Journal of Biomedical Practitioners

JBP

Periodico per le professioni biomediche a carattere tecnico - scientifico - professionale

Titolo articolo / Article title:

INTERPROFESSIONAL COLLABORATION AND HEALTHCARE ORGANIZATION: an exploratory investigation into the challenges and opportunities for rehabilitation professionals.

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Pagine / Pages: 125-159, N.2, Vol.8 - 2024

Submitted: 29 August 2024 – *Revised:* 4 September 2024 – *Accepted*: 20 November 2024 – *Published*: 22 December 2024

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Open Access journal – www.ojs.unito.it/index.php/jbp – ISSN 2532-7925

Journal of Biomedical Practitioners ©

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Periodico per le professioni biomediche e sanitarie a carattere tecnico - scientifico – professionale

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SOMMARIO / TABLE OF CONTENTS V. 8, N. 2 – 2024

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OPEN ACCESS JOURNAL
http://www.ojs.unito.it/index.php/jbp
ISSN 2532-7925

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A Scientific, Technical and Professional Practice Journal for Biomedical Practitioners

INTERPROFESSIONAL COLLABORATION AND HEALTHCARE ORGANIZATION: an exploratory investigation into the challenges and opportunities for rehabilitation professionals.

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Come citare / How to Cite:

Sottana, S., Vianello, A., Tognin, M., Mazzarotto, D., Ceccato, M., Visintin, D., ... Savietto, L. INTERPROFESSIONAL COLLABORATION AND HEALTHCARE ORGANIZATION: an exploratory investigation into the challenges and opportunities for rehabilitation professionals. *Journal of Biomedical Practitioners*, *8*(2). https://doi.org/10.13135/2532-7925/11370

N. 2, Vol. 8 (2024) – 125:159
Submitted: 29 August 2024
Revised: 4 September 2024
Accepted: 20 November 2024
Published: 22 December 2024

Think green before you print

ABSTRACT

INTRODUCTION

In the past five years, interprofessional collaboration within the rehabilitation sector has gained significant prominence in the Italian context, emphasizing the efficacy of collaborative methodologies in the treatment of patients with complex disabilities. The recognition of eight rehabilitation professions classified under the first cycle degree class L/SNT2 (Health Professions) has established a foundation for a patient-centered and multiprofessional model of care. However, comprehensive studies regarding the perceptions and implementations of interprofessional collaboration in Italy are notably absent, creating a substantial gap in academic literature and presenting numerous avenues for future inquiry.

AIM

The aim of this study is to fill this gap by exploring the perception of interprofessional collaboration among healthcare professionals, identifying barriers and facilitators to effective collaboration and assessing the impact of education on team working provided for in the interprofessional model of care.

TOOLS AND METHODS

The shared experiences of a cohort of professionals from the University of Padua were analyzed utilizing qualitative methodologies, specifically Focus Groups and Grounded Theory. This analysis facilitated the development of theory grounded in empirical data, providing nuanced insights into interprofessional dynamics.

RESULTS

The results highlight the critical importance of interprofessional collaboration and teamwork, showing the need to improve communication and knowledge sharing in order to optimize patient care. Emerging priorities include collaboration-centered education and organizational adaptation in order to handle complexities and limited resources, suggesting the expansion of collaboration models and the reorganization of rehabilitations environments.

The analysis highlighted the intricate nature of interprofessional collaboration as an ever-evolving phenomenon that necessitates the formulation of educational and organizational strategies capable of transcending existing barriers while embracing professional diversity.

CONCLUSION

In conclusion, interprofessional collaboration is essential for a rehabilitative and patient-centered approach, highlighting the need for health policies the encourages innovative interdisciplinary practices.

This study confirms the importance of interprofessional collaboration in improving patient care, promoting effective communication and collaboration among the different healthcare disciplines in the rehabilitation environment.

Keywords: Organization; Interprofessionalism; Rehabilitation; Collaboration; Health Policies.

INTRODUCTION

In Italy, interprofessionality in the rehabilitation field has undergone a significant evolution in the last fifteen years, reflecting an advanced professionalization process in non-medical healthcare figures. This development is part of a context in which autonomy and specialization of the different professions are more and more recognized and enhanced. In Italy, non-medical healthcare professions are divided into different categories, among which the rehabilitative ones. Health professions for rehabilitation are defined by the healthcare DM (Ministerial Decree) 29\3\2001 [1]. Currently, Italy recognizes 8 different professions in the field of rehabilitation. These include physiotherapists, speech therapists, orthoptists, neuro and psychomotor therapists of developmental age, podiatrists, psychiatric rehabilitation technicians, occupational therapists and professional educators.

In taking care of the patient that needs rehabilitative intervention can intervene different professionals. They are asked to work in a team, sharing the principles of intervention presented in the Individual Rehabilitation Project (IRP) [2]. The working group should be in fact built in relation to the specific objectives of the individual patient and without excluding some professional figures in advance. The patient, the family background, including the presence of a caregiver, should be put at the center of the care process.

The operating model of the rehabilitation working group, in particular for patients with complex disabilities, is interprofessional par excellence, that is centered on the participation of different figures, with integrated fields of intervention whose professional boundaries are flexible and based on project-led programs (top-down). This kind of approach allows us to address the different areas of problem, guaranteeing an overall and personalized treatment whose final result is considered as the product of the union of individual interventions and thus assessed in terms of overall outcome [2].

International literature on interprofessionality in healthcare (the so called interprofessional care) is already very vast. There are many scientific journals (e.g. the Journal of Interprofessional Care or the Journal of Interprofessional Education & Practice) that cover specifically this topic. The studies carried out so far focused especially on the different factors that may contribute to increasing collaborative practice among healthcare professions and, in particular, on the educational process, that is central to pushing for a collaborative culture in the healthcare environment and in overcoming prejudices related to different professional cultures, to institutional mechanisms (governance models for health facilities, structured protocols, etc.), as well

as to organizational and environmental policies (policies on conflict resolution, shared decision making processes, interprofessional communication strategies, space management and sharing) [3; 4; 5].

Despite its significance, the realm of interprofessional practices within the Italian healthcare system remains underexplored by sociological research [e.g. 6; 7].

Accordingly, this study originates from a debate emerged in the educational field within the "Methodology for Rehabilitation Research" course of the second year of the degree program in Rehabilitation Sciences of Health Professions (A.Y. 2023-2024) of the University of Padua. The course is reserved for healthcare professionals that are part of the eight rehabilitation disciplines. Through our professional experiences as rehabilitation practitioners, we have identified the necessity to advance the discourse surrounding interdisciplinary rehabilitation team dynamics by integrating the diverse backgrounds of all participating individuals.

AIM

The research team conducted an analysis, drawing upon their collective professional experiences, with the aim of addressing the following objectives:

- How is interprofessional collaboration perceived among healthcare practitioners?
- What are the barriers and facilitators that influence effective collaboration across various professional disciplines?
- What are the educational implications regarding interprofessional collaboration?

These inquiries were explored utilizing qualitative research methods, specifically through the implementation of Focus Group methodology.

MATERIALS E METHODS

To analyze and understand opportunities and limits of the "Interprofessional Care" model in the current (December 2023) Italian healthcare environment, specifically the rehabilitative one, was chosen a qualitative study using the Focus Group methodology. The Focus Group was used to study positive\negative aspects of interprofessional collaboration in the rehabilitative context and to explore attitudes, opinions, expectations, and suggestions of the individuals involved.

Following the "Standards for Reporting Qualitative Research (SRQR)" guidelines, the chosen approach was pragmatic and inductive, led by the analysis of the guiding questions. [8].

The answers to 13 questions chosen within the Methodology for Rehabilitation Research course were analyzed. The guiding questions were asked by the moderator and discussed during two different consultations in a short time (Table 1 – *Guiding questions made for participants*). There were no linguistic barriers among the participants. No funding or sponsorship was provided for the drafting of this study.

Topic	Time	Question
Rules of conduct	10 min	Which good communication rules should be followed during the debate?
Candidates' introduction	10 min	What is your name? Where are you from? In which organization are you currently employed? Could you please elaborate on your professional experience over the past five years? What qualifications have you acquired?
Introduction	10 min	Are you satisfied to be part of this study group?
Schedule	200 min	**1** What is interprofessionality among rehabilitators? **2** What should the interprofessionality model be based on? (model centered on participation, integrated areas of intervention and flexible professional boundaries) **3** What are the strengths and weaknesses of interprofessional collaboration? **4** What are similarities and differences between the different professions in the educational field? **5** What are similarities and differences between the different professions in clinical practice? **6** How does the holistic model influence health-rehabilitative interprofessionality? **7** What are the main strategies that could be implemented to promote interprofessionality? **8** Is team work between all rehabilitation healthcare professionals feasible? **9** Do all in the healthcare field speak the same language? Or are there intrinsic communicative problematics in various professions? **10** Is it possible to integrate different professional points of view aimed at a patient-centered treatment on clinical level? **11** How is it possible to balance organizational level and patient's wellbeing? **12** Is the presence of the case-manager necessary? What kind of figure should they be? **13** What are the future perspectives and challenges of collaboration between the different rehabilitation operators?
Conclusion	30 min	Among the various points that have arisen during our discourse, what do you deem essential to articulate as a conclusion to our dialogue, and what key insights would you like to retain moving forward?

Table 1 – Guiding questions made for participants

Partecipants' profile

A total of eight individuals participated in the Focus Group. The moderator was selected due to their expertise in facilitating focus group discussions. Participant recruitment occurred spontaneously and was predicated on the individuals' interest in the designated topic. The participants were requested to familiarize themselves with the most recent literature pertinent to the subject matter. All participants provided informed consent to partake in the study and completed a form detailing their personal information, which is summarized in Table 2 (*Focus Group Participants Profile*). Participants retained the autonomy to withdraw from the study at any point in time.

Initials	Age	Gender	Province of the place of work	Rehabilitation professional profile	Years of professional experience	Qualifications obtained	Role in coordination
M. C.	31	M	Trento	Physiotherapist	9	Bachelor's Degree Master	No
F. M. R.	32	F	Gorizia	Physiotherapist	5	Bachelor's Degree (2) Master (Management)	No
R. M.	23	M	Venice-Padua	Physiotherapist	1	Bachelor's Degree	No
D. M.	31	F	Venice	Physiotherapist	9	Bachelors' Degree Master	No
L. S.	24	F	Vicenza, Padua	Speech therapist	2	Bachelor's Degree	No
S. S.	26	M	Udine	Professional educator	4	Bachelor's Degree	No
M. T.	47	M	Padua	Professional educator	26	Bachelor's Degree Master's Degree Master (Management)	No
D. V.	58	F	Gorizia	Physiotherapist	36	University Degree Master (Management)	Yes

Table 2 – Focus Group Participants' Profile

Data analysis

Answers were recorded in audio format and transcribed for later analysis. They were organized by macro topics, as indicated in the relevant table, and analyzed with the aim to grasp both implicit and explicit meanings. In particular, the Grounded Theory methodology was used. Grounded Theory is a qualitative research methodology born in the Sixties that focuses on the generation of theories directly "rooted" (or "grounded") in the collected data rather than on the application of preexisting theories. [9]

This approach allowed us to identify key issues and to develop a deeper and structured understanding of the participants' experiences and perceptions, thus facilitating the emergence of new perspectives and proposals.

RESULTS

The responses obtained during the focus group were documented by the designated note-taker (refer to Attachment 1 – *Focus Group Responses Compilation*). An analysis of the responses was conducted through the identification of specific keywords (as presented in the left column) to discern commonalities in the responses provided by the various professionals. Subsequently, these keywords were categorized into overarching themes (*Macro topics*). The prevalence of distinct keywords was taken into account concerning the responses to individual inquiries.

Question 1: ***What is interprofessionality among rehabilitators?***	**Frequency**	***Macro topic***
SHARING	5	*Interprofessional team*
COLLABORATION	5	*Interprofessional team*
COMMUNICATION	5	*Interprofessional team*
DIVERSITY OF THE INVOLVED DISCIPLINES	5	*Interprofessional team*
PATIENT AT THE CENTER AS COMMON AIM	4	*Common aim*
MAXIMIZATION OF THE RESULTS	3	*New interprofessional organizational model*
CONTINUITY OF CARE	1	*Common aim*
AGREEMENT	1	*Interprofessional team*
ORGANIZATIONAL DIRECTION	1	*New interprofessional organizational model*
PATIENT INVOLVED	1	*Common aim*

PERSONALIZATION OF CARE	1	*Common aim*

Question 2: ***What should the interprofessionality model be based on?***		
INTEGRATED INTERVENTION	4	*Professional integration*
AGREED COMMON AIM: PATIENT'S NEEDS	3	*Common aim*
RESPECTS AND OPENNESS	3	*Interprofessional team*
HOLISTIC APPROACH	2	*Holistic view of the patient*
DEDICATED TO THE MORE COMPLEX PATIENTS	2	*Common aim*
ACTIVE PARTICIPATION	2	*Interprofessional team*
MOTIVATION	2	*Interprofessional team*
TEAM EFFORT	2	*Interprofessional team*
EDUCATION	1	*Interprofessional education*
ADEQUATE TIME AND SPACE	1	*New interprofessional organizational model*
ENHANCEMENT OF SHARING TIME AMONG PROFESSIONALS	1	*New interprofessional organizational model*
SHARING OF GREY AREAS	1	*Holistic view of the patient*
DISCUSSION-BASED MEETINGS	1	*New interprofessional organizational model*

Question 3: ***What are the strengths and weaknesses of interprofessional collaboration?***		
Strengths		
INTEGRATED PATH	8	*Interprofessional integration*
MORE COMPLETE PATIENT CARE	8	*Holistic view of the patient*
MORE EFFICIENT INTERVENTION: SHORTER OR MORE EFFECTIVE	4	*New interprofessional organizational model*

BETTER CARE QUALITY	2	*New interprofessional organizational model*
DIFFERENT POINTS OF VIEW	2	*Interprofessional team*
BETTER MISTAKES AKNOWLEDGEMENT AND CORRECTION IN THE REHABILITATION PATH	2	*New interprofessional organizational model*
GROUP ENHANCEMENT	2	*Interprofessional team*
PROFESSIONAL GROWTH	2	*Interprofessional education*
MOTIVATION	2	*Interprofessional team*
CONTINUITY OF CARE	1	*Common aim*
DISCUSSION	1	*Interprofessional team*
Weaknesses		
COMMUNICATIONAL CHALLENGE	6	*Common ideal language*
EDUCATION ON COMMUNICATION	6	*Interprofessional education*
OCCURRENCE OF CONFLICT	5	*Rehabilitative Case Manager*
COORDINATION NEEDED	5	*Rehabilitative Case Manager*
ORGANIZATION OF MOMENTS OF EXCHANGE	3	*New interprofessional organizational model*
REQUEST FOR MORE RESOURCES	2	*New interprofessional organizational model*
HIERARCHICAL VIEW	1	*New interprofessional organizational model*

Question 4: ***What are similarities and differences between the different professions in the educational field? And in clinical practice?***		
Differences		
SPECIFIC TECHNIQUES	5	*Interprofessional skills*
SPECIFIC SKILLS	5	*Interprofessional skills*
REHABILITATION PROFESSIONALS	4	*Common aim*

IMPROVING HEALTH AS AIM	4	*Common aim*
SIMILAR BASIS EDUCATION	3	*Interprofessional education*
PSYCHO-COGNITIVE AND PHYSICAL PROFESSIONS	2	*Interprofessional education*
DIFFERENT CHOICE SIDE FORMATION	2	*Interprofessional education*
INTERVENTION ORGANIZATION AND TIME DEDICATED TO THE PATIENT	2	*New interprofessional organizational model*
DIFFERENT PRIORITIES AND SENSITIVITIES	2	*Interprofessional skills*
Similarities		
SOME SHARED SKILLS	2	*Interprofessional integration*
DIFFERENT ASPECTS OF BACHELOR'S DEGREE	1	*Interprofessional education*
SPECIFIC LANGUAGE	1	*Common ideal language*
MANY SCOPE-DEPENDENT AIMS AND LITTLE GLOBAL VISION	1	*Holistic view of the patient*
SOME PEOPLE WORK IN TEAM BECAUSE OF PROFESSIONAL APPROACH	1	*Interprofessional team*
DIFFERENT AUTONOMIES	1	*Interprofessional skills*
COMMON MASTER'S DEGREE	1	*Interprofessional education*
SIMILAR WORKING METHODS BETWEEN SOME PROFESSIONALS	1	*Interprofessional skills*

Question 5: ***How does the holistic model influence health-rehabilitative interprofessionality?***		
THE PERSON IS OVERALL ESSENTIAL IN COMBINING INTERVENTION	3	*Holistic view of the patient*
INTERPROFESSIONALITY BASIS	2	*Interprofessional team*
THE NEED TO COLLABORATE TO BETTER WORK ON THE TREATMENT PROJECT EMERGES	1	*Common aim*
IDENTIFICATION OF THE UNDERLYING PROBLEM	1	*Common aim*

MULTI-PRONGED ACTION WITH A SINGLE AIM	1	*Common aim*
IMPORTANT BECAUSE THE ASPECTS INFLUENCE EACH OTHER	1	*Holistic view of the patient*

Question 6: ***What are the main strategies that could be implemented to promote interprofessionality?***		
PROMOTION OF COLLABORATION CULTURE	6	*Interprofessional team*
EDUCATION	5	*Interprofessional education*
PROTOCOLS AND COMMUNICATION TOOLS	4	*New interprofessional organizational model*
DEBATE-ADEQUATE TIME AND ENVIRONMENT	4	*New interprofessional organizational model*
TEAM WORK	4	*Interprofessional team*
KNOWLEDGE OF THE DIFFERENT PROFESSIONS	2	*Interprofessional skills*
MANAGEMENT	2	*New interprofessional organizational model*

Question 7: ***Is team work between all rehabilitation healthcare professionals feasible?***		
ORGANIZATION	4	*New interprofessional organizational model*
PROFESSIONAL ROLES	3	*Interprofessional skills*
PATIENT'S NEEDS	3	*Common aim*
HOLISTIC VIEW AND PATIENT'S COMPLEXITY	2	*Holistic view of the patient*

Question 8: ***Is there a uniformity of language among all professionals within the healthcare sector, or do inherent communicative challenges exist among the different professions?***		
A COMMON LANGUAGE DOES NOT EXIST	8	*Common ideal language*
TO-BE-DEVELOPED COMMON LANGUAGE	3	*Common ideal language*

DEPENDENT EDUCATION	3	*Interprofessional education*
COMMUNICATIVE PROBLEMATICS	1	*Common ideal language*
GROUP-DEPENDENT	1	*Common ideal language*
AGE-DEPENDENT	1	*Common ideal language*

Question 9: ***Is it possible to integrate different professional points of view aimed at a patient-centered treatment on clinical level?***		
YES	8	*Interprofessional team*
NEEDED EXPECIALLY FOR COMPLICATED PATIENTS	4	*Common aim*
RESPECT FOR DIFFERENT PERSPECTIVES	2	*Interprofessional team*
EFFECTIVE\OPTIMIZE	2	*New interprofessional organizational model*
NO	0	
MAYBE	0	

Question 10: ***How is it possible to balance organizational level and patient's wellbeing?***		
FOCUS ON THE PATIENT	4	*Common aim*
BY MAINTAINING OPERATIVE EFFECTIVENESS\EFFICIENCY	3	*New interprofessional organizational model*
REORGANIZATION (TIME, SPACES, IDENTITIES)	2	*New interprofessional organizational model*
TIME FOR DEBATE IS TIME FOR CARE	2	*New interprofessional organizational model*
BY ANALYZING INEFFICIENCIES SOLVABLE THROUGH TEAM WORK	2	*New interprofessional organizational model*
STRONG TEAM MADE FOR EFFICIENCY	1	*Interprofessional team*

Question 11: ***Is the presence of the case-manager necessary? What kind of figure should they be?***		
YES, THE PRESENCE OF THE CARE MANAGER IS NECESSARY	8	*Rehabilitative Case Manager*
COORDINATION	8	*Rehabilitative Case Manager*
ORGANIZATION	6	*New interprofessional organizational model*
REFERENCE POINT FOR THE PATIENT	5	*Rehabilitative Case Manager*
COMMUNICATION	4	*Interprofessional team*
EDUCATION	4	*Interprofessional education*
NECESSARY SKILLS	4	*Interprofessional skills*
RELATION	4	*Rehabilitative Case Manager*
MEDIATION WITH CAREGIVERS	3	*Rehabilitative Case Manager*

Question 12: ***What are the future perspectives and challenges of collaboration between different rehabilitation operators?***		
PROMOTION OF COLLABORATION	7	*Interprofessional team*
MANAGEMENT OF LIMITED RESOURCES	3	*New interprofessional organizational model*
COLLABORATION-AIMED OPERATORS' TRAINING	3	*Interprofessional education*
TO SPREAD COLLABORATION MODELS IN THE TERRITORY	2	*New interprofessional organizational model*
INCREASE OF CHRONICAL AND COMPLICATE PATIENTS	2	*Common aim*
MORE INVOLVEMENT OF PATIENT AND CAREGIVER	1	*Holistic view of the patients*
REORGANIZATION AIMED AT MOMENTS OF EXCHANGE	1	*New interprofessional organizational model*

Table 3 *– Analysis of the Responses that Emerged from the Focus Group*

Macro topics were eventually studied. Hereafter are shown the frequencies of relative occurrence, that is the summation of the keywords referring to a given macro topic, and the frequencies of absolute occurrence, that keep into consideration also the frequencies of the above mentioned keywords.

The frequencies of absolute occurrence consider how many answers contained a keyword belonging to a macro topic.

	Frequency of relative occurrence	*Frequency of absolute occurrence*
Macro topics		
INTERPROFESSIONAL TEAM	22	72
NEW INTERPROFESSIONAL ORGANIZATIONAL MODEL	25	60
COMMON AIM	17	45
REHABILITATIVE CASE MANAGER	8	39
INTERPROFESSIONAL SKILLS	9	31
INTERPROFESSIONAL EDUCATION	12	31
COMMON IDEAL LANGUAGE	7	21
HOLISTIC VIEW OF THE PATIENT	8	19
INTERPROFESSIONAL INTEGRATION	3	14
INTERPROFESSIONAL RESEARCH	1	1

***Table 4** – Analysis of the Macro-Categories*

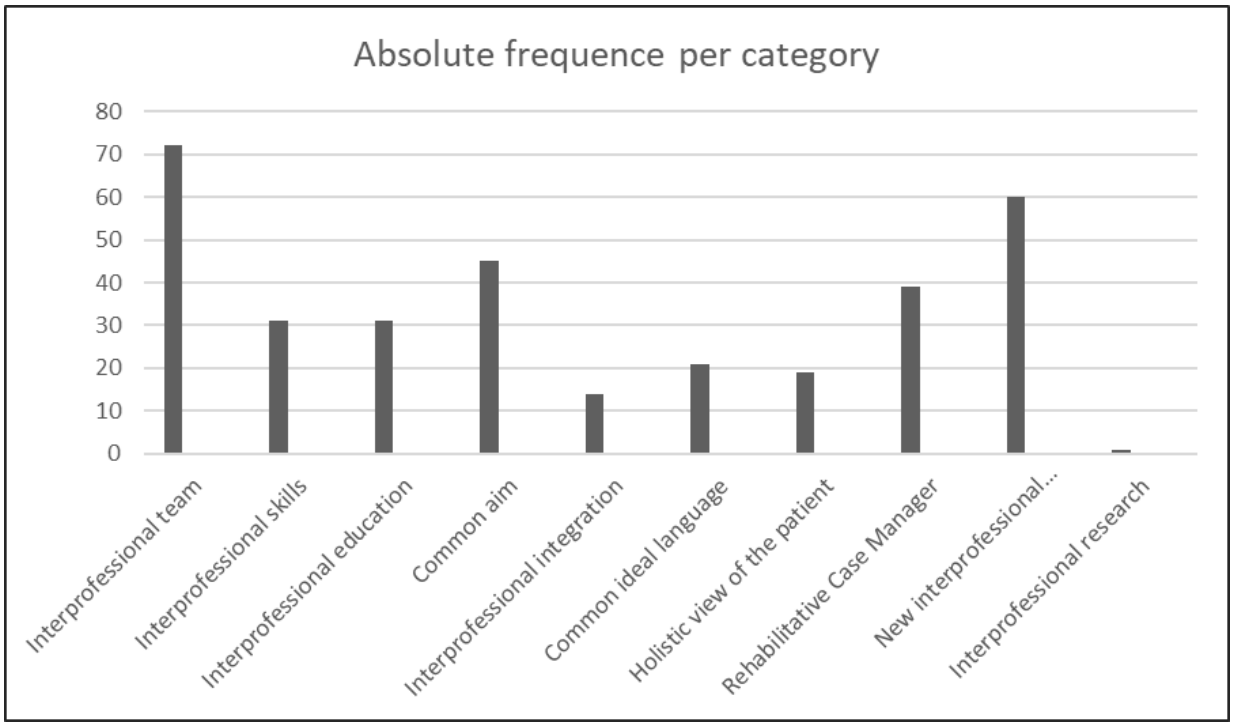

***Figure 1** – Graph of Absolute Frequencies by Category*

DISCUSSION

Interprofessional collaboration in the health-rehabilitation field seems to be a transversal concept compared to the holistic patient model. The concept is based on three fundamental pillars: interprofessionality among operators, centrality of the patient's needs within the rehabilitative team and sharing of a common aim. The ICF model update, that incorporates a holistic view of the individual thus including health, functionality, quality of life and development as interconnected elements throughout people's life, reflects this holistic understanding of care [10]. The majority of the professionals of the focus group underlined the importance of collaboration, sharing and communication between disciplines in defining interprofessionality in rehabilitation. In literature, interprofessionality in the health field is defined as the development of a cohesive and collaborative practice between professionals coming from different disciplines aimed to meet the patient's complex needs [11]. Integration of rehabilitation abilities and patient centrality represent the common aim and are intended to effectively meet the patient's need and to maximize therapeutic outcomes. Interprofessionality is also known as "interprofessional collaboration" (IPC) or "interprofessional care". Compared to homogeneous professional groups, interprofessional collaboration involves value, identities and professional status system, codes of conduct and working methods of each professional, with their own treatment preferences and their own professional language. To further study the concept of interprofessional collaboration, recognized theoretical teamwork and leadership models have been integrated with the aim to provide a more solid theoretical foundation. Among them, the "Framework for Teamwork" by

Salas et al. is particularly relevant. It underlines key components like shared leadership, assertive communication, mutual support and situational awareness. These elements are essential to facilitate the effective collaboration of different disciplines, thus improving the patient's outcome [12].

The "Transformational Leadership" model, developed by Bass and Avolio, is equally relevant to this study. This model promotes motivation and participation through vision and inspiration, that are fundamental to overcome the challenges connected to interprofessional collaboration. Through transformational leadership, leaders can positively influence the team spirit, making it more open to knowledge sharing and team work [13].

To further reinforce the validity of the results of this study, these were compared to the results of international studies that examine interprofessional collaboration in different health environments. In particular, the study by West et al. gives a precious comparative perspective by studying how collaboration dynamics occur in diverse health environments in Europe and North America [14]. This comparison allows to identify not only the common factors that contribute to the success of interprofessional collaboration, but also the specific barriers that may arise in different cultural and organization environments.

These detailed studies contribute to a more complete understanding of interprofessional dynamics and underline the importance of adopting theoretical and practical approaches that facilitate effective collaboration between rehabilitation professionals. It is necessary for future researchers to continue studying these models in different environments to improve interprofessional collaboration practices on a global level, thus enriching the quality of the health care offered to patients in rehabilitation.

According to Jabbar et at., to achieve interprofessional collaboration creation of trust, use of strong communication strategies, development of common management objectives, understanding of power differences necessary to the decisional process and adequate organizational healthcare facilities are necessary [15]. Despite the different professional profiles, the basis is represented precisely by interprofessional integration that requires active participation during the dedicated moments, overall respect and openness towards the knowledge of other disciplines aspects. Meeting the other professional means to discuss and enhance skills that they cannot convey in the shared care process. Moreover, it means to overcome the refusal to collaborate that can come from the other by having clear and at the center the patient's objective [16]. It also emerged the shared idea that this model requires the existence of adequate space and time, of motivated working groups, committed and trained to value sharing times. In accordance with Jabbar et al., it is clear from the beginning the need for the realization of organizational models and structures that allow the concrete creation of interprofessionality [15].

The focus group professionals also recognized significant advantages in the interprofessional approach to rehabilitation, like a more complete treatment deriving from integrated path that may lead to quicker and more complete outcomes, improving care quality. As argued by Allen at

al., positive effects on service quality and effectiveness are found as the result of specific functions [17].

The significance of uniting diverse viewpoints in error prevention is articulated. Reeves et al. also assert that interprofessional collaboration is associated with the "improvement in patient's safety, in the management of cases, in the optimal use of the skills of every member of the healthcare team with the provision of overall better healthcare services" [18].

As stated by literature, conflict is a persistent and inevitable problem within healthcare teams. It is necessary to better manage and solve it for the benefit of the patient. A positive resolution is essential to promote safe and effective care [19].

In this regard, a systematic meta-revision by Holly Wei et al. addressed the issue of interprofessional collaboration with the aim to define facilitators, barriers and outcomes: the article identifies organizational culture, effective communication and mutual trust as key factors [20].

Professionals in the rehabilitation field recognize a common basic training that provides shared skills, essential for the patient's integrated care. Other points of interest shared in clinical practice include interventions quality, in particular the pursuit of Evidence Based Practice and the maintaining of appropriate standards of care, focus on the patient during the decisional process, ethical aspects of the profession, collaboration with colleagues and importance of communicative effects [21; 22]. Guidelines cannot in fact replace clinical judgment, but can facilitate the decisional process and improve the quality of the care provided [23].

However, there are also significant differences in specializations and skills that emerge with advanced training and clinical practice and change according to the physical or psycho-cognitive orientation of the different disciplines. In general, each professional differs, also within the same profession, depending on the depth of their specialization. Despite all healthcare professionals sharing the aim to provide safe and effective care to patients, their responsibilities and skills in clinical practice may considerably change according to their education, specialization and role within the healthcare team. These differences highlight the importance of recognizing and enhancing individual specialization, while remaining committed to the respect of codes of ethics and attentiveness to the patients' different needs. The importance of an interdisciplinary approach that respects the different dimensions of the biopsychosocial model is crucial to guaranteeing an effective and patient-centered rehabilitative intervention. Derick Wade underlines the need for a deep understanding of the complexity and non-linearity between the different factors that influence health and rehabilitation and states that the complexity of the model derives from the unpredictability of the relations between these different factors. According to Wade, also in absence of dysfunctional components, a system can be considered not-working, thus underlining the importance of a holistic approach in the rehabilitation treatment [24].

Despite these difficulties, an interdisciplinary approach remains essential. However, as observed by Piotr Toderko et al. (2020), there is a lack of comparative studies that analyze the different strategies and practices within rehabilitation teams in Europe. This gap in research

underlines the need for further studies to facilitate harmonization and collaboration between European countries [25].

Marjam Körner notices the lack of studies on inter and multi disciplinarity in the approach to the patient and underlines the importance of these approaches as tools for organizational development and quality improvement, in particular in the rehabilitation environment. Körner highlights also that results in terms of outcome and process are significantly better in interdisciplinary teams, further enforcing the argument in support of the importance of interprofessionality and the holistic approach in rehabilitation [26].

Therefore, literature confirms the importance of an interprofessional model in rehabilitation while highlighting the need for further research to optimize these approaches. Patient's centrality, interprofessionality among operators and a common aim are key elements that, if effectively integrated, can significantly improve the quality of rehabilitation assistance.

According to the results of this study, interprofessional collaboration is a key measure in the promotion of health practice. Since the participation of representatives of the different health professions is required, it is useful to obtain adequate space and tools, flexible working time and dedicated educational path to improve collaboration. A study by H. Wei, R.W. Corbett, J. Ray, T. Wei of 2020 helps to understand these mechanisms. The ways of promoting interprofessional collaborative practice and the results obtained showed how human connections between team members represent a safe element that facilitates the process [20]. It is important to create a shared linguistic code and encourage continuing and specific education for all the professionals involved in the realization of an effective working group.

Group work is generally considered feasible and necessary for a holistic approach to complicated patients. However, it is underlined the importance of reviewing and improving the organization of healthcare facilities to effectively support this model.

As stated by J. Wais et al. in their study, interprofessional group meetings are seen as a key moment to exchanging information between the professionals involved. However, especially in bigger facilities, the hierarchical position of the medical directorate and the lack of resources may negatively influence interprofessional exchange [27].

It is also recognized that the specific needs of the patients may change, influencing the level of interprofessional cooperation required. It is necessary to have a collaborative definition of the objectives, placing the patient at the center of the process, rather than focusing on predetermined and specific programs [28].

In the rehabilitative environment, the professionals eventually recognize the presence of communication barriers due to different educational paths. This can make it difficult for professionals like speech therapists and professional educators to fully understand each other's' point of view. Literature recognizes the existence of communication misunderstanding and difficulties in the

health interdisciplinary field [29]. Caring for communication aspects is fundamental in the process of team building [30]. Well organized groups can overcome these differences, with older members that support younger ones, facilitating the integration of various professional "languages" and working towards the creation of a common language that is clear and simpler [31; 29].

In order to enhance the discourse surrounding the obstacles to interprofessional collaboration, it is imperative to analyze the role conflicts that arise within clinical practice, frequently stemming from misconceptions regarding the distinct responsibilities of each professional within the team. An illustrative instance of this can be observed in rehabilitation units, where physiotherapists, nurses, and other personnel may possess divergent perspectives on the methods to enhance patient mobility. Such discrepancies may incite tension, thereby affecting the collaborative environment and the efficacy of treatment.

To resolve this conflicts, it is essential to promote effective communication strategies, like the organization of regular meetings where the members of the team can express their opinions and expectations. Interprofessional education on topics such as mutual recognition of skills and effective negotiation is fundamental to reduce misunderstanding and promote a cohesive working environment. Moreover, the adoption of mediation techniques and the role of the team leader as neutral mediator are supported by literature, as stated demonstrated by Almost et al. in their studies. These studies highlight that leaders trained in conflict resolution techniques can significantly improve the working environment and team effectiveness [32].

The regular "team briefing" approach, as suggested by Lingard et al. (2007), before every shift or treatment session, can be particularly effective to clarify roles and expectations, thus contributing to decrease tension and improve collaboration [33]. These strategies not only mitigate disputes, but also promote a culture of mutual respect and understanding, that is essential for effective team work and continuous improvement of the patient's care. By implementing these approaches, interprofessional teams can transform potential conflicts in opportunities to learn and improve.

All the professionals involved in the focus group agree on the feasibility of integration between different professional perspectives in the field of rehabilitation with the aim of a patient-centered treatment. Half of the participants underlines that this integration is not only possible, but also essential for the effective management of patients with more complicated cases.

Balancing the organizational plan with the patient's wellbeing goes through some key aspects, such as the active engagement of the patient and the support to healthcare professionals in adopting a person-centered approach. Attention is thus paid to the patient's needs, but also to the implementation of effectiveness and efficacy, that is a managerial objective in health services. This also translates as optimizing available resources and prioritizing undeferrable needs, thus distributing them fairly. The study by P. Douglas, J.J. Carr, M. Cerqueira, J. Cummings, T. Gerber, D. Mukherjee, A. Taylor of 2012 offer a similar view by stating the need for an

extensive collaboration between different stakeholders to create a culture and an education that are medical, but also made for the patient and their needs [34]. From the focus group emerges the necessity to start from a multilevel analysis of the needs, involving local facilities, patients and welfare in the geographical area, since little consideration for the social aspect and the territorial context of the patient is perceived.

All the professionals involved recognize the crucial importance of the case manager in the rehabilitation field. The case manager plays a crucial role in the field of interprofessional rehabilitation teams, liaising with the different professionalities and the patient. They are responsible for the coordination and the integration of the different skills within the team, guaranteeing the personalization and the coherence with the patient's needs of the treatment plan [35]. To effectively fulfill these functions, the case manager should have advanced skills in team management, interpersonal communication and conflict resolution. It is essential that they have an advanced education on the interprofessional team work dynamics and on the integrated management of the treatment plans.

These skills facilitate effective collaboration between the team members, improving the effectiveness of the rehabilitation treatment and the overall experience of the patient. Therefore, the presence of the case manager not only optimizes clinical outcomes, but also supports the emotional and psychological wellbeing of the patient, making it a key element for the success of the latest rehabilitation practices.

Since the rehabilitation intervention goes from functional evaluation to the definition of rehabilitation objectives, requiring coordination and teamwork, a highly qualified team leader is necessary [36].

To effectively manage different personalities and integrate various points of view, this figure should have specific skills in coordination, organization and interpersonal relationships. The role of the case manager is considered fundamental to manage the overall needs of patients and provide a reference point for family members as well. The aim of this study is to emphasize the importance of interdisciplinarity in rehabilitation and the need to further promote collaboration between different health professionals. This emphasis is echoed in recent literature, as illustrated by the Forging Alliances in Interdisciplinary Rehabilitation Research (FAIRR) model, which describes how collaboration between researchers and clinicians may promote the interdisciplinary science needed to improve patient-centered outcomes [37]. Literature confirms the importance of effective teamwork between professionals from different fields to advance research and clinical practice, thus supporting the principle that interdisciplinarity is crucial to address the complexities of modern rehabilitation.

However, a systematic review of interdisciplinary care networks for patients with chronic musculoskeletal pain highlights that, despite the effectiveness of patient-centered interdisciplinary programs compared to usual care, there are still significant barriers to the effective implemen-

tation of such programs [38]. This underlines a discrepancy between the ideal of interdisciplinarity promoted by this study and the practical challenges in its implementation, suggesting the need for improved strategies to overcome these barriers.

Furthermore, the examination of interdisciplinary approaches within rehabilitation teams indicates that collaborative care significantly enhances rehabilitation interventions across diverse patient demographics. This finding bolsters the argument presented in this study concerning the criticality of cooperative engagement among professionals from varying disciplines. Nonetheless, existing literature acknowledges the necessity for additional research aimed at optimizing interprofessional collaboration to guarantee the consistent realization of benefits across assorted patient contexts and populations.

Stakeholder experience on collaboration in the context of interdisciplinary rehabilitation for chronic pain patients whose aim is to return to work highlights the importance of stakeholder collaboration and a tailored return-to-work rehabilitation plan. These results confirm the remark of this study on the need for effective collaboration. However, there are still inefficiencies in the concrete application of these strategies, indicating that, despite agreement on the theory, the practical application of interdisciplinary collaboration encounters significant obstacles.

Finally, the universal literature on the importance of interdisciplinary collaboration for excellence in patient care delivery further reinforces the message of this study. Basic education for all clinical professionals should include the knowledge, skills and attitudes necessary to effectively participate in interdisciplinary teams. This is in line with this study recommendation to further promote interprofessional collaboration.

This investigation underscores the vital significance of interdisciplinarity and collaboration within the realm of rehabilitation. Current scholarly literature corroborates these foundational principles while simultaneously illuminating the ongoing challenges associated with their practical application. Consequently, it is imperative not only to acknowledge the necessity of interprofessional collaboration but also to devise effective strategies aimed at surmounting the barriers to implementation, thereby ensuring that interdisciplinary principles are comprehensively integrated into routine clinical practice.

CONCLUSIONS

The analysis of the data of the Focus Group underlines the importance of interprofessionality in rehabilitation.

In particular, interprofessionality is based on sharing and collaboration and it provides for an integrated intervention model based on the specific skills of the individual profiles and characterized by a common aim, represented by the optimization of patient care.

However, professionals think that the current health organization is not adequate to develop interprofessional collaboration, considering significant organizational and communication barriers. The promotion of collaboration cultures, training aimed at communication within the rehabilitation team and the identification of spaces and times suitable for comparison are key elements to create an effective model for interprofessional collaboration. In this context, the role of the case manager is crucial.

The future challenges identified by the study concern the promotion of interprofessional collaboration and the adaptation of the rehabilitation setting that, even in a scenario of limited resources, ensures a holistic approach to care and guarantees effective, efficient, appropriate and personalized care to the patient.

LIMITATIONS OF THE STUDY AND FUTURE PERSPECTIVES

To assess the validity and reliability of the results, it is essential a critical discussion of the limitations of this study, such as the number of focus group participants and socio-cultural influences.

The sample of 8 participants of this study was selected within the University of Padua class context to represent the largest number of different professional disciplines in the field of rehabilitation, allowing a deep qualitative analysis of interprofessional interactions. The aim of this methodological choice was to optimize data collection through focused and manageable discussions. However, the limited sample size may affect the possibility of generalizing the results to different contexts. Due to this limitation, it is suggested caution in transferring results to other rehabilitation environments. Given its qualitative nature and the specific context of implementation, the results obtained may reflect the cultural and organizational peculiarities of the Italian health system and the contexts of origin of the participants, and may not be fully transferable to other geographical or clinical contexts.

It is underlined that, while offering significant insights into specific interprofessional dynamics, the results need to be interpreted with caution when considered in areas that differ than the one studied.

Future studies should expand the sample and include a wider range of professionals, both in terms of interviewees and rehabilitation professional profiles, and should consider including patient interviews to further verify and enrich the results. Such interviews should investigate the perception and satisfaction of patients with respect to the collaboration of professionals involved in the care process. Further research should also understand whether and how these results can be applied to other health, and therefore cultural, contexts, expanding the applicability of interprofessional dynamics to various contexts.

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ATTACHMENTS

Attachment 1 – Focus Group Answers Collection

Focus Group questions	Note-taker notes
What is interprofessionality among rehabilitators?	- Collaboration and communication between professionals of different disciplines in the rehabilitation field. - Interprofessionality means working together between different professional categories for the same patient, with integrated activities and common aims. - In collaboration with a multidisciplinary team, I engage in the management of patient care by sharing the objectives accomplished and discussing with various professionals involved in the process. This approach facilitates the coordination and integration of individual interventions. Furthermore, I contribute to the collective effort aimed at enhancing the functionality and organization of the service. - Interprofessionality means the development of a concerted and collaborative practice between professionals from different disciplines, aimed at responding to complex needs of the user/patient. It derives from the need to reconcile professional differences, sometimes characterized by different or even conflicting views, through continuous interaction and the sharing of knowledge and practices between the different professionals involved. In contrast to homogeneous professional groups, interprofessional collaboration encompasses the distinct systems of values, professional identities and statuses, behavioral codes, and methodologies inherent to each profession. In addition, interprofessionality also requires a change at the organizational and management level, as it involves the creation of environmental conditions that are able to develop and facilitate it. Interprofessional teamwork helps to maximize and strengthen the skills of individual professionals, improve efficiency, ensure continuity of care and their greater coordination, as well as involve the patient and/or family in the decision-making process. - Collaboration between different professional figures in the rehabilitation area with the general common aim of rehabilitating an individual with certain problems, each providing their contribution and skills in order to achieve the general aim set. - Model of collaboration in taking care of a patient, between different professionals, in which skills are integrated and merged to provide a better rehabilitation process. - According to the WHO, each group provide what it considers essential. Many different professions and with different backgrounds operators collaborate to reach a shared level of understanding that they did not have before and that they could not have obtained individually. Moreover, it comes from the need to reconcile professional differences, that are sometimes characterized by different or even conflicting views. - With interprofessionality I mean a working mode where the patient is placed at the center of the rehabilitation intervention and the different professionals share a personalized work plan created on the basis of the single case needs. The shared work plan allows all the professionals to interact

	and better integrate different skills to increase the appropriateness of the act of care.
What should the interprofessionality model be based on? (model centered on participation, integrated areas of intervention and flexible professional boundaries)	- It should be based on the active participation of all members, in an area of intervention that is integrated with flexibility and a holistic approach. - Active participation in effective and structured meetings made for comparison with the possibility of integrated planning in shared objectives among different professionals, especially for patients who need special attention or who have related problems. - Based on my personal experience: respect for each other's professionalism/ skills and for the boundaries related to individual areas, team work in gray areas where multiple professions can operate, ability to learn from each other, with the common goal to involve the patient in treatment choices and to consider their psycho-physical and relational needs. - It should be based on equal dignity, mutual recognition, the peculiarities of each individual and the ability to integrate them in the interests of the patient/user, for a complete achievement. - It is based on a common rehabilitative goal in a holistic vision of the person; we are all rehabilitators and the complicated patient, to achieve their goals, needs each of us, not always in equal measure. They need it to be treated not individually, but as a group (team), cooperatively. As our professional profiles and codes of conduct underline. - On collaboration and sharing between professionals, on multidisciplinary knowledge and skills, on the value of communication time between professions, on the concordance in the definition of rehabilitation objectives and on the team commitment in achieving them. - Education, counseling, diagnosis, care, palliative care. It follows the needs of the individual patient and family members with a promoted culture of professional collaboration. - The interprofessionality model should consider that adequate time and space are needed for a correct development of the model. The basis are the availability of adequate space and time, the right motivation among the operators, mutual respect and an educational path that supports the need to implement cooperative skills in the different operators involved.
What are the strengths and weaknesses of interprofessional collaboration?	- Better quality of care and a more comprehensive approach to the patient. Weaknesses may include challenges in communication and in coordination between professionals. - Strengths: discussion (it may not be possible in services where there is only one of us), debate with professionals who have different backgrounds, experiences, training and therefore different points of view! Possibility to create integrated paths in which the micro objectives are divided and therefore also the path will be shorter or more efficient (e.g. also tasks with work on multiple objectives). Weaknesses: it does not work if the work team is not good, meetings must be well structured, possibility of need for figures such as a moderator and a meeting coordinator, need for freedom of speech felt etc. In addition to this, difficulties in finding moments in which all the professionals are available. Another problem: communication difficulties between professionals with different languages (specific "doctor language" should be avoided).

	- Strengths: vision of the patient and of the problems from several professional points of view, lower risk of errors due to sharing the rehabilitation path, reduction of duplications: it is possible to work together avoiding that there are more professionals that do the same work, possibility to learn from each other. Weaknesses: if not well managed, conflicts may arise in the division of roles, communication difficulties between professionals, conscious or unconscious barriers to change, interpersonal conflicts that can have repercussions on the patient. In the organization of work on the patient (e.g. in the case of an evaluation of a speech therapist linked to that of a neuropsychiatrist e.g. for the drafting of a project concerning the assignment of Italian Law 104 and the assistance of support teachers or other cases) it may happen that the time between the two assessment are too long and that the aim cannot be achieved in the desirable time. - Working in interprofessional teams helps to maximize and strengthen the skills of individual professionals, improve efficiency, ensure continuity of care and their greater coordination, as well as involve the patient and/or family in the decision-making process. Conversely, "overlaps " may occur, or problems determined by professional differences, different or even conflicting views that hinder the necessary circularity and sharing in taking care of and managing the patient. - Strengths: multiple points of view, multiple skills, different solutions to a common problem that may be integrated. Weaknesses: the same as in a group work (difficulties in finding a common agreement since in many cases each of us prefers to work individually, because a choral work is more difficult. Hierarchical vision of the professions, difficult paradigm shift, difficulty in finding the time to discuss together, the organization is based on optimizing time and increasing performance, quantity prevails over quality). - Strengths: more energy, resources and skills to achieve shared aims and overcome difficulties, the value of the group, complete taking care of the patient. Weaknesses; diversity of opinions, need for holistic and communicative knowledge and skills, change of paradigm compared to the past. - On the one hand, the integration of more professional skills allows complete management in all its nuances of that particular patient, where some aspects considered secondary by one professional could be given more importance by another. On the other hand, different views of treatment/management could take much longer at the expense of a timelier intervention as well as generating conflicts within the same team. - The strengths are the completeness of the treatment intervention, the reduction of errors, a better therapeutic alliance, a better adherence of the patient to the treatment and a better expected final result. The weaknesses are an increase in the time required for the provision of the service, an increase in costs, a potential increase in conflicts between operators that can result in worsening the quality of the act of care, the need for training in communication for operators.
What are similarities and differences between the different professions in the educational field?	- Similar training bases that differ in specializations and specific skills. - Certain professions are characterized by a greater emphasis on physical activities, while others focus on cognitive and psychological aspects. Additionally, there can be variations in linguistic usage among different profes-

	sional fields. Some professionals are predisposed to collaborative work environments, particularly at the training stage, in contrast to their counterparts who may not have such inclinations. Furthermore, the anatomical specialization of certain professions may be more limited compared to others. - Analogies: some professionals have similar training and working methods and the intervention of one can in some cases replace the intervention of the other or they can work together doing shared sessions e.g. with the child (e.g. neuro and psychomotor therapists of developmental age and physiotherapists in children with coordination problems, autistic children (?)), others such as psychologists, child neuropsychiatrists have different training compared to the other professionals "in the sector " but they integrate effectively (if the group is functional). - Differences related to specific courses (both Bachelor's degree and CME and non-mono professional training). Analogies concern being figures dedicated to rehabilitation, in the respective codes of ethics etc... - Analogies: the paradigm is the same knowing, knowing how to be, knowing how to do it. Differences: physiotherapists are more focused on doing, manually speaking, educator are more focused on educating/helping, speech therapist are more focused on instructing, occupational therapists are more focused on compensating/replacing, neuro and psychomotor therapists of developmental age on making experiment/play, podiatrist are focused only on the foot, little global vision. - Analogies: similar basal formation (anatomy, psychology, relationship with the patient), "care training". Differences: different specialist training - The training domain varies for each professional, influenced by the specific Bachelor's Degree pursued and the subsequent training courses and master's programs completed during their professional career to satisfy Continuing Medical Education (CME) requirements. Legally and ethically, all professionals bear the responsibility of fostering the welfare of both individuals and the community at large. - All rehabilitation health professionals attend a Bachelor's Degree course with qualification to the profession. The future path includes a single Master's degree course for all rehabilitation figures and several first and second level masters. From the educational point of view, the difference consists in the initial course of studies, that is the different Bachelor's Degree course.
What are similarities and differences between the different professions in clinical practice?	- They share the common aim of improving the patient's health, but differ in specific treatment methods and techniques. - Factor time to devote to the patient, for some professionals it is a predetermined time, while others devote the necessary time. Some professionals need more compliance with the patient than others; some professionals have to work more necessarily in teams even just for organizational factor or because of the presence of more figures in that context. Another difference: some departments are more prone to teamwork between professions than others. - Analogies: for some aspects and for certain professionals part of the skills are shared but not always and not in all specific scientific fields; Differences: e.g. physiokinesitherapists make the functional diagnosis, physicians

	make the diagnosis. Autonomy can be more or less broad depending on what is contained in the professional profile. - Differences related to the treatment of the specific problem for which the person (user/patient) turns to the service, thus differences in the techniques and methods used (hence the need to adopt a broader view – the patient often turns to a service because it has a problem but it is not the only problem – and to develop skills to involve and integrate other rehabilitation professionals). - Analogies: we have a common mission, we are all rehabilitators, we are focused on people, similar work methodology for problems-objectives – strategies. Differences: different training, different priorities, different sensitivities, different ways of acting, different timing. - Analogies: rehabilitation objectives with patients, professional profiles with overlapping skills. Differences: sectoral and specialized knowledge and skills involve clinical eyes that look towards different areas and needs of the patient. - CLINICAL PRACTICE: even within the same profession there may be differences in the method chosen to treat patients, that are also different from each other (see the Master in Neurological, Sport, Respiratory Rehabilitation in Physiotherapy). The analogy basically concerns the final aim, that is to rehabilitate and re-educate the patient to carry out activities that he was previously unable to do independently, or at least pursue an improvement in his initial condition. - All rehabilitation health professionals attend a Bachelor's Degree course with qualification to the profession. The future path includes a single Master's Degree course for all rehabilitation figures and several first and second level masters. The clinical setting profoundly changes depending on the rehabilitation sector in which the professional operates.
How does the holistic model influence health-rehabilitative interprofessionality?	- It emphasizes the treatment of the person as a whole, which is fundamental in interprofessionality for a complete treatment. - The capacity for objective reasoning by the patient may facilitate a broader analysis of the fundamental issues, particularly in the context of psychological or cognitive disorders. This perspective enables a more efficient and comprehensive dialogue among professionals when formulating hypotheses. When adequately managed, this approach proves to be more practical and expedient; however, addressing two interrelated objectives simultaneously could potentially extend the duration of treatment. - Medicine in all fields is opening up more and more to holistic aspects. This means considering the totality of the patient, creating increasingly integrated care and education projects represents an important challenge for the future. - A complete patient's care not only in terms of health/disease but in a broader sense (no watertight compartments). - The founding basis, as the ICF model teaches us: everything can affect everything. - The understanding and acceptance of the holistic model is the basis for the realization of interprofessionality.

	- They are very linked concepts, as the result of an interprofessional collaboration involves a comprehensive approach to the patient according to a holistic model, oriented to everything to meet their needs. - The redefinition of the concept of health by the WHO, the spread of the biopsychosocial model and person-centered medicine, are changing the essence of rehabilitation practice, both at the level of the professional and the health organization. This process has led to a decentralization of the figure of the physician, a centralization of the patient and a progressive need for all health professionals to collaborate together with the care intervention.
What are the main strategies that could be implemented to promote interprofessionality?	- They include interprofessional training, the use of effective communication protocols and the promotion of a culture of collaboration. - In a clinic/hospital structure setting: if possible, divisions into "stable teams". Organization of schedules with at least one hour per week to reflect on patients proposed by professionals as "in need of more therapists/ collaboration between professionals". In the territorial home or not-home environment collaboration between professionals who take care of a certain patient is necessary to maintain the view on the global picture, even in progress (e.g. discussion also via videocall twice per month. Other support modes: shared diaries? But there is the problem of the specific language problem. Group comments section?) - Promote a peaceful and collaborative climate trying to smooth tensions, avoid judgment, encourage continuous and specific training for all professionals who can then share it with others and apply it on patients. - To promote mutual knowledge (respecting the specificities of each figure and levels of effectiveness), to know their respective job descriptions, to promote team meetings, shared supervision on specific cases, and multi professional training. - To give time to confront, to share, to know, more meeting, more community of practice, more informative meetings. To eliminate the hierarchical paradigm, to favor the managerial model, the concept of professional responsibility should be the basis, the desire to question ourselves and increase our ability to listen and be open to confrontation, the desire to learn from other points of view. - Teamwork, working group management, creation of a shared linguistic code, ensuring sufficient time to realize the interprofessional paradigm, multidisciplinary training. - Healthy work environment and open to dialogue, mutual knowledge between professionals to understand where the limits of each operation reach, simulations of clinical cases as "training", meetings to discuss critical issues and improvements. - Interprofessionality is a working mode that requires the presence of different representatives of the health professions, adequate space and equipment, flexible working times and dedicated training/experiential paths to improve collaboration between professionals.
Is team work between all rehabilitation healthcare professionals feasible?	- Requires effective organization and clear definition of roles.

	- It depends on the patient and the context of department and service. It is possible if all professionals serve that specific patient. Is it possible if there is a common point between professions (e.g. podiatrist/speech therapist?). - Yes. - It is possible and desirable. The need to integrate different professionals is emerging for a more complete and effective management of the patient, which does not leave areas of shadow, which sees the integration of different points of view that complete each other (without overlapping and/or hindering each other). More and more patients bring multidimensional problems, increased complexity. There is the need to integrate techniques with relational skills and to make communication completer and more effective. - Absolutely yes, but there must be a paradigm shift and a corporate reorganization. - Feasible yes, but not always necessary, depends on the needs of the patient. - It is possible and, in some cases, necessary. To date, longevity has increased but many patients present a complex picture, not only the neuromotor component is relevant but also the cognitive-behavioral one. - The concept of feasibility is random, in theory everything seems possible, but we must consider the practical reality and the organization of the health facility in which the aforementioned professionals should work together. Although cooperation seems desirable, from a practical point of view it is very difficult to achieve.
Do all in the healthcare field speak the same language? Or are there intrinsic communicative problematics in various professions?	- Each profession has its own specific concepts. It is important to develop a common language for effective communication. - There may be communicative problems sometimes dictated by ignorance in one or both parties. The same applies to the patients. - The languages may be slightly different, but in the "well-assorted and well-managed" groups eventually the languages integrate. - The creation of a common language (of a culture of interprofessionality) represents a process that must be built and cared for constantly. - No, in some cases, we should create a common shared language, avoid ambiguity, avoid unnecessary technicalities, favor simplicity, following the maxims of Paul Grice. - In my opinion today we do not speak the same language because of educational reasons, not because of intrinsic communicative problems - It is a time-consuming process also because of the level of experience and competence between young and older professionals. It is essential to first know each other well to well understand where the management of the veterans of the group tends to turn to manage the patient in the best way. - In the rehabilitation field there are no problems related to communication, especially if the cultural matrix of professionals is the same (for example if they studied in Italy). There may be some difficulties in understanding related to the specificity of intervention related to the training of individual rehabilitators: it is difficult for a speech therapist to fully understand the point of view, for example, of a professional educator and so on.
Is it possible to integrate different professional points of	- Possible and desirable, it requires effort to understand and respect the different perspectives.

view aimed at a patient-centered treatment on clinical level?	- Theoretically, it is the aim and interdisciplinary collaboration has shown itself (literature) effective and efficient. There is the need for an open optics to the point of view of other professionals and also for not to rigidly delineate the boundaries, while not encroaching. - Yes. - It is necessary to integrate the points of view in the interest of the patient/user (more and more multi problematic patients, increased life expectancy, chronicity etc). A shared treatment promotes greater effectiveness in care, greater compliance of the patient and family members. - It is not only possible, but even essential to be able to treat complex patients. How? By analyzing similarities and differences, getting in game, rearranging time and goals, finding a common language and all that we have said before. - Yes, it is possible. - The sharing of points of view for a more complete and uniform management of the patient is, so to speak, mandatory. It is one of the macro-objectives of interprofessional management. - There is no such doubt: the model of person-centered medicine (PCM) is testimony to the fact that it is necessary and represents the future of the act of care.
How is it possible to balance organizational level and patient's wellbeing?	- Constant focus on patient needs, maintaining operational efficiency. - "Interprofessionality" requires a reorganization of space and time, a reorganization of the perceived identity of one's profession for some. - By considering first of all the priority needs of the patient, without neglecting the main organizational needs that favor the efficiency of the service. It is necessary to set realistic objectives considering both the budget and the organizational needs of the company. All inefficiencies (e.g. ineffective interventions, duplication of intervention) must be carefully analyzed: EFFICIENCY AND EFFECTIVENESS. It is the watchword that managers have brought to health services: if there were more economic resources certainly this would be easier, but in any case, it is necessary to optimize the resources available by prioritizing the undifferentiable and priority needs of patients in order to distribute them fairly. Health education that allows the patient to become autonomous in the management of some chronic problems and to prevent the aggravation of others (it is important to invest in the health culture of citizens) is also useful. - It is necessary to maintain operational efficiency, optimize resources but focusing on the needs of the patient/user - Yes, if you understand that the time of confrontation is time of cure and is valid as a therapy itself. - I think it is necessary to discuss and reorganize working times with the whole company. - It is absolutely not easy, especially for demanding patients and with many associated problems. Sometimes it could happen that team discussion takes a lot of time with the achievement of small gains and little satisfaction on the part of the user. Only a solid group united by an excellent relationship and cooperation could prevent these problems and get to the root of the problem in less time.

	- We should start from an analysis of needs at several levels: starting from the needs of the local structure, the user and the social at the geographical level. Often changes and reorganizations of health facilities are proposed at a geographical level with mainly economic interest, for which the realities of the individual user and the social context of reference are consequently neglected.
Is the presence of the case-manager necessary? What kind of figure should they be?	- They are crucial to coordinate the various aspects of assistance and are essential in management and communication thanks to their knowledge and skills. - They should be a person who has the esteem of the team, who has idea of the profession of the participants, who is a good moderator and who knows how to manage and "exploit" the personalities of the team, with good organizational skills especially in the time to devote to cases etc... and make final decisions by collecting the various opinions. - The case manager is a very important figure. They should be a figure who, beyond the professionalism and specific skills of his profile, is dedicated to fully managing the needs of the patient, who takes care of maintaining the ranks and contacts with the various professionals, caregivers, institutions (e.g. educational institutions), etc. - The figure of a case manager can be very important as a reference for the user/patient and their family members, but also within the team. They should be a figure who has developed the ability to work in a team, with good relational skills (both in giving/transmitting information but also in the ability to grasp needs, needs and contributions). - Fundamental, they must be trained to do it, not everyone is able to do it. They should be a figure that pulls the strings, that compares with all the other figures continuously, that takes care of the entire path of the patient; the figure should not be the highest in ranking, but the figure that the patient needs the most and knows them best. - I think it is important to direct the group and manage the various professionalities in taking charge of the patient. - A reference figure that acts as a spokesperson and summarizes all the evaluations and operations of each professional in the team is very useful. - The presence of the case manager can certainly help the management of the shared rehabilitation project, but it is not always possible to identify them because it depends on the organization of the structure being examined. The CM figure should be a figure dedicated to the organization of the case and the relationship with the family environment and the patient. Organizational, relational, motivational and flexibility skills are needed.
What are the future perspectives and challenges of collaboration between the different rehabilitation operators?	- The management of limited resources, the adaptation to new technologies and treatment methods and the promotion of ever closer collaboration between professionals. - Making the hospital organization more collaborative, training operators for interprofessional collaboration. - Expanding the models of work in multidimensional teams in territorial structures is an objective that must be sought. Creating a culture related to

	multi-professional work and the strengths of team work to allow an increasing number of professionals to work together by integrating their mutual skills and responsibilities. - An increase of patients with chronicity, greater complexity/multiculturalism/combining technical skills with relational skills. Multi problematics means the need for treatment and management that goes beyond the single specific intervention; lower budget, greater involvement of the patient and family members in the care process; reduction of hospital beds and less GPs; need to promote more health education/increase the competence of patients and family members. - The future will be the complete holistic treatment of the patient. The patient will no longer be abandoned to themselves and the concept of (global) taking charge will finally be respected in all its facets. - To truly implement interprofessionality and the figure and role of the case manager in the various health realities (even those in evolution, such as proximity health). - Italy is one of the longest-lived countries with high rate of elderly population. As the quality of life is higher, many more problems will arise, such as physiological as we age. The goal is to ensure the best quality of life with less resources used in terms of costs and spaces in hospital wards. - An interesting aspect will certainly be to identify a new way in the health organization that allows and favors collaboration between professionals and that can integrate the health and social institutions. Establish training courses that refine collaboration skills and organize staff working hours so as to consider the necessary flexibility for meetings, updates, etc.