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Medication management for older adults in interprofessional primary care teams: a qualitative interview study of family health teams in Ontario, Canada

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Abstract

Background Team-based, interprofessional primary care models are arguably well positioned to care for patients with polypharmacy as they often have a pharmacist or allied health professionals to support patients with medication management. However, little is known about how teams work together to manage medications. This study aimed to explore how a team-based primary care organization including a mix of physicians and interdisciplinary health providers (IHPs), called Family Health Teams (FHTs), manage medications for older adults.

Methods We conducted semi-structured interviews ($n = 38$) with administrators, family physicians, and IHPs from six FHTs in Ontario, Canada. We followed the thematic analysis steps outlined by Braun and Clarke and adapted the approach to use a codebook.

Results Four themes were identified: (1) strategic goals and internal policies; (2) tailored programs and supports; (3) diverse team configurations and roles; and (4) teamwork and collaboration. Findings revealed variation in the ways physicians and IHPs worked together to manage medications for older adults and that different approaches to care and physician communication preferences were identified as challenges to medication management. Trust was an important factor in medication management among teams; the more physicians interacted with IHPs, the more comfortable and trusting they were in giving them an active role in patient care. Regardless of the approach to medication management, participants agreed that physicians ultimately had the final say in patient care.

Conclusions Despite an emphasis on teamwork in FHTs, there were few examples of true collaboration and shared care for medication management. To support older adults and others with complex health needs, opportunities to improve teamwork, strengthen collaboration, and optimize team composition should be identified and pursued.

Keywords Polypharmacy, Medication management, Family medicine, Interdisciplinary care, Qualitative research

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Background

Polypharmacy—often defined as the concurrent use of five or more medications [1–3]—is a growing public health challenge, particularly among older adults living with multiple chronic diseases [4–7]. Polypharmacy can lead to adverse drug events, hospitalizations, and avoidable health system costs [8, 9] among others.

Team-based, interprofessional primary care models are well positioned to care for patients with polypharmacy as they often have pharmacists or allied health professionals to support the monitoring and management of patient medication [10, 11]. Specifically, a pharmacist on a primary care team can dedicate time to medication reviews, identifying opportunities for deprescribing, patient education or monitoring, and providing consultation services to other providers. Other interdisciplinary health providers (IHPs) can similarly support patients taking new medications, such as additional monitoring for adverse drug reactions or address patient concerns or questions. One example of a team-based primary care model is the Family Health Team (FHT) in Ontario, Canada. FHTs are primary care organizations that include a mix of family physicians and IHPs, such as nurse practitioners, registered nurses, social workers, pharmacists, and others [12]. As of 2023, there were 187 FHTs with over 3.4 million rostered patients in Ontario [12, 13]. In Canada, the funding and delivery of primary care falls under provincial/territorial jurisdiction. While primary care models vary across the country, most family physicians are private providers but are publicly funded. Family physicians are the most common first point of contact with the health care system and play a gatekeeping role to specialist physicians. FHTs include family physicians that are most often paid using a blended capitation model. Funding is provided from the Ministry of Health for IHPs within the FHT, who are most often paid a salary.

Some studies show that FHTs improve coordination, collaboration, and communication within the teams [14–16], and enhance patient access to health services [15]. Facilitators and barriers to interprofessional collaboration has been explored, including a systematic meta-review that identified and grouped mutually inter-related factors at the organization, team, and individual levels [17]. Factors include, but are not limited to, organizational structures, supports and culture; team environments, power, leadership and role clarity; and individual values, goals, and relationships [17]. However, the effectiveness of team-based models in improving clinical outcomes and reducing healthcare utilization remains an area of ongoing research with mixed results [18, 19].

Few studies have explored the impact of team-based models on medication-related outcomes for older adults. A recent study by our team evaluated whether access to team-based models in Ontario and Quebec, Canada,

impacted medication management outcomes for older adults [20]. The analysis did not find that access to teams in either province improved medication management outcomes compared to other practice models [20].

As governments across Canada continue to invest in primary care teams to improve access and patient outcomes [21, 22], a greater understanding of how these teams operate and address medication management is needed. For the purpose of this study, we use the term ‘medication management’ to capture any activities related to prescribing, deprescribing, and monitoring and supporting patients with their medications. Given the expectation that team-based models improve medication-related patient outcomes, we conducted an in-depth qualitative exploration of Ontario’s FHTs to identify why these outcomes may not be realized. This study aimed to explore how FHTs in Ontario are managing medications for older adults, which may offer solutions for teams to realize their potential.

Methods

This work is part of a larger mixed-methods study investigating the effects of team-based interprofessional primary care on polypharmacy and inappropriate prescribing for older adults. Quantitative results are published elsewhere [20, 23]. Below, we report on semi-structured interviews with FHTs in Ontario, Canada.

Sample selection and recruitment

We purposively sampled from Ontario FHTs, which we sorted by region (urban vs. rural/remote), practice size (≥ 9 physicians), and whether they were allocated a pharmacist. A short list of FHTs was shared with the Association of Family Health Teams of Ontario, a membership organization, who contacted the Executive Directors of the FHTs. We aimed to recruit three urban and three rural teams to balance feasibility and the need for a diverse set of teams. Upon confirming interest, research team members provided the Executive Directors with a recruitment letter to distribute to their teams. Interested participants within these teams were asked to contact the project’s Research Coordinator (MR) directly to schedule an interview. We also asked participants to forward the recruitment letter to colleagues at their FHT, aiming for a sample size of approximately four to five participants per team, in line with recommended sample sizes for this breadth of research question [24]. Recruitment continued based on participant interest and until no new ideas or perspectives were brought up by participants.

Data collection

Semi-structured interviews were conducted by interviewers (MR, AG) trained and experienced in qualitative interviewing and primary care research between

December 2020 and February 2022. Interviewers had no prior relationship with respondents. The piloted interview guide included two sections relevant to this manuscript: (1) general experiences with prescribing/medication management for older adults and, (2) policies impacting medication management and multidisciplinary care. The interview guide was developed by experienced qualitative researchers to answer the research question and was piloted with a family physician and revised with feedback from the broader study's team of researchers and knowledge users. We also collected demographic information (gender, profession, and full-time/part-time status at the FHT). Directors were asked additional questions to provide contextual details about the FHT (see Supplemental Appendix 1 for the interview guide).

Interviews were conducted by telephone or Zoom and lasted 30–60 min. Participants received a \$50 gift-card. Interview recordings were transcribed verbatim by a transcriptionist and reviewed for accuracy.

Analysis

We adopted a pragmatic research philosophy [25] in our analysis, focused on understanding how the complex challenge of medication management for older adults is addressed by primary care teams. Inductive thematic analysis was used to identify and organize the data. We followed the thematic analysis steps outlined by Braun and Clarke [26] and adapted the approach to use a codebook [26, 27]. We developed a codebook iteratively; authors (MR, AG, JV, DR, EM, SA) reviewed two transcripts independently and open coded, where interview excerpts were labeled with descriptive codes to reflect key concepts and ideas. The authors met to discuss their coding and compile a preliminary codebook. Any disagreements were resolved by discussion and consensus. Another three transcripts and excerpts were coded by authors to further validate code labels and definitions in the codebook. After finalizing the codebook as a team, the remaining transcripts were coded by one researcher (MR) using NVivo qualitative software. These codes were compiled, consolidated, and organized into broad categories that formed preliminary themes and definitions. Themes were further refined, with some being consolidated or subdivided as sub-themes.

Table 1 FHT characteristics

Case No.	Location*	Pharmacist at FHT?
1	Rural	Yes
2	Rural	Yes
3	Rural	No
4	Urban	Yes
5	Urban	No
6	Urban	Yes

*based on postal code of the FHT

Trustworthiness

To address trustworthiness of the data, we considered credibility, dependability, confirmability, and transferability [28, 29]. We had prolonged engagement with the data to ensure our understanding and compared different viewpoints across cases and participants to enhance credibility. An audit trail was maintained through notetaking during data collection and analysis, and the majority of interviews included two researchers to reduce the effect of investigator bias and support dependability and confirmability. We also practiced reflexivity through ongoing discussions about potential biases in data interpretation. Lastly, for transferability, we provided a rich description about the participants and their teams to the extent possible while maintaining anonymity, and employed purposive sampling to ensure a diverse range of perspectives.

Results

We interviewed 38 participants from six FHTs (see Table 1 for FHT characteristics). There were no participant dropouts or withdrawals.

Participant characteristics are listed in Table 2. Two FHTs did not have pharmacists in post at the time of interview; one of these was an unfilled position (Case #5) and the other FHT expressed not having a need for a pharmacist (Case #2). Of the FHTs with pharmacists, most pharmacists worked at 1.0 full-time equivalent (FTE) except for Cases #3 and #6 (0.8 and 1.5 FTE, respectively).

We identified four main themes, including: (1) strategic goals and internal policies; (2) tailored programs and supports; (3) diverse team configurations and roles; and (4) teamwork and collaboration. Additional illustrative quotations are available in Supplemental Appendix 2.

Strategic goals and policies supporting medication management

The first theme describes organization-level goals and the strategies designed to achieve them, as well as government and organizational policies related to medication management and polypharmacy.

FHTs are mandated to submit quality improvement plans and annual reports and participants from some teams specified that their FHT had goals related to prescribing as part of their quality improvement efforts. One team (Case #1) explicitly cited addressing medication safety and reducing polypharmacy as a FHT goal. Participants from two FHTs (Cases #1 and #6) discussed minimizing (or deprescribing) opioids specifically:

So the opioid prescribing was probably one of the bigger ones. That's kind of when I noticed our physicians wanting to really scale back in how much they were prescribing, what they were prescribing, how

Table 2 Participant characteristics (n = 38)

Characteristic	Case 1, n=9	Case 2, n=5	Case 3, n=8	Case 4, n=5	Case 5, n=7	Case 6, n=4	Total, N=38 No. (%)
Gender							
Woman	9	5	6	2	7	4	33 (87)
Man	-	-	2	3	-	-	5 (13)
Profession/Role							
Nurse practitioner	2	2	3	1	-	1	9 (24)
Registered nurse	1	1	2	-	2	-	6 (16)
Executive director	1	1	1	1	1	1	6 (16)
Physician	2	-	1	1	1	2	5 (13)
Pharmacist	1	1	-	1	-	-	5 (13)
Registered dietitian	1	-	-	-	1	-	2 (5)
Other allied health	1*	-	1*	1*	2*	-	4 (11)
Full-time or Part-time							
Full-time (1.0 FTE)	8	4	7	5	-	2	34 (89)
Part-time (< 1.0 FTE)	1	1	1	-	-	2	4 (11)

*Other allied health included social worker (n = 1), kinesiologist (n = 1), occupational therapist (n = 1), mental health counselor (n = 1), and community services worker (n = 1)

often they were prescribing, and really starting to get opioid agreements done. (Case #4-Pharmacist)

To facilitate regular medication reviews, participants reported that FHTs had internal policies that patients should bring a medication list or all medications to each appointment (Cases #1, 3, 6). While not enforced, participants said it was recommended that routine medication reviews be embedded in appointments with older adults:

Especially for the seniors program, it's almost guaranteed every appointment. We ask the care provider who is attending the appointment with the individual to make sure that the medications are accompanying them. They'll bring them in bags, and they get spread out on the table, and they try to sort out why or who prescribed them, and how often they're taking them, and their understanding of why they're taking them at certain times. (Case #3-Executive Director)

This strategy was perceived as effective for minimizing adverse drug events:

...continuing to reiterate that [policy] has proved to be helpful over time in catching drug-related problems, especially when people have multiple prescribers. (Case #1-Pharmacist)

Other reported strategies implemented at the FHT level included creating an annual reminder in the patient's electronic medical record (EMR) to prompt a medication review for patients over 65 years (Case #6), "flagging charts for patients who take narcotics" (Case #1-Family Physician), conducting post-hospital follow ups within one week of hospitalization (Cases #3 and #4), and

limiting the number of prescribers. For example, Case #3 restricted nurse practitioners from prescribing opioids:

Each of the nurse practitioners, we have taken our opioid course. But [the clinic's executive team] asked that we don't prescribe any opioids from the Family Health Team. So when an opioid is to be prescribed, we contact the family physician. (Case #3-Nurse Practitioner)

FHTs reported using data from several sources to monitor and evaluate whether they were meeting their goals, including from EMRs, patient and provider surveys, anecdotal feedback reported by clinical staff, and physician practice reports ("MyPractice reports") from the government health agency. However, one physician participant noted that seeing their prescribing data did not greatly affect how they chose to practice:

I signed up to the My Practice report. [...] It's interesting to look at, but I'd probably say it doesn't really impact my decision-making process that much. (Case #4-Family Physician)

There also appeared to be tensions between achieving clinic-wide goals and respecting physician autonomy. One Director described the importance of getting physician buy-in for change:

We've realized over many years of doing this that our quality improvement has to be adjusted internally as opposed to really asking the physicians to make change for us. [...] if we can't get the physicians to buy in then we've gone to things that we can effect. (Case #3-Executive Director)

A registered nurse shared a similar perspective, noting that despite all working in the same FHT with the same medication-related goals, physicians work independently:

I would say that med reconciliation piece is the most important piece. And although I work for the Family Health Team, we work in collaboration with 23 different physician offices. And each physician office also has their own process and their own way of managing their practice. [...] We try and work on those things from a quality improvement space. But we also have to respect that each physician office is a sole proprietorship. So we don't have any authority to tell them how to practice. (Case #2-Registered Nurse)

Tailored programs and supports for medication management

All FHTs reported organizing programs tailored to the needs of their communities and ensuring that providers have access to resources to facilitate safe prescribing and medication management.

Older adults were considered a priority population in all cases and were eligible for many FHT programs. All but one case (#5) had programs exclusively for older adults. Programs for which older adults were eligible included disease management ($n=6$ cases) for cardiovascular diseases, diabetes, and lung health, memory clinics ($n=4$), palliative care ($n=3$), seniors' exercise and healthy aging education groups ($n=3$), and home-based care ($n=2$).

Depending on the FHT, some of these programs were said to be restricted to patients who were rostered to a physician in the FHT, while others were open to all community members regardless of their rostered status:

We opened our door to any patient in [location] contrary to the practice of all other Family Health Teams in Ontario [...] because it's a taxpayer-funded program, and it should have access for anybody who needs help. (Case #4-Executive Director)

In cases where in-home care was provided, participants spoke about the value of conducting home visits or assessments for older adult patients:

A lot of the seniors, they have a tendency to stock-pile medications in their home. And you wouldn't realize that if you didn't do a home assessment. So [...] I have found doing home visits really important. (Case #2-Nurse Practitioner)

Participants cited resources such as the Beers Criteria®, STOPP/START criteria, UpToDate, Rx Files, Lexicomp,

Choosing Wisely, and guidelines from health associations and organizations (e.g., Lung Health Association of Canada, Diabetes Association) to aid with prescribing and medication management. FHT providers also mentioned attending external training as part of continuing education requirements and trained team members on medications and medication management.

Medication management roles & responsibilities

Participants described how prescribing and medication management/reconciliation fit within the roles and responsibilities of team members.

Prescribing

Prescribing was often described as an independent (rather than team-based) process mostly done by family physicians. Nurse practitioners reported prescribing medications but with some restrictions imposed by the FHT, for example, with opioids. Specialist physicians were also mentioned by participants as playing an important role in prescribing for their patients.

Participants also discussed safety concerns with multiple prescribers outside of the FHT (e.g., drug interactions) and cited poor communication and integration of health care records:

Sometimes I find that if medications that are prescribed by their specialists, we may not know of that, right. And it could be a potential drug interaction with something [...] and that's always the scary part. (Case #6-Nurse Practitioner)

Another participant described role ambiguity between prescribing specialists and family physicians. In one case, instead of a specialist giving the prescription directly to the patient, they sent it to the patient's family physician to prescribe and complete follow-up:

It's been a surprisingly difficult thing to implement because the family doctors would like the psychiatrists to start the prescription because they're the most knowledgeable about it and they prescribed it. But it gets into this problem where then if the psychiatrist has to see everybody to see if the medication is actually working, it interferes with their access. (Case #5-Executive Director)

Medication management

In contrast to prescribing, medication management was generally viewed as everyone's responsibility. Participants spoke about conducting medication reviews during program intake, as a routine part of a regular appointment, or as providers deemed necessary. Medication review processes were not standardized within most FHTs and

were described as an “extra step” that physicians may not have time for:

I think there are some physicians who dedicate more time to [medication reviews] than others. And I mean I understand, like it's an extra step, right, with every visit to do. I mean certainly if there's no time in a visit and somebody comes in with, you know, seven things to talk about, there's no way I'm going to do that. (Case #5-Family Physician)

The same participant noted that some older adult patients were reluctant to ask questions and report undesirable side effects to their family physician. Older adult patients were also thought to be less likely to question their physician's recommendations:

I think it's different because when it's coming from me, like they have a relationship with me for seven years. ... In general, I'm not met with a ton of resistance. (Case #5-Family Physician)

Pharmacists working on-site at the FHT reported consulting with patients and providers, conducting medication reviews and making recommendations to deprescribe, and acting as an informational resource. Some pharmacists held additional certifications to actively manage medications for certain conditions, such as diabetes (Clinic #1). Community pharmacists were also said to conduct medication reviews and provide recommendations to physicians through MedsCheck, a publicly funded service for community pharmacists: [18]

We do see MedsCheck reports coming from pharmacists into the chart, so I know that's being done. (Case #1-Pharmacist)

Other IHPs (such as registered nurses and dieticians), conducted medication reviews and monitored patient adherence, directly or indirectly through observation and patient conversations. A registered nurse and a dietician agreed that although they cannot prescribe, they can monitor and adjust medication doses, such as with insulin, and make medication recommendations to physicians if required:

Neither of us can prescribe, obviously, as an RN or a registered dietitian, but we make medication recommendations to doctors. We have delegations. [...] Like the medications we can adjust, with then a note to the doctor to say we've made that recommendation. And then the doctor always has to prescribe it ultimately so that the patients have the right medication. (Case #5-IHP)

Participants said that IHPs offered longer appointment times and greater availability than physicians. As a result, IHPs were thought to better maintain patient information, address multiple patient concerns, spend more time on medication management, and build relationships with patients:

Sometimes if a patient has been seeing the nurse practitioner a lot more frequently than they see me, I find that there's a lot more therapeutic alliance with the nurse practitioner than with myself. And they just seem to listen to the nurse practitioner because of that alliance better than they would me. (Case #1-Family Physician)

Teamwork and collaboration

Various factors, including co-location, technology, working styles, and trust, were reported as influential to a providers' ability to collaborate on medication management.

All FHTs had multiple locations, either in a different building, on another floor of the same building, or a combination of both. Co-location was noted to contribute to a “team environment” (Case #1-Family Physician) and facilitated communication, but physicians and IHPs were not always co-located.

Participants shared that they most often used electronic forms of communication (e.g., EMRs, Microsoft Teams, Zoom). Because of the pandemic, FHTs accelerated the adoption of technology for direct patient care (i.e., video/telephone appointments) and e-prescriptions. EMRs were often discussed as facilitating collaboration and supporting continuity of care by sharing patient information across the team and avoiding duplication of effort. In one case, however, the IHPs explained that they must use two EMR platforms because a sub-group of physicians within the FHT uses a different platform than the rest of the clinic. When asked if this creates challenges, a participant replied:

Definitely. I mean I always have two EMRs open. So I've got to be double checking both for any tasks or messages coming in. Sometimes, yeah, things get missed. And that's because of the fact that if you don't open one... And primarily our hub is [EMR#1]. So sometimes with [EMR#2], things are missed or can be delayed because we're not readily checking it. (Case #4-Pharmacist)

Differences in working and practice style were prominent challenges to teamwork. Due to their professional autonomy, physicians were said to be free to provide and document care (e.g., EMR charting) based on their preferences rather than following a team standard. A participant from

one case reported that some family physicians have their own ways of inputting medication details:

So some individuals, they'll use the EMR for prescribing. Some individuals, and it's very few now, would actually use pen and paper for doing prescriptions. Some individuals, when they do the prescriptions, they will prescribe but they won't put a start and stop date. (Case #3-Executive Director)

Nurse practitioner participants noted that it takes time to learn the preferences and style of each physician:

It's very clear, looking at different family doctors' practices, how they like their EMR set up, what information they've decided to have on that patient profile. So that's decided in house in their office. Certainly if we diagnose something, we'll add a new diagnosis, but we won't adjust anything that's already been input there. It would be easy for us to just go in and adjust everything and make it look pretty. But at the same time, there's an element of stepping on toes. And we don't do that - just to keep everything cool. (Case #2-Nurse Practitioner)

Trust appeared to be an important factor in relationships between providers; physician participants shared that the more they interacted with IHPs (nurses, pharmacists, and allied health providers), the more comfortable and trusting they were to give IHPs an active role in patient care and utilize the team-based model. Overall, physicians' use of IHP services and FHT programs varied. A pharmacist (Case #4) reflected on their collaboration with the clinic's family physicians and said that one of the physician groups "are a little bit more hesitant." One physician shared that they did not initially realize the benefit of working with IHPs:

Honestly, it took a while at the beginning to get used to it. Because we worked and lived without any help for so long that when we first got the IHPs, we kind of really didn't know...we didn't know what to offload or how we can access it. But once you get comfortable and we've gotten familiar with utilizing them, 1) it helps maybe take some things off of our plate, but then it also helps to add things that we never could have done before, right. So it definitely it helps a lot with that. (Case #4-Family Physician)

One pharmacist described that physicians often referred patients to a specialist instead of following their advice when making medication recommendations. This exemplified an interprofessional challenge and was thought to delay timely care for patients:

So we just leave it to the specialist in the end, and they're the ones who usually come up with the solution. And in the end it's usually what I've suggested. But we usually have to wait weeks or months just to get them involved. So that's a little disappointing. So yeah, so it's difficult. And you don't want to step on the clinician's toes at all. You just don't want to have that negative image. A lot of the time you give your input and just wait and see, and follow up with the patient according to your discretion, according to if you feel the patient needs it. (Case #6-Pharmacist)

Regardless of how well providers worked as a team, most participants agreed that physicians ultimately had the final say in patient care:

Well, although it is team-based and collaborative, when it comes down to it, the physician is the one with the license who is writing the prescription [...] whether we agreed on our final outcome of our discussion or not. (Case #3-Pharmacist)

Finally, some participants discussed benefits of the team-based model that was said to promote patient-centred care:

I think that team-based practice provides a much more holistic care for the patient. So that does include the medication management. The ones that are involved in a program or do see more interdisciplinary caregivers compared to just their family doctor, I think they have a potential for more shared decision-making and more collaborative care. And that should improve medication management because you've got a nurse practitioner or a pharmacist or somebody else thinking about other aspects than just the medical model. (Case #2-Pharmacist)

Discussion

Our findings showcased a range of approaches employed by FHTs and revealed challenges and opportunities for improvement. At an organizational level, efforts to address medication management and related outcomes were often part of broader organizational goals, strategies, and quality improvement initiatives. This finding aligns with other studies that show that organizational [30, 31] and interprofessional [15, 32–36] factors can affect interdisciplinary primary care teams. In our study, these organizational aspects appeared to influence medication management and allowed teams to prioritize older adults through program offerings.

Medication management processes and collaboration between physicians and IHPs varied. All care providers were said to play a role in medication management for

older adults, but physicians were primarily responsible for making and adjusting prescriptions. Despite this model's emphasis on teamwork, collaboration between physicians and IHPs varied by physician, likely limiting the potential impact of these teams on medication-related outcomes at a population level. Nevertheless, participants highlighted how IHPs support medication management. For example, reported in our study and others, nurse practitioners offer longer appointment times compared to family physicians, which has been demonstrated as effective for caring for patients with complex health needs [37]. Research has found that Canadians are highly satisfied with care provided by nurse practitioners [38] and are comfortable seeing a nurse practitioner instead of a family physician [39].

Interpersonal challenges, respecting physician autonomy, and ambiguous or unoptimized roles reported in our study align with previous work that identified power dynamics and professional hierarchies within primary care [40, 41] and challenges in rethinking traditional roles and scopes of practice [42]. Frustrations with EMR use and practices were prominently reported by study participants—a long-standing and persistent challenge of interdisciplinary care [15, 17, 43]. Brown et al. suggest that high-functioning teams recognize and optimize each member's scope of practice [44]. Bajcar et al. proposed a framework to consider the roles and responsibilities of members of the team who contribute to medication management, including primary and supportive roles [45].

Consistent with other qualitative studies [32], our participants perceived that interdisciplinary teams contribute to patient-centered care and improved medication management. However, the combined challenges and issues might clarify null results in past quantitative studies on the effects of FHTs on medication management outcomes [20].

Implications

Our study has some practical implications for policy makers and organizations looking to improve medication management in interdisciplinary primary care practices. The creation of tailored programs for older adults may support medication management, particularly by IHPs. However, simply creating an interdisciplinary team does not automatically result in teamwork. Attention should be paid to relationships between providers and building trust and understanding of scope of practice and abilities of IHPs. Frameworks, such as the one proposed by Bakar et al., could be used by teams to clarify the roles and responsibilities of each provider. Lastly, teams could consider whether and how EMR use contributes to or hinders teamwork and medication management.

Strengths and limitations

Interviews were conducted by trained interviewers for consistency and depth in data collection. Employing an inductive thematic analysis approach allowed themes to emerge from the data and the iterative process of codebook development and validation by multiple researchers enhanced credibility and reliability of the analysis. Purposive sampling from a diverse range of FHTs considered factors such as geographical region, practice size, and the presence of a pharmacist is another strength of the study. However, the study's focus on a single primary care model in Ontario, Canada may limit the transferability of findings. Despite efforts to recruit diverse participants, there may be different perspectives or experiences among those who volunteered to participate and those who declined. Finally, data collection occurred throughout several COVID-19 waves, which may have influenced participants' experiences and perceptions.

Conclusions

This work provides insights about how interprofessional primary care teams manage medications for older adults. We identified opportunities for strengthening team collaboration in medication management that may improve patient care. Future research could further investigate the expanding role of pharmacists in primary care settings, and the impact of policy actions intended to promote collaboration and improve appropriate prescribing in primary care.

Abbreviations

EMR	Electronic medical record
FHT	Family Health Team
FTE	Full-time equivalent
IHP	Interdisciplinary health provider

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12875-025-02942-7>.

Supplementary Material 1. Interview Guide

Supplementary Material 2. Additional Illustrative Quotations

Supplementary Material 3. COREQ Checklist

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Authors' contributions

AG, DR, SA, and EM designed the study. MR collected the data (conducted interviews), assisted with project management, coded interviews and conducted analyses, and drafted the manuscript. AG was also involved in the collection of data, oversaw the analyses, and drafted the manuscript. All authors reviewed and validated the codebook and took part in discussions about the interpretation of findings. All authors participated in reading and revising the manuscript and approved the final version of the manuscript.

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Data availability

All data requests should be submitted to the corresponding author.

Declarations

Ethics approval and consent to participate

Research ethics approval was received from Ontario Tech University (#14877), with harmonized approval from partnering universities, compliant with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2 (2014)) and the ethical principles of the Declaration of Helsinki. All participants gave explicit informed consent prior to starting the interview.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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