Canadian Chiropractic Association

Healthcare Professionals

Qualitative Research Report

November 9, 2018

Contents

1. About This Project

1.1 Background and Research Objectives

The Canadian Chiropractic Association would like to engage medical professionals in a research setting to assess reaction to a referral tool developed by the association.

1.2 Methodology

Details of the focus groups and recruitment strategy are outlined below.

Group	Date and Time	Audience	Other Criteria
1	Wednesday, October 24 @ 5:30pm	Family Physicians and Orthopedic Surgeons	• Mix of regions across Canada • All must refer patients to Non-Prescribing Practitioners
2	Wednesday, October 24 @ 7:15pm	Nurse Practitioners and Pharmacists	

Since the methodology for this research is qualitative, it is not representative but rather provides directional, thematic and insight-driven findings in this domain. The conclusions drawn, and opinions expressed, are those of the authors.

2. Overall Summary

- **There is much openness to having tools and relationships that allow for better patient care and outcomes**. The healthcare professionals participants in the study are ultimately seeking to provide the best care and treatments they can for their patients. As such they are open to hearing more, and receiving communication, about the PPR Referral Tool, and for developing better communication with non-prescribing practitioners.
- **The PPR Referral Tool generally tested well**. Overall, there was much positive feedback on the general efficacy and usefulness of the tool. The opportunity to provide specific referral information relevant to the patient in a comprehensive form was of interest.
- **The PPR Referral Tool in its current form is in need of modifications for improved relevance and likelihood to adopt**. Chief among the concerns is the current length, as it feels like more of a time commitment than some participants felt they would put into a form. Further, there were specific concerns about sections and these were broadly split amongst the occupations – family physicians and orthopedic surgeons had legal concerns about the Red and Yellow flags, while nurse practitioners and pharmacists found the purpose and organization of the Management section confusing.
- **Having options for use the form is of importance, since many are using conventional channels for communication while others are adopting more digital/modern technologies**. Healthcare professionals also use multiple channels according to need or situation, even if they might have a preference for one that they use most often. EMR and EHC, though still in early stages, are viewed to be the inevitable way of the future for the medical field, and so developing this option in a way that seamlessly integrates with these new technologies is key.

- **Participants provided ideas on making the form about more than just a referral** – it has potential to be a living document that can be used by multiple healthcare professionals in managing a patient's care, increasing communication, and ensuring positive outcomes

3. Context and Communication

3.1 Communication

While some healthcare professionals have a longstanding means of communication with non-prescribing healthcare professionals, others have more dynamic and flexible communications which adapt with changing times or needs.

There are various factors that affect how healthcare professionals communicate:

- Level of comfort with a certain type of communication; this is driven by habit and/or personal preference
- Whether or not the healthcare professional is personally communicating, or if it someone else in the office
- What is mandated or allowed by their provincial ministry or health authority
- What technology is or isn't available
- Ease and convenience
- Available templates/tools

Family physicians and orthopedic surgeons are more driven by personal preference and comfort levels, while nurse practitioners and pharmacists are more likely to be using different means of communications that may change over time – for example, they might have a preferred template that they use, but are open to and have used newer versions as they come along.

More "traditional" methods such as phone and fax are predominantly used by physicians, while nurse practitioners and pharmacists are more likely to use email. Notably, very few use any kind of electronic health communications – this is partially driven by preference, but also a perceived lack of convenience and availability. Some have a need for a record or documentation for their correspondence, and fax is the preferred method in these situations. For situations that are more urgent, phone is used.

Most participants believe that medical records and communication will inevitably shift to being primarily online regardless of their personal preferences, with a few who mention that records are already being moved to digital in their province. While this is mostly considered a positive change, there are a few who feel resigned or pulled along by these changes and recognize that this will mean a different way of working and communicating than what they are accustomed to.

"Fax is secure, efficient, and the correspondence is written down – good for record-keeping."

"I write freehand […]"

"I just type into my EMR records."

"I just am sort of old school and I much prefer, if I have a question or a concern relating to a patient, I just find it much easier to pick up the phone, try to speak to that person. You can explain the question or the concern much easier and make sure it's appropriate and to the right person, so I just think you can resolve things quicker that way than often in writing where once it gets sent you never know who quickly you'll get a response."

"I know that within my regional health authority any e-mails are secure and so I can talk about confidential information or a name, use a patient's name with the e-mails. I find that then it's more convenient because the other person can get back to me when they have a minute, or I can there then just send the e-mail when I have a minute without having to play telephone tag to communicate."

"[…] the interface normally comes by the ministry of health and they have to approve the non-prescribing professionals […] how they do it I don't know but they have to go to the approved vendor. In my province only, a couple of vendors are approved but in Ontario nine are approved so it varies from province to province. That could be a very nice way to address for us because we like everything recorded."

Nurse practitioners and pharmacists are more likely to use a template or form in their communications with non-prescribing healthcare professionals – these might be ones obtained externally, while others developed their own. Mentions were made of trying to keep the templates similar in terms of information to what is required or already used by their hospital or regional health authority. Forms might also vary depending on the referral being made – that is, which practitioner the patient is being referred to. Those who like forms believe that they are more efficient and less time consuming than making multiple calls or sending emails.

Family physicians and orthopedic surgeons are often much less formal and simply fax, pick up the phone, or write something down on a piece of paper, particularly since non-prescribing practitioners do not require a referral from a physician. Others are not aware of any templates that are available, or they have concerns about the amount of time required to fill out a templated form.

Mentions were made by a few that they had never thought of using a specific template before but would consider using one or thought it was a good idea. Approval of tools was mentioned as a component/factor in their use – by the relevant ministry or health authority – in situations where templates are subject to administrative oversight.

"For a non-prescribing practitioner, we would still use the same type of template with respect to the information regarding the patient, but when it comes to the wording for whatever the question might be, then that one's usually free form."

"So for example, if we're referring to or we're sending information to our social worker, we're sending more information, you know, to do with their mood and diagnoses around sort of things like that. But then for our physio it's more MSK diagnoses that might be on the form that we tick off or things that we want them to focus on. That's what I mean, depending on the practitioner that we're sending to depends on what kind of form we're using."

"I don't use a template because it's not available, I would communicate directly through the electronic health record with physios or other allied health professionals in my clinic but with me to use a template to communicate with someone at another clinic it would be time consuming and that would be an extra step we may not have time for."

"Part of the reason [I developed forms] was I wanted to minimize the phone calls and the extra work I was having to do, so this way it's there and I already know they have it."

"No [I don't use a tool]. I had honestly never thought of it! It might be a helpful tool, especially if I could then add it to the patient's chart. Of course it would have to be developed and approved by the Health Authority."

"We use a custom template I made up for our practice most of the time."

3.2 Relationships with Non-Prescribing Practitioners

Most do not have any direct relationships with non-prescribing practitioners. Instead, referral practices are driven by a few different factors;

- **Patient preferences and positive/negative word-of-mouth** of their experiences with the practitioner – feedback is received and likelihood to refer again is driven by this, or the professional lets the patient choose their own
- **Geography/location** – whatever is convenient for the patient; for example, if there are only a limited number in their area, or if the patient would like to go to someone closeby
- **Cost/Coverage** – whether the patient is paying out-of-pocket, through employer insurance, or if they will need to be directed to a practitioner who is paid through public funding; for example, within a hospital setting.
- **Patient expectations** – understanding patient expectations and desired outcomes, and making a referral accordingly

"We have our usual list to select from. I guess so-called favourites."

"I rarely suggest a specific therapist, it usually comes down to if the patient has some familiarity with one, let them go where they are comfortable."

"It depends on setting and reason for referral and PT needs, where they live, current insurance etc. to determine who would be best to refer them to."

"I am in a rural area, so most people prefer to see someone in closer proximity. There are a limited number of Physiotherapists, Occupational Therapists, etc. in our town. If someone would prefer to see someone from outside the small town (i.e. – they might not want to see the local mental health worker because they are related or are friends), I refer to someone in the closest city/town."

"I know that if they've got certain insurance then I can refer them to those services instead, so I usually ask what people's coverage is before I even prescribe or send them to another allied health professional."

"I guess basically what I'd look at is what they're hoping to get out of the treatment without any false expectations. People have misconceptions about certain things that they believe aren't going to work, so if they're already going in there going 'oh well my friend had, you know, believed that this didn't help them, then that kind of, they've already got that negative feeling for it. And then depending on coverage and all that, then I would determine what else I feel would be a better option for them. Again it depends, like a chiropractor is a great option for musculoskeletal but sometimes a physio is going to give the patient more of what they want. They're not expecting to get up and walk perfectly again, they just want to get up and not be in so much pain. So, I kind of gauge what their expectation is as to, and I do present all the options to the patient. I just tell them what each can do and then kind of let them make that decision."

4. MSK Assessment Tools

4.1 Treatment Plans and Referrals

For knee, back or neck pain, most participants will start with over-the-counter medications and analgesics to alleviate symptoms; although many patients have already tried these before going to a healthcare professional. These are recommended as a first line of treatment, or in conjunction with treatments such

as massage, physiotherapy, exercise, acupuncture, or chiropractor as part of a multi-pronged approach. The patient themselves might also have a role or opinion in their own course of treatment. The exception is orthopedic surgeons in that they are often much further downstream when the patient has been sent to them, and so medication and treatments are for after-surgery care.

Use of narcotics was debated unaided amongst the healthcare professionals – while surgeons wanted caution in terms of family physicians who prescribe them to patients before surgery, family physicians countered that the same caution should be exercised post-surgery. Nurse practitioners also mention a more conservative approach/environment as it relates to prescribing narcotics.

"It's usually multi-modal in terms of the approach. Modalities, meds, the appropriate therapy maybe knee supports with knee arthritis, exercises mostly for the neck and back issues."

"Medications – acetaminophen, NSAID, other analgesics, muscle relaxants."

"Treatment typically includes explanation of cause, targeted exercises, and OTC meds. If they fail, they may be referred to appropriate healthcare provider that the patient may wish to visit."

Assessment and diagnosis of MSK conditions is typically a more complex process than just pain management and there are many approaches to managing and treating these. After understanding a patient's history and conducting an exam, and ruling out red flags (such as a potential tumour), therapy /treatment may involve:

- Ordering imaging
- Referrals to a physician or orthopedic surgeon
- Attempting to treat the condition (for physicians)
- Lifestyle adjustments such as diet and exercise

Many do provide referrals to non-prescribing practitioners and this can be right away, based on a patient's preference, after other items that have been tried first, or as part of a larger pain management plan. A few characterize non-prescribing practitioner services as "complementary". Using pain charts as a guideline, and/or understanding a patient's discomfort level, is also an important factor to consider when considering a course of treatment – it can affect timing in terms of the need to potentially escalate to other treatments or referring the patient to surgery.

"Most of the time as a family physician we see a lot of these soft tissue injuries and all that and the majority of the patients like everybody has alluded to is not covered by the medical plan so you end up assessing and making sure there are no red flags and then we know that it takes four to six weeks to get back no matter what they do so I actually personally give them exercises for what would help to strengthen them."

"A lot of these conditions we're talking about end up being self-limiting particularly the acute neck or back pain. You wait for a reasonable period of time and if they're getting better you just carry on with the non-operative and symptomatic things that you've talked to them about and if they're not improving, they might go to the therapist to be properly instructed in terms of a home exercise program."

"The only other thought I have is we talk about non-prescribing practitioners and, nobody has brought up musculoskeletal weight loss or just weight issues and that's another non-prescribing practitioner that is going to become more and more important in musculoskeletal care as the population gets heavier.

"History, physical and investigate… I refer non surgical candidates… if sx candidates I refer to colleagues who can operate on particular pathology."

"Want to know if patient has seen PT, massage or Chiro in past and what was their satisfaction response. Thus, we involve patient in decision making."

"Complete history and focused exam. Based on this info then perhaps diagnostics […] based on the results I would either manage the condition myself or refer to physiotherapy, massage, etc."

"I don't think it's necessarily when I feel that something is beyond my expertise, I think it's when I think that PT/massage/Chiro would be complementary to what I offer. Working as a team."

4.2 Communication with Non-Prescribing Practitioners

For family physicians and orthopedic surgeons, they would like a note on progress or consult letter and are more interested in any issues or concerns with the patient and tend to be more outcome-driven in the information they seek. Family physicians are also required to fill out "attending physician statements" in some cases for the purposes of workplace disability claims, and so hearing from the non-prescribing practitioner is important in this context.

For nurse practitioners and pharmacists, this is an area that would benefit from improvement – some of these participants said that they rarely receive any follow-up communication from practitioners, but this would be of great interest in their treatment of their patients. A few receive updates directly from the patients themselves. These healthcare professionals would like more detailed updates at more touchpoints than their physician/surgeon counterparts.

In terms of the point at which they receive an update, preferences varied – initial assessments would be beneficial in understanding the plan for treatment, updates would help in communicating a patient's progress, and discharge would aid in helping them understand outcomes and any other action required by the healthcare professional, both for information purposes, and to inform the patient's continued care and treatment.

"Initial assessment and discharge, anything unexpected in between."

"Brief report/note, progress from the practitioner when can they return to normal work."

"*I typically get in writing from the therapist either their progress or how they are doing but usually I only get a letter if there are concerns. I'm seeing the patients post-op and I'm doing assessments, I have a pretty good idea how they're doing but it's still nice to hear from the therapist if they have a specific concern particularly if they are not progressing, regaining range of motion, those types of things."*

"Just sometimes I'll send them to any of the, like chiro, physio, I don't think I've ever gotten a note back for massage, and usually with physio I'll get a note when either they've said there's nothing more we can do for them or they've discharged them and this is what went on in the last six weeks. And chiro, I rarely get a note from unless they want an x-ray […] it's very annoying because I don't know what's going on with the patient until they come back and really tell me what went on."

"I very seldom get back any follow up letters."

"Prefer to receive correspondence as soon as possible after patient's initial assessment – updates if anything I can do to complement therapy (i.e. OTC); I will ask for updates in initial referral and will follow up if I haven't heard from them."

"I like getting correspondence all along so that there is continuity of care for the client and learning about their progress with the allied health."

"I like to hear back as soon as the patient has been assessed or treated, with information on the treatment success and goals. Also, any further follow up or suggestions to me for further treatment."

"My patients most of the time update me, especially with chiropractors. In my practice, chiropractors are a very popular choice for my patients. Yeah so, but I prefer to hear back from the practitioners from time to time, and if I don't get it I usually follow up, especially when I chat with my patients, I see them, yeah, in follow up."

5. PPR Referral Tool

5.1 Appeal and Likelihood to Use the PPR Referral Tool

Some found the PPR Referral Tool very appealing and found it to be a highly useful, useable and relevant document. Some thought that there are aspects that stand out / are appealing, or that in general it is more detailed and comprehensive than what they are currently using. Some said they are likely to use the form, either in its current iteration, or if modified or made shorter.

"The tool provided here is the perfect tool for a primary care physician. I would love it if this is what I was getting […]

"[…] like that it includes red/yellow flags and past medical history […]"

"This form provides minimal information needed for decision making process for Orthopedic practice. I am finding it user friendly."

"It appears user friendly and I like that it provides for some quick and pertinent information as well as gives opportunity to get more in-depth if needed. It looks like an excellent tool."

"An excellent form. So comprehensive. Would love to incorporate it into our forms. The best one I have seen to date."

"[…] I like the layout of it, the information that's there, and then it gives me a chance to inform them of what we've tried, you know, what their expectation is, what we've tried and what's worked or what's not worked. It just definitely details things a little, gears things a little more so they've got more background history."

"I would personally use this form."

Some were less enthused about certain aspects of the PPR Referral Tool.

- Physicians and Orthopedic Surgeons expressed deep concern about the "Red flags" section and to a lesser degree, the "Yellow flags" section on the first page, and this was mainly about privacy and confidentiality of patient information, and their potential liability. Suggestions were made by these individuals to eliminate this section, to simply state that there are no red or yellow flags, or to modify them to be guidelines or reminders, rather than check boxes.
- Some thought that the second page could/should be eliminated entirely, or that it could be used for other purposes (as outlined below). General concerns about length and the potential amount of time needed to fill it out were voiced.
- The "Management" section generally caused a great deal of confusion as to its purpose, the terms used and how it was organized.
    - The headings and what they meant, and their purpose, was not clear
    - The word "Conservative" in front of "Management" caused confusion, as participants were unclear on the meaning of this.
    - The professions listed under the various categories caused some confusion, and the rationale for why a few were located where they were was not clear.

"I'm a little concerned about some of the red flags and yellow flags if you send something out that says, please be aware that this patient is an IV drug user, or he's depressed or he's a substance abuser and he does a poor job satisfaction you're going to end up in court being sued by these people."

"You are disclosing certain information that could be subject to privacy regulations because remember we have naturopaths too these days and they don't operate under Medicare. So, there's no obligation as far as I'm concerned […] that we should necessarily release any information to that. What I do is I obtain an opinion on that, and so I would have to send information to the patient. I give any information to the patient, they can do whatever they like. They can frame it, they can publish it, but I will not release any information to certain individuals unless the patient does it."

"[…] I feel like it would be a lot of work for the family physician to fill out."

"It's too long. Most are one page. Not wanting to get involved in flagging. Management best left to the specialty of healthcare provider."

On moving nurse practitioner to the same category as family physician:
"I think what it is, is there has to be more understanding of what the nurse practitioner role really is in each province. I'm not sure, it differs Manitoba to Ontario or Ontario to Québec or whatever. But I think there has to be a greater understanding of the nurse practitioner role. A lot of people when you say you're a nurse practitioner, they don't really understand who you are or what you are. And then you tell them and then they're just totally amazed that you can prescribe […] they're just totally amazed."

"…maybe if they just leave the term conservative off I would be a little happier and it would be under management[…]"

A few said that they were unlikely to use the PPR Referral tool – this is partially due to personal preference, particularly for those who have used a particular method for many years, and because they don't currently

experience any pain points as it relates to making referrals. Orthopedic surgeons felt there was more information in the tool than they would normally need to provide.

"This one I think is a lot more comprehensive in terms of the sort of things that the family doctors might see and other individuals that need to get involved with the care. But in terms of the patients out of surgery it's probably more than we need."

Suggestions for optimized use emerged from the discussions about how these might be best leveraged in order to maximize uptake and efficacy of the PPR referral tool:

- Having the tool become a "living document" that is used by more than one professional for a patient's treatment plan – for example, the first page could be filled out by the healthcare professional, and the second page filled out by the non-prescribing practitioner. Using the tool to start a dialogue about a patient's treatment and having a holistic and comprehensive approach as a team was appealing. Making the tool more outcomes focused.
- Having a version that is uploaded and interfaces with current EMR systems is key for some – these participants have templates that are regularly uploaded and the PPR Referral Tool could easily be another that they use.
- Providing an example tool that has been filled out was suggested as helping users to understand how the tool and the sections within it are meant to be used.
- Adding a place for a patient's occupation was suggested

"Yeah, I agree that the second page doesn't seem necessary coming from me, but I would like this information coming back from one of the allied health practitioners."

"Follow up section would be good so that they can complete form and send back."

"So, this thing about outcome measures with respect to, you know, what they think the patient is able to aspire for or work towards. And then management, that whole table there becomes sort of a re-referral to other healthcare practitioners so that the patient sort of is able to approach the other healthcare professionals moving forward."

"I think the comprehensive plan would be great. I think it would definitely increase the amount of paragraphs that would be added and it would be through the electronic system."

"I think if I was getting it, I would like to know what the patient does for a living is it a labour or an office-based job? Then I think just the tick box if this is a referral coming to me whether or not it's a motor vehicle accident or a work place disability claim, it just kind of adds context to the presentation and it also at least in BC gives me some more avenues to get them treatment in terms of faster imaging and then they have their pick and choice of which therapist they want because it's not coming out of their pocket so they can go anywhere."

Further, preferences for how the tool might be filled out and sent varied – having a choice when filling the tool out was a key finding for likelihood to use, since there was no one strongly preferred tool or method for making referrals to non-prescribing practitioners. When sending information electronically, the ability

to auto-fill information, and privacy and password protection, would be important features to keep in mind.

"[…] ideally connected to my electronic health record -- would not go to another website to fill this out."

"Fillable PDF and hand filled forms both equally important."

"I would use this form both electronically and pen and paper. In some of my rural practices it would have to be pen and paper. The barrier would be if it was only used as an online tool."

"Even in our EMR we've got a lot of templates that just self-populate all the important information and then you can delete or add and all that and then you can print it out and give it to the patient and that's what we do with most of our forms."

"[…]if we have the option it's okay, it's just I find when it's through e-mail or stuff like that usually we need like a safe, like a password and stuff like that to make sure if we sent for privacy thing. Like I know there's a lot of policies around that stuff, for us in New Brunswick."

5.2 Communication and Relationship Development

Participants provided various ideas on how the form might be communicated to healthcare professionals, and what might motivate them to learn more about it. While some preferred electronic/digital communication, others suggested in-person.

"As a group we often meet to discuss relevant journal articles that have been published in our area of interest, it's often done in an informal setting where a group of us, often 6, 8, 10 of us will discuss the papers and it will be around either a lunch or dinner type of thing."

"I will present it at the next general meeting of all the physicians in the office. Get them enthusiastic and about it and the other NPs."

"e-learning; motivation to use is that it has all the info that I need to provide."

"Always updates through emails, newsletters, yes surveys."

Interest in increasing interprofessional communication with non-prescribing practitioners is high. Many do not currently have any relationships with them, but believe there are various opportunities for improved networking, communication and relationship building that might facilitate these.

"As I and our hospital progresses to more EMR go to more electronic communication."

"Best method is through effective written communication as that ends up being in patient records in keeping with spirit of Collaborative Care model."

"I know like having been in chronic pain for the last several years, in Ontario we have a network […] and all these different practitioners meet once a week, it's all online or through like Zoom or Telehealth. And there are all different professionals talking about, you know, challenging patients and how we can work

together, you know, within the province and who to refer to and, you know, helping each other. And it's not just nurses or nurse practitioners or physicians, there's chiropractors and physios and occupational therapists, and chiropractors. And so just learning from each other."

"I guess it all depends where you're working at too, right. Like it all depends if you're in a certain area but […] conferences, e-mail, I guess lunch and learn, dinners as people said. So I guess there are multiple ways of being able to share the information."

6. Themes and Recommendations

Goodwill towards non-prescribing practitioners is high and could be better leveraged. Facilitating a broader dialogue about improving patient care and ensuring positive outcomes as part of the outreach for the PPR Referral Tool might be considered. Networking, relationship building and increased communications are all opportunities that could be supported.

The PPR Referral Tool could be a suite of Tools that are customized to occupations, different channels, or as part of a larger patient care plan. Rather than using the form as a one-size-fits all format, there could be more Tools developed that meet different needs – ones that are more succinct and outcome focused for family physicians and orthopedic surgeons; ones that are at different stages of care (further upstream or downstream – for example, post-surgery) or having a document that is filled out by multiple professionals that could live electronically or be "owned" by the patient themselves.

Understanding the external environment in which the healthcare professional is referring is important. Varying degrees of administrative oversight, privacy and legal issues, whether or not the form is filled out personally by others, understanding where each province is in terms of EMR – are all contextual factors that are important in uptake of the PPR Referral Tool.

7. Contacts

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8. Appendices

8.1 Focus Group Screening Questionnaire

CANADIAN CHIROPRACTIC ASSOCIATION

PRESCRIBING PROFESSIONALS ONLINE FOCUS GROUPS

Recruitment Screener

fv – Oct 10, 2018

For all groups, recruit 8 professionals for 6 to show

Session	Target	Date	Time
1	Family Physicians (4) and Orthopedic Surgeons (4) Mix of regions	Wednesday, October 24 Via Ipsos' Ideation Exchange online platform and Teleconference	5:30-7:00pm (EST)
2	Nurse Practitioners (6) and Pharmacists (2) Mix of regions	Wednesday, October 24 Via Ipsos' Ideation Exchange online platform and Teleconference	7:15-8:45pm (EST)

Hello, my name is _____ from Ipsos, a national market research and public opinion firm. We are conducting a research study about referrals and/or prescribing habits of medical professionals.

If they would prefer it, leave message and number and let the professional call back.

Once connected to the physician, repeat introduction if necessary.

This study will involve participation in an online focus group and teleconference lasting approximately 90 minutes. You will need access to the internet, a laptop computer and telephone line in order to participate. This will be a roundtable discussion with a small number of other participants from across the country.

We will be sending you a short 2-page document to read and review in advance of the group discussion. However, there is no need to write anything down or complete any exercises.

It is scheduled to take place [INSERT DATE & TIME]. You will receive an honorarium of $xxx in appreciation for your time. The session will be audio recorded for notetaking purposes.

Would you be interested in taking part?

Yes - **CONTINUE**

No - **THANK AND TERMINATE**

Record if Male or Female – Do not ask.

Recruit half males, half females for each group.

I would like to ask you a few questions to determine if you qualify for the research study. I promise that I have absolutely nothing to sell you.

1. Please tell me the province in which you practice medicine.

Ontario] **Central**
Quebec]

British Columbia] **West**
Alberta]

Manitoba] **ManSask**
Saskatchewan]

Prince Edward Island]
Nova Scotia] **Atlantic**
New Brunswick]
Newfoundland]

Recruit at least one per region for each Group

2. I would like to confirm your professional designation. Are you a…

Family Physician/General Practitioner

Nurse Practitioner

Pharmacist

Surgeon [specify]_____

Other - Terminate

For surgeon, please recruit Orthopedic only for Group 1. Otherwise, terminate other types of surgeons.

3. How many years have you been in practice in this field?

Less than 1 year

1 – 3 years

4 – 5 years

6 – 10 years

11 – 15 years

16 – 20 years

21 – 30 years

Over 30 years

Recruit a mix of tenures.

4. Please tell me which if any of the following non-prescribing practitioners you refer your patients to, and how frequently you make these referrals. Tell me which of the options is the best fit. [ROTATE ORDER]

Specialty	At least 1x per week	2-3 times a month	Once a month or less	Never
Acupuncturist				
Chiropractor				
Dietician				
Massage Therapist				
Naturopath				
Occupational Therapist				
Osteopath				
Physiotherapist				
None of the above	TERMINATE			

If professional does not refer patients to any of the above, terminate. Otherwise, recruit a mix of frequencies.

5. Please tell me which if any of the following non-prescribing practitioners you directly interact with and how frequently these interactions happen. Interactions might include phone calls, emails, faxes, or face-to-face. Tell me which of the options is the best fit. [ROTATE ORDER]

Specialty	At least 1x per week	2-3 times a month	Once a month or less	Never
Acupuncturist				
Chiropractor				
Dietician				
Massage Therapist				
Naturopath				
Occupational Therapist				
Osteopath				

Physiotherapist				
None of the above	TERMINATE			

If professional does not interact with any of the above, terminate. Otherwise, recruit a mix.

6. Please tell me on a scale of 1 to 5 your perception of the following non-prescribing professionals. [ROTATE ORDER]

   The numbered scale is as follows: 1 is extremely poor, 2 is poor, 3 is neutral, 4 is positive, and 5 is extremely positive.

Specialty	Rating [RECORD]
Acupuncturist	
Chiropractor	EXCLUDE THOSE WHO PICK NUMBER "1" or "2"
Dietician	
Massage Therapist	
Naturopath	
Occupational Therapist	
Osteopath	
Physiotherapist	

IF PROFESSIONAL QUALIFIES:

We would like to invite you to participate in this study, which is taking place [INSERT DATE & TIME]. In appreciation for your time, we are offering each participant $xxx.

As mentioned in the introduction, there is a 2-page document to review that will discussed during the focus group.

This is a small study with a limited number of participants. If for any reason you are not able to participate, please contact us at [RECRUITER TO PROVIDE CONTACT INFO].

Collect contact info for reminders / instructions / pre-read document

If professional has an assistant or admin in charge of their scheduling or for interview details/confirmation, record contact info for them

PROFESSIONAL

Name_____

Telephone_____

Email_____

ADMIN ASSISTANT (IF APPLICABLE)

Name_____

Telephone_____

Email_____

8.2 Focus Group Discussion Guide

DISCUSSION GUIDE FOR CANADIAN CHIROPRACTIC ASSOCIATION

PRESCRIBING PROFESSIONALS

ONLINE AND TELECONFERENCE FOCUS GROUPS

fv – Oct 22, 2018

SESSION BREAKDOWN

Welcome and Introductions	10 Minutes

Section 1: Context and Communication	15 Minutes
Section 2: MSK Assessment Tools	20 Minutes
Section 3: PPR Tool	40 Minutes
Wrap-up and Final Questions	5 Minutes
SESSION TOTAL	90 Minutes

DETAILED SESSION AGENDA

MODERATOR WELCOME (10 MINUTES)	• Welcome & thanks for attending • Overview of the session purpose • Neutrality of Ipsos and importance of honest feedback • Rules of engagement - informed and respectful dialogue • Anonymity of your participation - remarks are not attributed and your privacy will be protected • Audio recording for notetaking purposes; observers on the phone • Technical considerations in using online Ideation Exchange platform • Quick round of intros during first question - your first name, where you are located and how many years you have been in practice

Unless otherwise noted, all questions are open-ended.

SECTION 1: CONTEXT AND COMMUNICATION (15 MINUTES)

We are here today to have a discussion on non-prescribing professional referrals in Canada.

ONLINE QUESTION – OPEN END

Q1. Do you communicate with non-prescribing healthcare practitioners? This could be you yourself personally, or others in your practice who communicate with these practitioners on your behalf.

ONLINE QUESTION – CLOSED END

If yes, please tell me how (check all that apply):

- Email
- Fax
- Regular mail
- Phone
- EHC

ONLINE QUESTION – OPEN END

Please tell me why you choose to communicate this way, and how often you communicate. Have you tried other methods in the past? I

If no, please tell me why you don't communicate with non-prescribing healthcare practitioners.

ONLINE QUESTION – OPEN END

Q2. Do you currently use a template or form to communicate with non-prescribing practitioners about patients?

If yes, please tell me which one you use and why.

If no, please tell me why you don't use one.

Q3. I'd like to understand **how you choose the non-prescribing practitioners you refer patients to**. Please tell me in as much detail as possible your thought process as you make the referral.

Moderator to probe/prompt:

- based on profession (e.g. tell patient to see a physiotherapist)
- based on previous practitioner relationships with a provider (i.e. trust and have a long referral relationship)?
- if a referral relationship has been established, how was this relationship started?

SECTION 2: MSK ASSESSMENT TOOL (20 MINUTES)

ONLINE QUESTIONS – ALL OPEN END

Q4. What is your **typical treatment plan** for patients who have back pain, neck pain or knee pain?

Q5. How do you **assess and diagnose an MSK condition**? If a patient has an MSK condition, do you typically refer to another non-prescribing healthcare practitioner (chiropractor, physiotherapist, massage therapist) or refer at all? If so, what type of information would you prefer to receive when you refer to a non-prescribing practitioner?

Moderator to probe:

- What elements do you include in your referral?
- If you are using a referral form/tool, how long have you been using it?

Q6. After this referral, **when and how** would you prefer to receive correspondence from the non-prescribing practitioner?

- Upon initial assessment?
- Re-evaluation?
- Discharge?
- Other?

SECTION 3: PPR TOOL (40 MINUTES)

For the rest of the session, I'd like to get feedback on the Non-Prescribing Practitioner Tool you were sent when you were contacted about the study. For those of you who chose not to review the document in advance, it is available for download here: **[LINK PROVIDED THROUGH STUDY SITE]**

ONLINE QUESTIONS – ALL OPEN END

Q7. Please tell me **which if any referral tool you are currently using for MSK conditions**. How does the PPR referral tool compare with your current referral tool?

Q8. What did you **like** about the PPR tool? What did you **dislike** about the PPR referral tool?
Was the PPR referral tool user-friendly?

Q9. Would this tool **help you in referring to a non-prescribing healthcare practitioner**?

Q10. Can you see the PPR referral tool being used in your practice? Would you personally use this referral tool?
If yes, please tell me why. Would you choose to complete a referral tool online (fillable PDF) or with pen and paper? Why would you choose to use this method?
If no, what are the barriers to use? What would make you more likely to use this in practice?

Q11. How relevant was the content within the PPR referral tool? Are there any discrepancies with the medical terminology used in the PPR documents?

Q12. How Now that you have seen the tool and how it would work, what would motivate you to learn about and use the PPR and its tools? How should we talk to you about these tools in a way that resonates?

Q13. How can we increase interprofessional communication, between you and non-prescribing practitioners?

FINAL QUESTIONS AND ADVICE (5 MINUTES)

Q14. What are your final thoughts and advice to my client? Was there anything missing from our discussion of this topic today?

THANKS & WRAP