Care**

A third way to demonstrate leadership as a primary care physiotherapist is by advocating for models of care that better meet the needs of patients by leveraging the expertise of all team members.

While evidence suggests team-based models of care better address the health needs of people, the majority of people in Canada are rostered to primary care teams that only have physicians or nurse practitioners and nurses. Therefore, advocacy for wider interprofessional teams is needed to further develop teams that better meet the needs of the communities that they serve.

There are many places in Canada without a physiotherapy presence on primary care teams, and consequently, there is a need for advocacy at the health system level. The Canadian Physiotherapy Association (CPA) and the provincial branches, along with researchers, educators, and clinicians, have advocated for the inclusion of physiotherapy in primary care services, and that work is ongoing.

Consider this example from the Yukon. Although physiotherapists are not currently integrated within primary care teams, there is a strong presence of physiotherapists as community liaison coordinators for people living in small communities with no other health services. These coordinators identify home care and personal support services for people with mobility needs and bring care to the community throughout the year. Leaders in physiotherapy, including the Physiotherapy Association of the Yukon, will draw on the existing physiotherapy services to make the case for the integration of physiotherapists in future primary care models.24 This advocacy work will build on the Yukon's recent review of the health system, which included comprehensive consultation of people and groups throughout the territory.

**Note:** The Yukon's review has resulted in proposed changes to the health system organization, called *Putting People First*. This proposal identifies the Nuka System of Care as a culturally safe and Indigenous-led way to create strong relationships between primary care teams and people seeking care, by centring individuals and their stories and values in the design, development, and decision-making of the health system.[25]

Advocacy to integrate physiotherapy will draw on successful, existing models of physiotherapy services, as well as priorities for the community being served. The examples described throughout this module demonstrate how physiotherapists can advocate for additional services and roles in primary care teams to meet the needs of patients by leveraging the results of quality improvement, program evaluation, and research, and to build capacity through learning and mentorship.

**Activity: Case Study**

You will now explore a case study that was first introduced in **Module 05: Service Delivery Models for Physiotherapists in Team-Based Primary Care.**

- **Joining the Primary Care Team**

You are a physiotherapist who has now been working on a primary care team for a year, where you are co-located with physicians, psychiatrists, pharmacists, nurses, social workers, dietitians, quality improvement specialists, and administrators. You are the first and only rehabilitation professional to be a part of this team. The team provides care to about 10,000 patients.

You usually provide one-on-one visits with people for a wide range of issues and offer a group program for people with chronic pain. A physician and a social worker are starting to plan an initiative to offer primary care services at a nearby housing complex where many residents experience precarious employment and housing, and live with multiple chronic and acute health conditions. As the physiotherapist you realize many residents are not likely to have access to physiotherapy services, and you want to get involved. Your team values collaborative leadership, so you feel confident to share your expertise and perspective on this project.

*Answer the questions to reflect on some leadership skills you can draw on to get involved.*

**Question 1 of 3: How could you apply advocacy skills to advocate for physiotherapy services that help meet the needs of the residents?**

**Feedback:**

You can consult residents to understand how to meet their needs, share with the team how health needs in this population can be addressed by physiotherapy, and provide expertise on barriers and enablers to accessible physiotherapy services to meet these needs.

**Question 2 of 3: As a physiotherapist, how could you contribute to the quality improvement and program evaluation processes for the new services?**

**Feedback:**

You could help identify the needs and priorities of the residents and propose strategies to evaluate whether those needs and priorities are being met. If the residents identify needs related to functioning or participation, you could provide expertise on how health indicators or outcome measures to evaluate the potential impact of the new services on these goals.

**Question 3 of 3: How can you facilitate student learning throughout this project?**

**Feedback:**

During the development phase, the physiotherapist can collaborate with a learner to help with planning and development. This would provide the student with valuable experiences seeking out and interpreting relevant research, scanning for similar models that have been implemented elsewhere, and engaging the community in program development. During the implementation phase, the physiotherapist could offer clinical placements. By including learners, the physiotherapist is building

the capacity of future physiotherapists to work in similar settings and spreads awareness of how physiotherapists participate in primary care teams.

**Reflection Question:** What other leadership skills or qualities would you draw on personally for this example?

In this section, you learned about the differences between quality improvement, program evaluation, and research, as well as examples of primary care physiotherapists' roles in each. You then explored the importance of mentorship and education in primary care and were introduced to behaviours that may facilitate positive and collaborative mentorship relationships. Finally, you learned how to support the learning of physiotherapy students through innovative placement models in primary care.

In the next section, you will learn how an individualized learning plan can be used to address learning needs related to collaborative leadership in primary care.

**Continue to Section 03**

**Page link:**

https://hqontario.ca/Quality-Improvement

https://www.cdc.gov/steadi/pdf/Steadi-Evaluation-Guide_Final_4_30_19.pdf

## SECTION 03: INDIVIDUALIZED LEARNING PLAN

This module, **Physiotherapy Leadership in Team-Based Primary Care**, was designed to help you develop new foundational knowledge and identify potential learning needs or opportunities to address your learning needs related to collaborative leadership in team-based primary care.

*Continue to review the new foundational knowledge presented in this module, as well as the potential learning needs and opportunities you may have identified.*

**New Foundational Knowledge from Module 08**

- Collaborative leadership practices.
- The role for physiotherapists in quality improvement, program evaluation and research initiatives.
- The importance of mentorship and support for learners in primary care.
- The need for advocacy to promote physiotherapy in primary care.

**Potential Learning Needs and Opportunities**

- Understanding how to apply quality improvement and program evaluation strategies.
- Identifying ways to get involved in mentorship.
- Creating opportunities for learners.
- Using knowledge gained to promote advocacy efforts to expand the role of physiotherapy in team-based primary care.

**Revising your Individualized Learning Plan (ILP)**

Now that you have completed this module, you will revise each activity within your ILP.

First, revisit **Activity 1: Competency Self-Assessment.**

- Review the self-assessment ratings, learning needs, and priority levels you identified for the Module 08 competencies when you first completed **Activity 1**.
- Modify your self-assessment ratings, add any new learning needs that you've identified, and adjust your priority ratings, if needed.

*Continue to reveal the competencies relevant to this module.*

**Module Competencies**

3.4 Apply evidence-informed approaches to enhance team collaboration and effective team functioning in primary care.

3.5 Collaboratively and constructively engage in addressing and seeking to resolve disagreements among interprofessional primary care team members.

4.4 Lead or actively participate in program evaluation and quality improvement activities in team-based primary care.

4.5 Supervise and/or mentor team members who participate in the delivery of physiotherapy services in primary care.

4.6 Safely manage data from persons seeking care in accordance with pertinent institutional and jurisdictional policies.

5.2 Identify, implement, and evaluate opportunities for innovation in delivering primary care services.

5.3 Provide leadership for the advancement of physiotherapist roles within primary care teams.

5.4 Mentor physiotherapists or physiotherapy students to prepare them for future primary care roles.

5.5 Participate in collaborative leadership within the primary care team.

6.1 Deliver evidence-based and person-centred approaches to team-based primary care.

6.2 Participate in research to advance the delivery of physiotherapy services within team-based primary care.

6.3 Engage in critical self-reflection, self-directed learning, and professional development to advance contributions to service delivery as a primary care team member.

6.4 Support the professional development of students and other interprofessional primary care team members.

Next, revisit **Activity 2: Values Self-Assessment.**

- Refine your list of values if the module inspired you to consider any personal values that you did not initially identify.

Then, revisit **Activity 3: Professional Developing and Networking Self-Assessment.**

- Record any professional development or networking goals or opportunities you may have identified by completing this module.

Finally, revisit **Activity 4: Creating your Individualized Learning Plan.**

Examine the competencies, learning goals, and professional development and networking opportunities you identified for the short-, intermediate-, and long-term. Update your ILP based on the refinements you made to your learning needs and priority ratings **(Activity 1)**, values **(Activity 2)**, and professional development and networking opportunities **(Activity 3)**.

**Continue to Conclusion**

## MODULE CONCLUSION

As you conclude this module, hopefully you have gained valuable insights and tools to enhance your leadership capabilities within interprofessional primary care teams. Throughout this learning journey, you've explored various collaborative leadership approaches, delved into strategies for advancing the role of physiotherapists in primary care, and emphasized the importance of actively contributing to quality improvement, evaluation, and research initiatives. Additionally, this module highlighted the significance of mentorship and education in team-based settings, and underscored the advocacy role in championing team-based models of care that prioritize patient well-being. Remember, effective leadership is a continuous process of self-reflection and growth.

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