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"We have to what?": lessons learned about engaging support staff in an interprofessional intervention to implement MVA for management of spontaneous abortion☆,☆☆

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Abstract

Background: Including support staff in practice change initiatives is a promising strategy to successfully implement new reproductive health services. The Resident Training Initiative in Miscarriage Management (RTI-MM) is an intervention designed to facilitate implementation of manual vacuum aspiration (MVA) for management of spontaneous abortion. The purpose of this study was to identify training program components that enhanced interprofessional training and provide lessons learned for engaging support staff in implementing uterine evacuation services.

Study design: We conducted a secondary analysis of qualitative data to identify themes within three broad areas: interprofessional education, the role of support staff, and RTI-MM program components that facilitated support staff engagement in the process of implementing MVA services.

Results: We identified three key themes around interprofessional training and the role of support staff: "Training together is rare," "Support staff are crucial to practice change," and "Transparency, peers and champions."

Conclusions: We present lessons learned that may be transferrable to other clinic sites: engage site leadership in a commitment to interprofessional training; engage support staff as teachers and learners and in shared values and building professionalism.

Implications: This manuscript adds to what is known about how to employ interprofessional education and training to engage support staff in reproductive health services practice change initiatives. Lessons learned may provide guidance to clinical sites interested in interprofessional training, improving service delivery, or implementing new services.

Keywords: Practice change; Miscarriage; Team training; Implementation; Support staff

1. Introduction

The safety and efficacy of office-based uterine aspiration using manual vacuum aspiration (MVA) are known [1–3]; less well understood is how to successfully integrate the service [4]. Using MVA to manage spontaneous abortion in an office setting is cost-effective and permits continuity of care in primary care settings. It also may require new staff roles. Interprofessional and team training, which includes training across all roles in patient care, is an innovation in medical [5–7] and continuing [8,9] education, can facilitate

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implementation of new services [10], and has been associated with better team communication [9] and clinical preparedness by physicians [11]. Interprofessional training may also be effective in achieving practice change [10,12–16]; however, it is challenging to implement [17] and does not yet have strong evidence to support its impact [18–21]. The small existing literature addressing interprofessional training in reproductive health services suggests that including support staff in practice change initiatives is a promising strategy to facilitate implementation of new services [4,22,23].

Our previous work [24,25] underscored the importance of support staff in practice change but did not tell us which parts of the interprofessional training intervention were most important for engaging support staff in the process; this is a key gap in the team training literature [21]. The purpose of the current analysis was to focus on the role of interprofessional training in implementing MVA services at Family Medicine residency sites in Washington State. We used qualitative data to highlight training program components that enhanced interprofessional training, providing lessons learned about engaging support staff in implementing MVA services for spontaneous abortion.

2. Materials and methods

This study is a secondary analysis of a larger prospective mixed-methods impact and process evaluation of the Resident Training Initiative in Miscarriage Management (RTI-MM), which took place in Washington State from 2008 to 2010. Details of the conceptual framework, program characteristics and study design are reported elsewhere [24,25]. Briefly, the RTI-MM trained over 400 individuals, about half of whom were not physicians. In this study, we refer to these nonphysician professionals as clinical or administrative support staff. The RTI-MM was designed to facilitate implementation of office-based management of spontaneous abortion, with a focus on MVA. The intervention includes a didactic session, a hands-on simulation exercise using a papaya model [26], and follow-up sessions targeted at support staff and preparing systems to provide MVA services. Support staff were encouraged to attend all training sessions.

Data collection took place between 6 and 18 months after the initial training session and after all training sessions were completed; timelines were different for each site based on project rollout. All individuals (physicians and nonphysicians) who attended an RTI-MM training session received a recruitment email from the Family Medicine Residency Network, a co-coordinating body of family medicine residency sites. Potential participants contacted the first author (B.G.D.) to learn more about the study, review the consent process and schedule an interview. The first author (B.G.D.) conducted all telephone interviews, which were recorded, and focused on use of MVA at the site prior to the RTI-MM training, the implementation process at that site, remaining barriers to implementation, perceptions of the site champion, and whether the similarity of spontaneous and induced abortion was a challenge to implementing MVA at their site. The first author (B.G.D.) transcribed each interview into a case summary organized by interview question as a first stage of data reduction and synthesis. She then read all transcripts, noting the emergence of overarching themes. Coding was an iterative process. A short initial code list was developed, and we next refined the code list to include emergent themes [27]. Finally, after all case summaries were coded, we refined the code list a final time, merging overlapping codes and renaming codes. Following data coding, we developed matrices [28] to display summarized data by key themes across and within subjects [29] and stratified by role and site [30] to facilitate comparative analyses [31].

Full results of our primary qualitative analysis, focused on barriers and facilitators to implementation of MVA services, are published elsewhere [25]. In this secondary analysis [32,33], we used a subset of our data to identify themes within three broad areas: interprofessional education, the role of support staff and RTI-MM program components that facilitated support staff engagement with implementing MVA services. This study was approved by the University of Washington Human Subjects Division.

3. Results

Thirty-six participants completed an interview, of whom 14 were support staff (8 clinical and 6 administrative) and 22 were physicians (10 residents, 12 faculty). All 10 programs were represented in the data. We present brief exemplars for each key theme organized by our three broad areas of interest: "Training together is rare," "Support staff are crucial to practice change" and "Transparency, peers and champions" ("Champions" are key individuals in the social network who support the innovation or change [15]).

3.1. Interprofessional education: "training together is rare"

Support staff and physicians spoke often about the rarity of support staff and physicians training together. Support staff found it novel and helpful to be included at all:

> "I think the most helpful for me was that my workgroup was included in the discussion. At first I thought well how does this apply to me…it was good that we were included in the discussion and they thought enough of our participation to include us." (Administrative support staff)

Physicians found it novel and helpful to have a forum to hear what support staff think. "We did have support staff present…and we discussed their biases in terms of doing this [uterine evacuation] in the office and it was actually rather interesting because of all the support staff, I don't think there was a single one [who] was in favor of doing an in-office manual vacuum aspiration." (Faculty MD) Several participants, both physicians and support staff, echoed a participant