Exploring Patient-Centred Primary Care in Family Health Teams

By

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Institute of Health Policy, Management and Evaluation

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Abstract

Background: Family Health Teams (FHTs) are primary care models established to provide comprehensive, patient-centred care to Ontarians through an interprofessional team approach. However, little is known about how patient-centred interprofessional team care is operationalized in a FHT, specifically regarding the workflow processes employed across diverse clinical contexts.

Objectives: To (1) define patient-centred care in an interprofessional primary health care team context; (2) to identify factors that act as either enablers or barriers to operationalizing patient-centred care; and (3) propose a framework of patient-centred interprofessional team care.

Design: Qualitative approach
Method: Semi-structured interviews were conducted with 16 patient and 24 provider participants from three Family Health Teams in Ontario, Canada. Participants were asked to describe experiences defining aspects of patient-centred care and how contextual factors influenced their experiences. Interview questions were guided by the Patient Centred Clinical Method (Stewart et al. 2003). Transcripts were coded by two independent investigators using a content analysis approach, followed by discussion to reach consensus. Data analysis was guided by the qualitative analysis framework defined by Miles and Huberman (1994): data reduction, data display and conclusion drawing/verification.

Results: Patient-centred care is provided by the “wider provider”, defined by participants as a patient’s interprofessional primary health care team. The wider provider is formed through referrals and may adjust in response to patient needs. Members of the wider provider leverage information collected by one another to address scope appropriate patient needs. Participants described contextual factors (such as co-location status of providers and access to electronic patient records); and individual factors (such as physician referral practices) that act as either intentional or unintentional workflow “blocks” on the functioning of the “wider provider”. These “blocks” encourage alternate patterns of workflow, or “workarounds”, which impact both the patient and provider experience.

Conclusion: In an interprofessional primary health care team context, a patient-centred experience is defined by factors beyond just the patient’s relationship and interaction with an individual provider. This study presents a novel framework of patient-centred care in an interprofessional primary health care team context.
Key words: patient-centred care, interprofessional team, Family Health Team, primary health care, workflow, co-location, copresence, electronic medical record
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List of Abbreviations

EMR – electronic medical record

FHN – (read as “Finn”) Family Health Network

FHO (read as “Foe”) – Family Health Organization

FHT (read as “Fit”) – Family Health Team

OMHLTC – Ontario Ministry of Health and Long-Term Care

PCCM – Patient-Centred Clinical Method

PCMH – Patient-Centred Medical Home
Definitions

**co-location status:** refers to whether or not providers are located at the same clinical site at the same time. A provider can have full-time co-location status, part-time co-location status or not be co-located with other providers.

**copresence:** being available for contact (Zhao and Elesh 2008). In this thesis copresence describes providers who are mutually accessible to other providers within their referral group for patient referrals and inter-communication; that is, they are engaged and willing to participate in teaming with other providers in their referral group.

**interprofessional primary health-care team:** a group of two or more providers from different health-care professions that form around an individual patient to provide primary care.

**intentional block:** a block that is considered an *intentional* change in workflow (Halbesleben et al. 2008).

**physician inter-referral practice:** a physician’s inter-referral practice reflects his or her unwritten protocol for how an allied health-care provider can refer one of the physician’s rostered patients to another provider within the FHT. Physician inter-referral practices are informally established by each physician and are understood by allied health–care providers working with that particular physician.

**provider notes status:** provider notes status refers to whether a provider’s patient notes are available for viewing by other members of a patient’s interprofessional team or if they are restricted. A closed notes status means that the provider has restricted the access to his or her patient notes so that other providers cannot access them. An open notes status implies the opposite: the providers’ patient notes are available.
**teaming:** defined as “teamwork on the fly”, an active process of forming teams as needed that requires members to possess specific skills to enable them to form and participate in teams (Edmondson 2012, p. 13).

**unintentional block:** blocks that are not designed to intentionally disrupt workflow (Halbesleben et al. 2008).

**workaround:** “work patterns an individual or a group of individuals create in order to accomplish a crucial work goal within a system of dysfunctional work processes that prohibits the accomplishment of that goal or makes it difficult” (Morath and Turnbull 2005, p. 52).

**workflow block:** something that is considered a disruption in workflow (Halbesleben et al. 2008).
Chapter 1: Introduction

1 Introduction

A patient-centred approach to health care is advocated in Canada (Romanow 2002; Canadian Medical Association 2008; OMHLTC 2015) and around the world (Institute of Medicine 2001; Coulter et al. 2013). This is particularly evident in primary health care, where a patient-centred approach has been associated with improvements in patient satisfaction and outcomes (Stewart et al. 2000; Little et al. 2001; Barry et al. 2001).

Primary health care is defined as the point of first contact care with a health system, having priorities of accessibility and comprehensiveness, as well as being person-focused and longitudinal (Starfield 1994). Starfield (2008) defines primary care as

…person-focused care over time, comprehensive in dealing with all but uncommon problems, coordinating when care has to be sought elsewhere and the places of first recourse when there is a new health problem or need. It deals with people and their constellation of diseases, that is, with their morbidity burdens rather than with their specific diseases one by one. (p. 59)

Primary care has earned its critical role in health care by virtue of its association with care that is high quality, cost-effective and equitable (Starfield et al. 2005). In Canada, however, challenges in primary care delivery instigated national primary care reform directives in the early 2000s, followed by initiatives at the provincial/territorial health system level because health-care regulation and delivery in Canada is under provincial/territorial jurisdiction but governed by the Canada Health Act, 1984, a national legislative framework (Hutchison et al. 2011).

Ontario was one of the leaders in primary care reform in Canada. In response to national directives, the Ontario Ministry of Health and Long-Term Care (OMHLTC) introduced Family Health Teams (FHTs) in 2005 to address some of the goals of the 2003 First Ministers’ Accord.
on Health Care Renewal (Health Canada 2004b; Hutchison et al. 2011) and subsequent 2004 First Ministers’ 10-Year Plan to Strengthen Health Care. The Accord—which formed the basis of the 2004 First Ministers’ Meeting: 10-Year Plan to Strengthen Health Care (Health Canada 2004c; Health Council of Canada 2009)—was an action plan “to improve timely access to quality care for all Canadians” (Health Canada 2004b). The resulting 10-Year Plan to Strengthen Health Care proposed a joint federal and provincial/territorial commitment to ensure that “50% of Canadians have access to multidisciplinary teams for primary health care by 2011” (Health Council of Canada 2009, p. 12; Hutchison et al. 2011).

1.1 Family Health Teams (FHTs)

FHTs represent one of several primary care models introduced by the OMHLTC (others include Family Health Networks and Family Health Organizations). FHTs are interprofessional, “locally-driven family health-care delivery organizations” (OMHLTC 2010, p.4). They were established to provide comprehensive, patient-centred primary care to Ontarians through activities such as chronic disease management, health promotion, disease prevention, and care coordination with other levels of care (such as hospitals and specialists) (OMHLTC 2010). FHTs are made up of a variety of health-care providers, including family physicians, nurses, nurse practitioners, pharmacists, mental health workers, social workers and dieticians (Hutchison et al. 2011). They also may build links with other community health organizations (such as home care services). According to OMHLTC literature, the makeup of the FHT is determined by local needs and providers who “are committed to working together collaboratively to provide comprehensive, accessible, coordinated family health care to a defined population, including patients who do not currently have a family health-care provider” (OMHLTC 2010, p.4). The extent to which this occurs, however, may vary across FHTs.

FHTs represent an interprofessional team model of practice (Glazier et al. 2012b), whereas Family Health Networks (FHNs) and Family Health Organizations (FHOs) are models of physician payment. FHNs and FHOs operate under a blended capitation model of physician remuneration, each with a defined basket of required services (Glazier et al. 2012). Physicians who are members of a FHN or a FHO may also be members of a FHT (Glazier et al. 2012).
This is because FHTs “require that physicians be paid through either one of the blended capitation models (FHNs or FHOs) or a blended salary model” (Glazier et al. 2012b). The OMHLTC provides funding for other non-physician FHT resources, such as interprofessional team member salaries, electronic medical records and an executive director (Glazier et al. 2012; Rosser et al. 2011).

FHTs are governed under one of three structures (physician-led, community-led, or mixed) and vary in structure and size, from a single clinic site where all providers are co-located, to multiple clinic sites that share resources (Howard et al. 2011; Hutchison 2008). There are currently 184 FHTs in the province of Ontario that service more than 3 million patients; they were approved and established in five waves (OMHLTC 2016). Patients are registered with a FHT physician or group through a formal rostering process (The Conference Board of Canada 2014).

To date, FHTs have demonstrated some benefit over other primary care models, but there is room for improvement (The Conference Board of Canada 2014; Glazier et al. 2015). For example, FHTs are reported to have improved access to many health services, such as mental health services (Kates et al. 2011), and reduced wait times, in large part because they leverage the expertise of non-physician health-care providers (The Conference Board of Canada 2014). Patients also report high satisfaction with their interactions with FHTs, with the majority agreeing (or strongly agreeing) that they were given sufficient time to talk with their regular provider, that their input was sought when planning treatment, and that their opinions and concerns were respected (The Conference Board of Canada 2014). These findings support early claims that FHTs are patient-centred, where “the patient is a key member of the team and uses information and support to make informed decisions on how to manage his/her self-care needs” (OMHLTC 2010, p.4). FHTs have also been described as Ontario’s Patient-Centred Medical Home (PCMH) (Rosser et al. 2011), referring to a U.S.-led initiative to transform primary care delivery (Hoff et al. 2012) that has been associated with some improvements in patient outcomes (Driscott et al. 2013; David et al. 2015), although results have been mixed (Hoff et al. 2012).
1.2 Patient-centred care

The move toward patient-centred primary care is backed by decades of discourse describing patient-centred care as high-quality care (Institute of Medicine 2001), “the cornerstone of good medical practice” (Canadian Medical Association 2008, p.1), and even a “moral imperative” (May and Mead 1999, p. 85). Patient-centred care also has been associated with improved patient satisfaction and outcomes (Wolf et al. 2008; Duggan et al 2006; Little et al. 2001; Stewart et al. 2000), although results have been mixed (Dwamena et al. 2012; Mead and Bower 2002; Martsolf et al. 2012).

Elements of patient-centred care have their roots as far back as the eras of Hippocrates and Galen (Srinivasan 2011). The past century saw the ideas of Carl Rogers, whose philosophy of client-centred practice included an emphasis on empowering the patient to participate in his or her own recovery, facilitated by the provider catalyst within a client-centred doctor–patient relationship (Rogers 1946). This was followed by the work of Dr. Michael Balint and his wife, Enid, who are credited with coining the term “patient-centred medicine.” It has been suggested that Dr. Balint was “the first to explore [the doctor–patient relationship] in the context of general practice” (Lakasing 2005, p. 724).

The appeal of patient-centred medicine in the mid-twentieth century was thought to have been, in part, a response to “dissatisfaction with the conventional biomedical model of medicine” (Mead et al. 2002, p .283). This model was thought to devalue patient experience and personal accounts of illness, which was contrasted by the more “holistically” viewed approach of patient-centred care (May & Mead 1999). The Balints described patient-centred care as a way of medical thinking where a doctor would try to understand each patient “as a unique human being” (Balint 1969, p.269). Dr. Balint strongly believed that the doctor–patient relationship was “intrinsically therapeutic,” as if “the doctor [was] the drug” (May and Mead 1999, p. 66). According to Balint, patient-centred medicine “tries to understand the complaints offered by the patient, and the symptoms and signs found by the doctor, not only in terms of illnesses but also as expressions of the patient’s unique individuality, his tensions, conflicts and problems” (Balint et al. 1970, p.26).
Many authors have since evolved and expanded the concept of patient-centred care. The result is an array of terms, definitions and models describing a similar phenomenon (e.g. Balint et al. 1970; Stewart et al. 2003; Mead and Bower 2002; Davis et al. 2005; Laine and Davidoff 1996; Hall et al. 2007; Duggan et al. 2006; Gerteis et al. 1993; Patronis Jones 1997; Sumsion 2005; Starfield 2011; Rogers 1946). Thus, there still is no universally accepted definition and operational model of patient-centred care and practice (Gachoud et al. 2012). This may be because, as Bensing (2000) describes, patient-centredness is a “fuzzy concept” that he defines as “a global concept that everybody will recognize in its overall meaning, but yet can have a quite different connotation for different people when going into more detail” (p. 21). This has resulted in variation in how patient-centredness is defined and measured across the literature, with studies often focusing on one or more aspects of a patient-centred approach, making generalization difficult.

There are common elements among many of the existing definitions and models of patient-centred care. Several authors describe the importance of the following:

- acquiring a holistic view of the patient, where non-physical aspects are explored (such as emotional state) (Balint et al. 1970; Mead and Bower 2000; Stewart et al. 2003);
- understanding the patient’s meaning of illness (Mead and Bower 2000; Stewart et al. 2003);
- encouraging patients to play an active role as partners in their care and treatment decision-making (Davis et al. 2005; Herbert 2005; Mead and Bower 2000; OMHLTC 2005; Stewart et al. 2003); and
- establishing treatment goals together to reach a common understanding (Herbert 2005; Mead and Bower 2000; Stewart et al. 2003).

As Laine and Davidoff (1996) report, the ultimate goal of a patient-centred approach is to achieve “health care that is closely congruent with and responsive to patients’ wants, needs and preferences” (p.152).
1.3 Model of patient-centred practice: the Patient-Centred Clinical Method

Stewart et al. (2003) have proposed a definition and model of patient-centred care that encompasses many of the patient-centred elements described above. Thus, this model was selected to guide this study. According to Stewart

patients want patient-centred care which (a) explores the patients’ main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients’ world—that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor. (Stewart 2001, p. 445)

Stewart et al. (2003) operationalized their definition into a model, the Patient-Centred Clinical Method (PCCM), which is a model of clinical practice describing patient-centred care that was developed in the context of a dyadic doctor–patient relationship within family medicine. They note, however, that “its messages are relevant to all disciplines of medicine and to other healthcare professions” (Stewart et al. 2003, p. 4). Thus, when referring to the PCCM, the term “doctor” will be replaced with “provider” for the remainder of this dissertation to reflect the multiple disciplines studied. Further, the term “patient-centred” care will be used throughout this document to stay consistent with the terminology used in the PCCM (Stewart et al. 2003), acknowledging that there is a recent shift toward using the term “person-centred” in some contexts (e.g., Cancer Care Ontario 2015).

The Stewart et al. (2003) model consists of “six interactive components” (see Stewart et al. 2003, p. 6). According to Stewart et al. (2003), “patient-centred clinical practice is a holistic concept in which components interact and unite in a unique way in each patient–[provider] encounter” (p. 6). Although they have recently updated the PCCM (Stewart et al. 2014), the following six components described by Stewart et al. (2003) guided this study, and are described in detail below
1. exploring both the disease and illness experience;
2. understanding the whole person;
3. finding common ground;
4. incorporating prevention and health promotion;
5. enhancing the [provider]-patient relationship; and
6. being realistic.

1.3.1 Exploring both the disease and the illness experience

In this component, the provider explores the patient’s “unique experience of illness” (Stewart et al. 2003, p.6) and conducts the physical examination, asking the patient’s feelings toward their illness, how it impacts them and what they expect from the provider. The objective biomedical diagnosis of disease is what every patient with that shared diagnosis “has in common” (Stewart et al. 2003, p. 36). The subjective aspect—or each patient’s experience of his/her illness—is unique. As Stewart et al. (2003) explain, “disease and illness do not always co-exist” (p. 36). A patient could have an undiagnosed condition and feel healthy, meaning they would have disease but no illness experience. Similarly, a patient could have no diagnosed disease yet feel an emotional and physiological response to something such as extreme stress or worry: this would be their illness experience.

1.3.2 Understanding the whole person

This component explores patient contextual factors that are thought to contribute to a patient’s life experience and overall perspective. Knowledge of these factors is considered to be important because “the meaning of health and illness [for a patient] varies with the surrounding circumstances…[since] information only becomes useful knowledge when it is placed in the context of a particular patient’s world” (Stewart et al. 2003, p. 71).
“Proximal factors” include the patient’s family situation, financial security, education level, employment status and available social support network. “Distal factors” include a patient’s cultural-related influences and perspectives, the community (or communities) to which they belong (and by which they are influenced) and the media. Distal factors also include broader sociohistorical and system-level contextual factors (such as the surrounding ecosystem and the health-care system through which the patient must navigate) (Stewart et al. 2003). Awareness of these factors “helps the [provider] recognize the patient’s problems as more than isolated, episodic phenomena...and can increase the [provider’s] sensitivity to the multiple factors that influence the patient’s problems and broaden awareness of the patient’s life history...” (Stewart et al. 2003, p. 54).

1.3.3 Finding common ground

According to Stewart et al. (2003), “finding common ground is the process through which the patient and [provider] reach a mutual understanding and mutual agreement in three key areas: defining the problem; establishing the goals and priorities of treatment and/or management; and identifying the roles to be assumed by both the patient and the [provider]” (p.83). In fact, “finding common ground” may be the “linchpin of the Patient-Centred Clinical Method” (p. 84).

The key elements of finding common ground are that the provider supplies patients with easy-to-understand, pertinent information and establishes an inclusive environment where patients are comfortable, free to express their perspectives and encouraged to ask questions. The main tasks of finding common ground include the following:

- The [provider] and patient must “reach a mutual understanding and agreement about the [patient’s] problem(s)” (Stewart et al. 2003, p. 87).
- The [provider] and patient must reach an agreement on the goals and direction of treatment and care management through two-way dialogue where perspectives are heard and treatment options are presented.
- The [provider] and patient must determine, define and agree on the roles and responsibilities of both patient and [provider] (Stewart et al. 2003).
The central task is for the provider to *listen* to and respect the patient’s “needs and preferences” (Stewart et al. 2003, p. 95); this will help ensure that common ground is indeed found.

Stewart et al. (2003) state that not every patient prefers an active participatory role in the decision-making processes regarding their health care, and this sentiment has been well documented in the literature (Arora and McHorney 2000; Bruera et al. 2002; Carlson and Hakvic 2006; Deber et al. 1996). The message here is that patient preferences regarding their role in decision-making should be respected by health-care providers.

### 1.3.4 Incorporating prevention and health promotion

The World Health Organization (WHO) (1996) defines health promotion as “the process of enabling people to take control over and to improve their health” (as reported in Stewart et al. 2003, p. 102). Disease prevention, on the other hand, “is aimed at reducing the risk of acquiring a disease,” and it includes both risk reduction or the avoidance of disease acquisition and/or disease complications (Stewart et al. 2003, p. 102). As described by Stewart et al. (2003), “effective patient care requires attending to patient’s personal experience of health, illness and disease, understanding patients in the context of their lives, and finding common ground regarding preventive care and health promotion” (p. 102). This illustrates the interactivity of the components of the PCCM, where the goal is to “find the methods of health promotion and preventive care which most appropriately match the patient’s world…” (p. 108)—an outcome that may be achieved by finding common ground.

### 1.3.5 Enhancing the patient–provider relationship

According to Stewart et al. (2003), “the fifth component emphasizes that each contact with the patient should be used to build on the patient–provider relationship by including compassion, trust, a sharing of power and healing” (p. 7, emphasis original). Stewart et al. (2003) describe this component as context-focused (as opposed to process-focused) because the patient–provider relationship is thought to be the foundation on which other components are based.
The patient–provider relationship is therapeutic in nature, its purpose being to help the patient. Particularly in a patient-centred context, this relationship must be based on trust—specifically that the patient trusts the provider(s) and respect his or her expertise, medical ability, intentions and interest in the patient’s well-being. A provider must genuinely be a compassionate, empathetic and caring individual who is “fully present and engaged with the patient” (Stewart et al 2003: 118).

Another essential factor in the patient-centred patient–provider relationship is the “sharing of power and control between the [provider] and the patient” (Stewart et al 2003, p. 121, referencing Brody 1992). While Stewart et al. (2003) refer to patient visits as “meetings between experts” (Stewart et al 2003, p. 121), this does not mean that every patient and provider must share equal control in clinical decision-making. Rather, it represents the fact that “each patient–[provider] partnership is unique and changing over time...An ability on the part of the doctor to remain open and alert to these shifting needs for control and is an essential aspect of a partnership” (Stewart et al 2003, p. 121). The purpose of promoting this type of therapeutic relationship is ultimately to foster a sense of self-efficacy among patients and the belief that they have control over their world and themselves.

1.3.6 Being realistic

“Being realistic,” which is the sixth and final component of the PCCM, requires that providers be “realistic about time, participate in teambuilding and teamwork and recognize the importance of wise stewardship in accessing resources” (Stewart et al. 2003, p. 7).

With respect to time, Stewart et al. (2003) argue that providing patient-centred care does not lengthen consultation time in the context of a primary care consult; thus, such care is a realistic achievement in a typical clinical visit. Inter-related with time is “timing”: the idea that the provider must address patient concerns at the appropriate time by recognizing and considering patient priorities balanced with the seriousness of the problem.

Regarding teamwork, Stewart et al. (2003) note the limitation of uniprofessional practice in meeting all of a patients care needs. Thus, they argue that discipline-diverse teams of
providers may be “advantageous, perhaps even essential” (p. 138) for providing patient-centred care.

Finally, Stewart et al. (2003) describe “the use of wise stewardship in accessing resources,” as striving to be efficient and effective in resource utilization for patient care. This could mean effective use of information technology (IT), fewer diagnostic tests and other approaches (Stewart et al. 2003). As Stewart et al. (2003) explain,

essential skills needed by clinicians are flexibility and a readiness to respond in a manner that expresses both concern and a willingness to work with the patient in the future. They need to work with patients to establish mutual agreement...This applies to both defining the problem and deciding on the most realistic treatment or management plan that avoids misuse of resources...(p. 134)

Stewart et al. (2003) go on to state that their clinical method is not a “rigid, linear technique” (p. 8), and that its purpose is to ensure that “the patient’s particulars and preferences are taken into account and an agreed plan arrived at” (p. 12). In fact, “being patient-centred means taking into account the patient’s desire for information and for sharing decision-making and responding appropriately” (p. 13).

1.4 Patient-centred care: moving from the patient–provider dyad to the interprofessional primary health-care team

Patient-centred care and interprofessional teamwork have historically occupied distinct spaces in the primary health-care literature, with the merits of each (both actual and assumed) lauded nationally and internationally (e.g., Romanow 2002; Institute of Medicine 2001; Coulter et al 2013). Patient-centred interprofessional primary team care—or collaborative patient-centred care (Herbert 2005; Fox and Reeves 2015)—is the phenomenon that has emerged at the crossroads of these two discourses, and it has materialized into initiatives such as Ontario’s FHTs.

Herbert (2005) defines collaborative patient-centred practice in primary care as
a practice orientation, a way of health-care professionals working together and with their patients. It involves the continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient. Collaborative patient-centred practice is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among care givers, optimizes staff participation in clinical decision-making within and across disciplines, and fosters respect for disciplinary contributions of all professionals. (p. 2)

However, there is still no national consensus on an operational definition and model of patient-centred interprofessional primary team care. Furthermore, FHT interprofessional primary health-care teams are diverse in terms of membership, processes employed to meet patient needs and contexts in which providers operate; this means that there may be numerous ways that tasks defining patient-centred care are performed. These different workflow processes and influencing factors may impact the way that both providers and patients experience care. Thus, there remains a black box in our understanding the processes of how patient-centred care is operationalized in an FHT interprofessional primary health-care team context and the factors that influence these processes. In the context of interdisciplinary teamwork, Schofield and Amodeo (1999) emphasize that the black box may represent a range of “team intervention” processes to which patients are exposed.

This thesis focuses on process in context. It aims to open up the black box representing the interactions between multiple health-care providers and a patient during the operationalization of patient-centred care. At the same time, however, it recognizes that not only might there be more than one pattern of workflow for performing a particular task, but that each process may depend on (and be shaped by) multiple factors. Finally, this study also considers both the patient and provider perspectives in exploring process, as each stakeholder may have vastly different experiences of the same phenomenon that may or may not be recognized or considered by the other.

Incorporating the patient voice is increasingly becoming recognized as a critical component of research (Black and Jenkinson 2009; Domecq et al. 2014). To the author’s knowledge,
however, this is one of the first studies to explore the operationalization of patient-centred interdisciplinary primary care team processes across a range of clinical contexts in FHTs. Similarly, it is one of the first to examine the connections and relationships between patients, multiple providers and contextual factors on process from the perspectives of both patients and providers.

1.5 Research question, study purpose and study objectives

This study seeks to answer the question “what is patient-centred interprofessional primary team care?” Thus, its purpose was to understand how patient-centred care is defined and operationalized in an interprofessional primary health-care team context, and to understand what enables—and what prevents—patient-centred care processes from occurring. Because of the patient-centred and interprofessional team focus of FHTs, they were selected as a suitable context to explore the phenomenon of interest.

Using a qualitative approach (Creswell 2003), interview data were collected from both patients and providers from different professions who participated in interprofessional primary health-care teams within one of three FHTs in Ontario, Canada. Interview questions were designed to inquire about specific processes that occurred when two or more providers addressed the care needs of a shared patient.

The PCCM (Stewart et al. 2003) was the framework that guided the interview question design and data collection in this study. The creation of the PCCM was primarily based on work in a family practice context (Stewart et al. 2003), so it is depicted and described operationally in the context of a patient–provider dyadic relationship. Stewart et al. (2003), however, do emphasize that the PCCM is a “model of practice—a mindset and methodology of placing the patient at the centre of care” (p. 135). Thus, they argue that the PCCM is easily transferable from a patient–provider dyad to a team context.
This thesis had the following objectives:

1. define patient-centred care in an interprofessional primary health-care team by identifying
   a) areas of alignment or disagreement between patient and provider perspectives
   b) areas of alignment or disagreement between participant description of patient-centred care and what is defined by the PCCM (Stewart et al. 2003);
2. identify factors that act as either enablers or barriers to operationalizing patient-centred care; and
3. propose a framework of patient-centred interprofessional primary team care.

1.6 Thesis overview

This thesis explored the perceptions that patients and providers participating in FHTs had about the processes they experienced when elements of patient-centred care were being operationalized. This chapter introduced the concepts of patient-centred care and interprofessional teamwork, and it outlined the study purpose and objectives. Chapter Two provides both context and rationale for the study, and it includes a review of relevant empirical literature. Chapter Three provides a detailed account of the methods and methodology utilized in this study, while Chapter Four presents the study results, including a detailed description of the three FHTs explored in this study and the main findings. In Chapter Five, the results and their relevance are discussed in the context of the existing literature, as are study implications, strengths and limitations, and proposed future directions. Following the thesis are study appendices, which include supporting documents referred to throughout the dissertation.

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1 Crotty (1998) distinguishes between methods and methodology. He describes methods as “the techniques or procedures used to gather and analyse data related to some research question or hypothesis” (p. 3). A technique such as interviewing is a type of data collection method. In contrast, methodology refers to the strategy of inquiry, or as Crotty (1998) describes it, “the strategy, plan of action or design lying behind the choice and use of particular methods…” (p. 3).
Chapter 2: Background

2 Introduction

Chapter One introduced the phenomenon of patient-centred care, the Patient Centred Clinical Method (PCCM) and its relationship to interprofessional teamwork. This chapter provides a contextual foundation and rationale for the study. The chapter begins with a review of existing empirical literature on patient-centred care and provides support for elements of a patient-centred approach, many of which are reflected in the PCCM components (Stewart et al. 2003).

The next part of this chapter presents a discussion of patient-centred care in interprofessional teams, identifying the inquiry challenges created by contextual diversity in teams. This is followed by a review of contextual factors that are thought to influence team process, highlighting the importance of exploring process in context. This is crucial because the objectives of this thesis centre on an exploration of processes employed in the operationalization of elements of patient-centred care, and those processes cannot be separated from the contexts in which they occur (Hackman 2012). The chapter concludes with the rationale for this study.

2.1 Empirical evidence supporting patient-centred care

A patient-centred approach to care has been associated with improvements in patient outcomes (Zolnierek and DiMatteo 2009; Weiner et al. 2013), patient satisfaction (Sidani 2008; Wolf et al. 2008; Tak et al. 2015), patient adherence to treatment recommendations (Fuertes et al. 2007), and improved health-care utilization and expenditures (Epstein et al. 2005), although results have been mixed (Dwamena et al. 2012; Mead and Bower 2002; Martsolf et al. 2012). A patient-centred approach also has been explored in different health-care contexts, including (but not limited to) primary care (e.g. Stewart et al. 2000; Little et al. 2001); and with a variety
of patient populations (e.g. Wolf et al. 2008; Mirzaei et al. 2013). Variation in how patient-centred care is defined and measured, however, challenges generalizations about a patient-centred approach (Mead and Bower 2002). Furthermore, studies typically focus on only a few components or attributes of patient-centred care. The following section reviews the empirical evidence on a patient-centred approach to care.

Provider behaviour in the clinical visit matters, and it has been shown to influence patient outcomes. In their examination of interactions between patients with chronic disease and physicians, Kaplan et al. (1989) found that when physicians support greater patient control and information seeking behaviour—and patients demonstrate these behaviours—there is an association with better patient health status. They conclude that “physicians may influence the outcomes of those patients not only through the medical care process, but also by shaping how patients feel about the disease and their ability to control or contain its impact on their lives” (Kaplan et al. 1989, p. S124).

Patient-centred provider communication has been associated with higher patient satisfaction and quality rating of care services. A study with gastric bypass surgery patients by Wolf et al. (2008) measured the effect of patient-centred care provided by nurses on patient satisfaction and quality of care. It found that the group that received patient-centred care—defined as increased communication and information exchange with a nurse before admission and active patient involvement in care planning during their hospital stay—rated patient satisfaction with service and quality of services significantly higher than patients in the control group receiving regular care. No difference, however, was found in overall scores of satisfaction and quality.

In another study exploring perceptions of satisfaction and quality among patients who had a recent hospital stay, Rathert et al. (2012) found that several dimensions of patient-centred care were associated with patient quality and satisfaction ratings of care. With respect to physical comfort, Rathert et al. (2012) specify that rather than the experience of having pain, this dimension included patient perception regarding whether they thought that everything that could be done had been done to help control their pain. This led Rathert et al. (2012) to postulate that “even if patients have pain, if it appears to them the staff is doing everything they can to help, patients will have a better overall experience of care” (p. 205).
A patient-centred approach to care has also been associated with patient adherence, defined as “the degree to which patients follow the recommendations of their health professionals” (Zolnierek and DiMatteo 2009, p. 826). In a meta-analysis of 127 studies, Zolnierek and DiMatteo (2009) found a significant relationship between patient adherence and patient-centred physician communication practices, citing a 19% higher adherence among patients of physicians who communicate well. Similarly, Fuertes et al. (2007) reported an association between “doctor-patient agreement and trust”—referred to as the “working alliance” (p. 30)—and better patient adherence to treatment recommendations. Pinto et al. (2012) found that this alliance was developed when providers involved patients in the clinical consultation, specifically, by listening and asking patients about emotional issues.

The impact of patient-centred decision-making on patient health-care outcomes also has been explored. Weiner et al. (2013) found that patient-centred decision-making—which they define as “adapting care to patient context,” particularly a physician’s consideration of patient needs and circumstances in care planning (p. 574)—is associated with positive patient health-care outcomes such as improved control of hypertension. Further, Starfield et al. (1981) found that better patient outcomes are associated with patient–provider agreement on problem prioritization.

There have been several studies that explore a patient-centred approach in a primary health-care context. In their study of primary care practices, Stewart et al. (2000) found that a patient’s perception of the patient-centredness of a visit with a physician was associated with a reduction in subsequent diagnostic tests and referrals, as well as “improved health status” (p. 803). In particular, it was patient perception that common ground between patient and physician had been achieved (component three of the PCCM) and not assessment of patient centredness of the visit based on an audio recording of that visit. As Stewart et al. (2000) explain, “physicians may learn to go through the motions of patient-centred interviewing without understanding what it means to be a truly attentive and responsive listener” (p. 800).

Little et al. (2001), in their observational study exploring the relationship between patient perception of patient-centred care in primary care practices and patient outcomes, found a positive relationship between certain aspects of a patient-centred approach and specific patient outcomes. Specifically, they found that “communication, partnership and a positive approach
are most strongly related to [patient] satisfaction; a positive approach is related to improved symptom burden; and interest in the effect of life, health promotion, and a positive approach are most strongly related to enablement” (Little et al. 2001, pp. 910–11).

In their exploration of communication in primary care visits, Barry et al. (2001) found a relationship between the patient-doctor communication pattern and patient measures of a successful consultation. Patient outcomes were most positive when the communication pattern patients experienced in the visit matched what they expected or desired, compared to when there was lack of alignment. For example, when patients expected and wanted their doctor to explore aspects of their life and psychosocial context that may be affecting their illness, and the doctor ignored or blocked this discourse, outcomes were considered poor (Barry et al. 2001). Barry et al. (2001) found this particularly in patients with chronic physical problems, where the doctor would remain rigidly within a biomedical communication structure, which they called “strictly medicine”, while the patient wanted a more holistic discussion considering their experience and life context, referred to as the “lifeworld”.

Finally, in their cross-sectional study of primary care practices, Epstein et al. (2005) explored the relationship between the interaction style of physicians and costs associated with diagnostic test expenditures. They found fewer diagnostic test expenditures among physicians who exhibited a more patient-centred communication style (Epstein et al. 2005).

However, results regarding the outcomes of a patient-centred approach, in both primary care and other health-care contexts, have been mixed (Dwamena et al. 2012; Mead and Bower 2002). Dwamena et al. (2012), reviewing randomized controlled trials looking at patient-centred provider interventions, reported inconsistent results across studies with respect to the relationship between patient-centred interventions and outcomes such as patient satisfaction, health behaviour and status. Despite this, patients report wanting a patient-centred approach to care (Mirzaei et al. 2013; Little et al. 2001).
2.2 Patient-centred care and interprofessional teams

The growing incidence of patients with chronic, complex health-care needs (Health Council of Canada 2007; Broemeling et al. 2008; Daar et al. 2007) means that patients often bring multiple concerns to each primary care visit (Bodenheimer and Pham 2010). They also may consult with more than one provider to address their needs, typically in primary care (Tracy et al. 2013). Although Drinka and Clark (2000) note that “neither every type of patient nor every situation calls for a team approach” (p. xviii), some argue that multiple providers, in the form of an interprofessional health-care team, are necessary to meet all of the needs of a patient with chronic illness or with complex needs (Hall and Weaver 2001; Reeves et al. 2010; Alexander et al. 1996; Bodenheimer 2007; Fox and Reeves 2015). It has even been suggested that a team approach may be necessary for providing patient-centred care (Stewart et al. 2003).

Further, as Eichhorn (1974) observed,

the use of interdisciplinary teams for health care delivery has accelerated due to the increasingly complex and broadening definition of health care. Whereas earlier, health care was confined to the treatment of disease, health care is now defined in terms of total human wellbeing, and addresses itself to the maintenance of health and prevention of disease…Because health problems have become defined in complex and multifaceted terms, health organizations have discovered it is necessary to have the information and skills of many disciplines in order to develop valid solutions and deliver comprehensive care to individuals and families. (reported in Larson and LaFasto 1989, p. 17)

This broadened definition of health care is reflected in the PCCM components, where patient needs—including complex physical and psychosocial needs, supportive care needs, contextual constraints and care decision-making preferences—are considered more broadly than in the traditional biomedical perspective (Stewart et al. 2003). The skills of multiple providers, in the form of an interprofessional team, may be considered advantageous or even necessary to provide patient-centred care, particularly in primary care. The challenge, however, is that there is not a single, standard type of interprofessional primary health-care team: they are diverse in
their composition, workflow patterns (Tesluk et al. 1997) and context. The next section presents a background on interprofessional teams and teamwork.

### 2.3 Interprofessional teams and teamwork

Teams of people have been described in many different ways (Cohen and Bailey 1997; Katzenbach and Smith 1993; Payne 2000; Poulton and West 1993; Clements et al. 2007; Hackman 1990). The definition adopted in this thesis is one from the organizational literature that states a team is “a collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social systems and who manage their relationships across organizational borders” (Cohen and Bailey 1997, p. 241).

Teams are not all the same, however, as Lemieux-Charles and McGuire (2006) point out: “a team is a multidimensional construct, and team structures and processes can vary widely according to their membership, scope of work, tasks, and interactions” (p. 265). These and other differences are reflected by an array of taxonomic classification systems created to describe different team types (Hollenbeck et al. 2012; Devine 2002; Cohen and Bailey 1997). The main purpose of classification is, as Devine (2002) reports, to “describe the structure and relationships of objects in a simplified fashion that allows general statements to be made about classes of objects” (Devine 2002, p.292). Classification is thought to facilitate the generalization of findings between team contexts (Devine 2002).

Existing team classification systems are not without their critics. Hollenbeck et al. (2012) suggest that it may be challenging for researchers to find a perfect taxonomic label for their team of study. Many taxonomic descriptions, they say, include static, mutually exclusive categories that are “coarsely described” and “too broad” to include potentially important nuances that are unique and important to the team of study (Hollenbeck et al. 2012, p. 83). Accounting for every potentially influential team nuance may lead to an unwieldy number of team types; therefore, Hollenbeck et al. (2012) argue that a shift from “generating idiosyncratic taxonomic structures [for teams] to developing a new consensus on the critical underlying dimensions most useful for comparing and contrasting different teams” is warranted (p. 83).
If one were to apply an existing classification system to Family Health Teams (FHTs), Cohen and Bailey’s (1997) “work teams”—or their health-care equivalent, “care delivery teams” (Lemieux-Charles and McGuire 2006)—might be an adequate fit. Cohen and Bailey’s widely referenced classification system distinguishes between four different types of teams based on the type of work (or “task type”) they perform (Cohen and Bailey 1997). These include “parallel teams,” “project teams,” “management teams” and “work teams” (Cohen and Bailey 1997). As Cohen and Bailey (1997) report, work teams are “continuing work units responsible for producing goods or providing services. Their membership is typically stable, usually full-time, and well defined.” (p. 242).

This classification is limited when it comes to FHTs, however, and that becomes evident when considering that patient primary care needs are not static. According to the OMHLTC, through a FHT, patients will “have access to different health-care professionals who have the right skills to meet [the patient’s] health needs” (OMHLTC 2014). If one assumes that patient needs change over time, does this mean that their providers also will change over time to match those needs, an evolution that would argue against a stable, full-time and well-defined team membership?

Further, as the name implies, FHT are described as interprofessional teams (e.g. Rosser et al. 2011; Goldman et al. 2010; Meuser et al. 2006). As an interprofessional team, the FHT thus must be distinguished from the interprofessional team caring for an individual patient. It is hard to imagine an entire FHT with a large provider membership cumulatively providing care to a single patient or all FHT members being “interdependent in their tasks” and “[sharing] responsibility for outcomes” (Cohen and Bailey 1997, p. 241). This raises the question of what the interprofessional primary health-care team is in a FHT context. Is a FHT as a whole an interprofessional primary health-care team that provides a service, or is it comprised of multiple, independent interprofessional primary health-care teams centred around individual patients? Understanding and defining the interprofessional primary health-care team, although not a formal objective of this study, was therefore a critical first step in understanding the processes of patient-centred care.

Another challenge in categorizing team type by task is the diversity of task types in both the PCCM and primary care. A large part of primary care focuses on individual patient needs,
which may be different for each patient and are thus somewhat unpredictable. Following Fleishman’s (1982) “behaviour description scheme” in task classification—which classifies “human tasks in terms of what individuals actually do while performing a task” (Fleishman 1982, p. 827)—primary care tasks may be “intellectual” or “cognitive” (e.g. treatment decision-making). They also may be “physical” (e.g. drawing blood), which typically involves linear, more defined and predictable processes (Devine 2002). There are many cognitive-focused tasks in the PCCM, and their unpredictable and non-linear nature leads to the assumption that there may be multiple different processes and workflow patterns (Tesluk et al. 1997) employed to accomplish those tasks, particularly if more than one provider is involved in a patient’s care.

Further, task operationalization processes are thought to be influenced by context (Roberts and Glick 1981). An objective of this thesis was to explore factors that act as enablers or barriers to operationalizing patient-centred care in interprofessional primary health-care teams. An overview of the relevant literature is presented next.

2.4 Factors at the individual and organizational level

Teams do not exist in isolation. Rather, they are embedded within a larger context or environment, and this context is thought to affect how they function (Cohen and Bailey 1997; Sundstrom et al. 1990). As explained earlier in this chapter, FHTs are contextually diverse, meaning that there is no standard organizational structure that they all possess. There has been some work that describes FHT characteristics (e.g., Rosser et al. 2011) and factors that affect interprofessional collaboration in FHTs (e.g., Goldman et al. 2010; Razavi 2014). There also is literature that identifies factors that impact interprofessional teamwork (e.g., Korner et al. 2016; Virani 2012) and that explore the relationship between contextual factors (such as co-location of providers and use of electronic documentation and communication systems) on provider interaction and team function (e.g. Xyrichis and Lowton 2008; Rumball-Smith et al. 2014; Chaudhry et al. 2006; Denomme et al. 2011; Reitz et al. 2012; Brown et al. 2009). Despite this, it is not clear if and how contextual factors, both individually and in combination, affect processes involved in the operationalization of patient-centred care in FHTs.
2.4.1 Individual-level factors

Individual-level factors that are thought to influence team process and outcomes have been described in the literature as “competencies” (Stewart et al. 2003; MacDonald et al. 2010; CIHC 2010). Competencies have been referred to as non-technical “behaviours” (Hoffman 1999; Woodruffe 1993) that an individual working within a team would have to demonstrate “in order to perform tasks and functions with competence” (Woodruffe 1993). Some studies have reported an association between specific provider competencies (such as a shared team identity, knowledge of roles and trust) and positive team outcomes (e.g. Gaboury et al. 2009; MacDonald et al. 2010; Mitchell et al. 2011; Solheim et al. 2007).

Stewart et al. (2003) propose that in order to practice patient-centred care within an interprofessional team, team members should have “shared values, goals and visions enhanced by an understanding and valuing of each team member’s perspective and scope of practice” (p. 137). Others have reported on the importance of shared team philosophy (Brown et al. 2015) or a shared team identity among team members, particularly in professionally diverse teams (Mitchell et al. 2011; Worchel et al. 1998). Mitchell et al. (2011) found that when team members in professionally-diverse teams have a strong team identity, performance is enhanced. Conversely, they found that team effectiveness is negatively affected when team identity is absent. Lichtenstein et al (1997) reported that as teams become more diverse from an identity perspective, “intergroup relations among team members suffer and perceived level of team integration declines” (p. 429).

The concept of “shared identity” of team members has its roots in Tajfel’s social identity theory (1982), where members of a social group or category (e.g. a team) favour the members of their group (called the “ingroup”) “against the members of the outgroup” (Tajfel et al. 1971, p. 172). This may have implications for how care is operationalized in professionally-diverse FHTs.

Another attribute of team members that Stewart et al. (2003) describe is that of understanding each provider’s scope of practice. This is often referred to as “knowledge of roles”
Lack of role clarity by providers has been described as a barrier to interprofessional collaboration (Conference Board of Canada 2012). MacDonald et al. (2010) highlight the importance of “knowledge of the professional role of others” as a competency of interprofessional collaborative practice for patient-centred care, where providers should be able to describe the boundaries of their own allowed scope of practice and that of others, and to respect and seek out their contributions. Similarly, Gaboury et al. (2009), in their study of factors that affect interprofessional collaboration, found that “capacity to acknowledge one’s own limits was identified as a major personality characteristic that stimulates appropriate patient referral and safer care for the patient...[and] comprehensive understanding and knowledge of colleagues’ health-care abilities and perspectives based on their health care paradigm appeared to be vital to the team cohesion” (p. 710). They associated an awareness of team-member skills and knowledge with a “higher level of trust among team members” (p. 712), which they postulated has a positive influence on interprovider referral patterns. Further, Solheim et al. (2007), in an exploratory qualitative descriptive study of health-care providers, reported that “knowledge of roles enhances cohesion and decreases competitiveness” between team members (p. 630).

Alongside the competency of understanding provider roles is the idea that provider roles should be clearly identified with defined boundaries (Belanger and Rodriguez 2008; Wagner 2000). Belanger and Rodriguez (2008) describe “role definition” as one of the components of high-performing teams (p. 1251). Role confusion among provider team members—and subsequent disappointment when expectations for other team members were not met (Arksey et al. 2007)—was thought to result in a decreased quality of patient care (Arksey et al. 2007; Belanger and Rodriguez 2008). In contrast, role clarity of providers on primary care teams was suggested as an important component for facilitating the potential for the team to “improve the quality of care for patients with chronic illness” (Wagner 2000, p. 571). This is contrary to suggestions that a provider’s role becomes less distinguished (more blurred) as multiple providers become a more integrated team (Boon et al 2004).

Dieleman et al. (2004) found that knowledge of provider roles and skills was key if team members are to attain another competency; trust of one another. This has been echoed by
others (e.g. Pullon 2008). Trust, often described as “confidence” (Jones and George 1998) or “respect” between team members (Pullon 2008), is defined by Mayer et al. (1995, p. 712) as “the willingness of a party to be vulnerable to the actions of another party based on the expectations that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party.” Trust between individuals has been associated with “cooperative behaviour” (Jones and George 1998) and is considered by some to be another core competency for teamwork—or as Pullon (2008) reports, an “assumed precursor” for interprofessional relationships (p. 134).

Mickan and Rodger (2005) describe trust and “commitment to the team” as being developed by providers communicating and participating in team tasks together over time. This, they say, generates a sense of cohesion or camaraderie among team members. They described a feeling of “mutual respect” among team members in teams considered to be “effective,” an atmosphere “where individuals were open to the talents and beliefs of each person, in addition to their professional contributions” (p. 366). In their review of interprofessional collaboration in FHTs, Gocan et al. (2014) report that a team culture of mutual trust and respect is essential.

### 2.4.2 Organizational factors

Co-location of providers and use of electronic medical record and communication systems are both factors that have been shown to enable aspects of interprofessional team practice. The following section presents empirical evidence of their impact in teams.

Co-location means that providers have a “shared geographic location” (Cook et al. 2001). In their literature review, Xyrichis and Lowton (2008) found evidence to suggest that sharing a location or “team premises” allows individuals to become more familiar with one another. Co-location of providers has also been found to support trust between providers (Donnelly et al. 2013), and allow for “ease and timeliness of interprofessional…communication” (Cook et al 2001, p. 149). Co-location of different disciplines has also been associated with enhanced capacity for chronic disease care and management services (Rumball-Smith et al. 2014). Conversely, lack of co-location resulted in team members “being less integrated with the team,
which may limit team functioning and effectiveness” (Xyrichis and Lowton 2008, p. 143). Furthermore, members of face-to-face teams in non-health-care disciplines reported more satisfaction and support than did virtual team members (Gera 2013).

Despite this, there also has been successful teamwork with virtual teams where members are geographically dispersed (Brahm and Kunze 2012; Robert Jr et al 2009). A condition for functioning virtual teams is having a climate of trust (Brahm and Kunze 2012), which is enabled by co-location (Robert Jr et al 2009), but can also be developed virtually (Robert Jr et al 2009). Thus, co-location of providers may not be essential once trust is formed.

Electronic medical record (EMR) use has been associated with improved and perceived patient safety (Chaudhry et al. 2006; McGuire et al. 2013). Its use has also been associated with continuity of care (Ragaz et al. 2010) and increased efficiency in primary care (Reitz et al. 2012; Denomme et al. 2011; Chaudhry et al. 2006) and mental health care centres (Tsai and Bond 2008). This may be because it prevents duplication of efforts (Goldman et al. 2010), such as reductions in test duplication (Canada Health Infoway 2013), as long as patient data are consistently entered by providers (Denomme et al. 2011). On-site technical support also was felt to be critical (Shachak et al. 2013).

Well functioning, supported EMR systems are thought to be critical for interprofessional collaboration (Gocan et al. 2014). They have been shown to positively impact team member interactions and communication through functions such as electronic messaging (Denomme et al. 2011). Electronic messaging was thought to enable timely access to patient information by clinicians (Brown et al. 2009). In their descriptive qualitative study of health-care professionals in primary care teams, Brown et al. (2009) found that participants perceived that electronic communication, particularly through the messaging system, allowed for timely sharing of information.

In their study exploring clinician perspectives on the use of EMR in a collaborative primary care setting, Reitz et al. (2012) found that clinicians were satisfied with EMR because its use enabled long-term efficiency, a more complete medical record, enhanced organization and communication between disciplines. They also found that when clinicians had access to one another’s notes, they were more aware and supportive of each others clinical activities.
Clinicians did report challenges with EMR use, however, noting difficulties with learning the system; and issues regarding blocking access to mental health notes (Reitz et al. 2012).

Finally, regarding an association between EMR use and patient outcomes, results have been limited. In their longitudinal study with diabetic patients in primary care, O’Connor et al. (2005) found that utilization of an EMR system led to improved process outcomes (such as number of diabetic tests done), but that evidence supporting an association with better patient health outcomes (in this case, glycemic control) was lacking.

2.5 Rationale for this study

Little is known about processes that occur in interprofessional primary health-care teams, such as FHTs, particularly when there is contextual diversity across a FHT’s clinical sites. To this author’s knowledge, this is one of the first studies to explore processes that are used to accomplish specific patient-centred care tasks across multiple contexts within FHTs from the perspective of both providers and patients. Thus, this study will contribute to the emerging literature on patient-centred interprofessional teamwork by providing insight into the so-called black box of process in context. An understanding of process in context has multiple applications, including designing and targeting interprofessional education, designing interprofessional team infrastructure and resource support, and providing a foundation for further research into the complex influence of multiple contextual factors on process.

The next chapter describes the methods used to meet the study’s objectives, which were to (1) define patient-centred care in an interprofessional primary health-care team, (2) identify factors that act as either enablers or barriers to operationalizing patient-centred care, and (3) propose a framework of patient-centred interprofessional primary team care.
3 Introduction

The following chapter describes the methodological strategy employed and the methods used for data collection and analysis in this thesis. Methodological issues and limitations are highlighted and discussed where relevant throughout the chapter.

3.1 Theoretical perspective

A realist/post-positivist perspective best describes the ontological and epistemological stance of this study. A realist ontology postulates that objects exist (or past processes occur) independent of the mind. They exist (materially or historically), regardless of how individuals perceive them. However, the meaning of the object or process does not exist separate from the mind. Individuals may interpret their own “truth” or “meaning” of that object or process, which would be reflected in how they describe it. That truth or meaning, in turn, is influenced by their individual life contexts and experiences (Crotty 1998, p. 29). Thus, the meaning of an object or process is not a universal and searchable truth waiting to be empirically discovered through experimentation or other methods. Instead, the meaning of an object or process can be approximated through exploring various perspectives on a common phenomenon within defined contexts, and that was the approach employed in this thesis.

A post-positivist epistemological stance is reflected in the acknowledgement of the potential influence that the interviewer (principal investigator) has on the data collected. Throughout the data collection and analysis process, the principal investigator remained cognizant of the potential for “researcher effects” (Miles and Huberman 1994) and participant “social desirability bias” (Jo et al. 1997; Fisher 1993; Zerbe and Paulhus 1987). This is discussed in further detail below (see Section 3.4: Enhancing methodological rigour of the study).
3.2 Methodology (strategy of inquiry)

This study used a flexible methodological strategy\textsuperscript{2}—specifically, a qualitative approach (Creswell 2003). A qualitative approach allows one to explore the meaning of a phenomenon for participants and to understand the process of events and actions (Verhoef et al. 2002). It is an approach that often is considered to be “the best strategy for discovery, exploring a new area, [and] developing hypothesis” (Miles and Huberman 1994, p. 10). It also provides data that are “well-grounded, rich descriptions and explanations of processes in identifiable local contexts...[often leading to] serendipitous findings and to new integration; they help researchers to get beyond initial conceptions and to generate or revise conceptual frameworks” (Miles and Huberman 1994, p.1).

Creswell (1998) identifies five main recognized methodological traditions used in qualitative research: grounded theory, case study, phenomenology, ethnography and biography. At the onset of this study, the intent was to use a case study methodological strategy, with each FHT defined as a case. Yin (2009) defines a case study as “an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context” (p.18). It is a useful approach for addressing questions of “how” or “why,” particularly when the investigator does not have control over the events (Yin 2009).

Although this approach initially appeared to be suitable, it became evident over the course of the data collection process that there was a great deal of contextual diversity within individual FHTs (and individual sites within multisite FHTs), and that factors that were perceived to influence process varied by each process described by participants. For example, two provider participants could describe the referral process very differently due to specific combinations of contextual factors unique to their experience. Thus, it was important to consider context for a

\textsuperscript{2} A flexible methodological strategy is one where the study’s design is open to modification to accommodate “new information or discovery during data collection” (Yin 2009, p.62).
particular experience from the participant’s perspective, as participants often transitioned in and out of different contexts within their FHT depending on the experience. This challenged the notion of defining a FHT, or even a site within a FHT, as a case, or “bounded system”, as is required by a case study approach (Creswell 1998). Therefore, alignment of the methodological strategy within the constraints of a defined tradition was determined not to be suitable. Thus, rather than exploring an existing bounded system, the focus was on exploring processes experienced by both patient and provider participants when operationalizing specific tasks and the factors that they perceived to influence these processes.

As articulated by Hackman (2012), “any robust understanding of group behaviour and performance requires attention to both the individual level of analysis (e.g. the attributes of members) and the contextual level (e.g. attributes of the organizational or cultural context within which the group operates)” (p. 441). Thus, factors at both the individual and clinical context levels were explored to see if they had a perceived impact on the operationalization of patient-centred processes of care.

Distinguishing units of analysis when exploring the phenomenon of interest is somewhat artificial, however, because each unit does not exist in isolation. Rather, factors in each unit may be “moderators” (Hackman 2012), both of one another and the processes being explored. Thus, as Hackman (2012) recommends, a “cross-level analysis of group phenomena” (p. 433) should be employed. That concept informed the approach taken in this project of exploring process with consideration of influencing factors at multiple levels.

### 3.3 Methods

The next section describes the process of FHT selection and recruitment, participant recruitment (providers/administrators and patients), data collection and analysis.
3.3.1 FHT selection and recruitment process

All participating FHTs had to meet four inclusion criteria in order to be eligible for selection for the study. FHTs who responded to the study request and met inclusion criteria were selected and accepted into the study.

3.3.1.1 Inclusion criteria

All FHTs were required to meet the following criteria:

1. be OMHLTC-designated FHTs;
2. be located in Ontario, Canada, within approximately 200 km of The University of Toronto;
3. have a minimum of three health providers from different professions who met the provider inclusion criteria described below (section 3.3.2.1); and
4. have been operational as an FHT for at least 12 months.

3.3.1.2 Recruitment process: FHTs

A list of FHTs, their locations and primary contacts was compiled using publicly available information obtained from the OMHLTC website. From this list, a shortlist of FHTs within 200km of the University of Toronto was created.

Seventeen FHT contacts from this shortlist were sent a study information sheet (see Appendix 1) by either post mail or by email attachment. These letters introduced the study and requested the participation of their FHT. Of those FHTs who were contacted, three replied but did not meet inclusion criteria, four replied but were not interested, eight didn’t reply, and two expressed interest (FHT 1 and FHT 2).

FHT 1 expressed interest in participating in an email reply to the initial request from the FHT gatekeeper. A follow-up conversation with an administrator (FHT contact, but not gatekeeper)
from FHT 1 confirmed both the FHT’s desire to participate and that they met inclusion criteria (see Appendix 2 for Contact Telephone Script). The conversation also allowed the primary investigator to answer questions about the study.

FHT 2 also responded to the initial request to participate by email. A follow-up conversation with the executive director (FHT contact and gatekeeper) from FHT 2 confirmed both the organization’s desire to participate and that it met inclusion criteria. Questions about the study were answered at that time as well.

FHT 3 was contacted by email based on referral from the executive director of FHT 2. A follow-up conversation with the executive director (FHT contact and gatekeeper) of FHT 3 confirmed both their desire to participate and that they met inclusion criteria. Any questions that the executive director had about the study were answered at that time.

In addition to answering questions about the study, the initial telephone conversations with FHT contacts served to develop rapport with the FHT contact. This is an activity that has been suggested as a way of helping attaining access to participants (Handron 1992; Reeves 2010).

Following the initial contact and conversation, FHT contacts were each sent a questionnaire (see Appendix 3) and clinic consent form (see Appendix 4), which they returned to the principal investigator by email or fax.

3.3.2 Participant recruitment

The approach to sampling provider and patient participants was non-probabilistic (Guest et al. 2006; Mays and Pope 1995), meaning that participants were not randomly selected. As statistical generalizability (Guest et al. 2006) was not a goal of this study, a non-probabilistic sampling strategy was appropriate. The purpose of non-probablistic sampling is to “identify specific groups of people who either possess characteristics or live in circumstances relevant to the social phenomenon being studied (Mays and Pope 1995, p. 110). This means, however, that the findings may be “context-bound” (reported in Onwuegbuzie and Leech 2007, p. 118),
meaning that they may be relevant within the particular context that was studied. This section describes the sampling and recruitment process of provider and patient participants.

### 3.3.2.1 Sampling and recruitment process: providers

Provider sampling for this study employed several concurrent strategies, specifically stratified purposive (criterion-based) sampling (Guest et al. 2006; Onwuegbuzie and Leech 2007; Miles and Huberman 1994; Sandelowski 2000), convenience sampling and snowball sampling (Onwuegbuzie and Leech 2007).

In this study, provider participants all had to meet defined inclusion criteria but were selected based on specific selection criteria. The inclusion criteria were as follows:

1. must be a provider working at a participating FHT;
2. must have worked at the FHT for at least six months; and
3. must be able to understand and communicate in English.

The selection criteria were as follows:

1. A range of providers from different health-care professions.
2. A range of providers practicing within a variety of clinical contexts. This included providers working in situations where they were (a) working with another provider at the same site at the same time (co-located), (b) working at different sites than providers with whom they were sharing patients (not co-located), (c) using an EMR system to document patient information and communicate with other providers with whom they were working and (d) using paper-based records to document patient information.

Provider participant inclusion and selection criteria were communicated to FHT contacts. Based on the inclusion and selection criteria, the FHT contacts communicated a selective list of potential provider participants (who had been identified by FHT gatekeepers in instances where they weren’t the FHT contact) to the principal investigator; the principal investigator, in turn, communicated preferred participants from the recommended list to the FHT contacts based on the selection criteria. The FHT gatekeepers either approved or rejected provider
participant requests from the principal investigator, resulting in a provider participant pool produced through a filtering process among the FHT gatekeepers and contacts.

The FHT contacts then introduced the study to selected providers from their FHT and provided them with the study information sheet (see Appendix 5) and provider consent form (see Appendix 6).

The FHT contacts in FHTs 1 and 3 arranged provider interview times. Provider interviews from FHT 1 were back-to-back interviews over a consecutive two-day period; for FHT 3, the interviews occurred over three days (a one-day period, and a separate two-day period). The contact from FHT 2 arranged some provider interviews and provided the principle investigator with email contact information for other providers from FHT 2. The principle investigator then contacted these providers from FHT 2 by email to arrange an interview time. Provider interviews from FHT 2 were conducted over two non-consecutive days.

3.3.2.2 Sampling and recruitment process: patients

Similar to provider participants, patient participant selection was achieved via a non-probabilistic (non-random) strategy: purposeful, criterion-based sampling (Guest et al. 2006; Onwuegbuzie and Leech 2007; Miles and Huberman 1994; Sandelowski 2000). Patient participants had to meet the following inclusion criteria, and an effort was made to select them based on the following selection criteria. The inclusion criteria were as follows:

1. has been a patient receiving treatment at a participating FHT;
2. has been a patient of the FHT for at least six months;
3. has had consultations with at least two providers from their FHT from different health-care professions for a common or related condition in the past three months;
4. can understand and communicate in English;
5. is 18 years or older; and
6. is able to provide informed consent.

There was one exclusion criterion:
1. a patient who is also a health-care provider (e.g. physician, nurse or social worker).

Finally, the selection criteria were as follows:

1. males and females; and
2. range of ages.

Patient participants were not recruited directly by the principal investigator; rather, patient recruitment was overseen by the FHT contacts. This strategy was employed on the request of each of the FHT gatekeepers. The principal investigator emailed each of the FHT contacts the patient information script (see Appendix 7), patient study information sheet (see Appendix 8) and patient consent form (see Appendix 9). FHT contacts were instructed to ensure that patients were recruited by following the recruitment script provided by the principle investigator. FHT contacts also were briefed on the inclusion, exclusion and selection criteria described above, and they were instructed to only include patient participants who met the criteria.

A list of recruited patient names and telephone numbers from each FHT was emailed to the principal investigator by the FHT contacts. The principal investigator then called each patient to ensure they met the inclusion criteria, to provide further information about the study, to answer any questions and to arrange a mutually convenient time for an interview (see Appendix 10 for patient recruitment script). The practice of pre-booking telephone interviews is advocated by Miller (1995) for achieving interview compliance (as opposed to cold calling participants).

3 See appendix 20 for ethics amendment
3.3.2.3 Sample size: providers and patients

The initial intention was to recruit patient and provider participants from each of the three FHTs. As the study progressed, it became clear that each FHT represented one or multiple distinct clinical contexts. Thus, there was an intentional shift to purposeful recruitment of participants from a variety of clinical contexts within the FHTs according to two factors: (1) whether or not providers were co-location with other FHT providers and (2) whether or not an EMR system was used. Some providers practiced part-time out of two or more sites within a FHT and could therefore describe and compare experiences in more than one clinical context.

New participants were recruited until the principal investigator and her supervisor agreed that saturation (Strauss and Corbin 1998; Sandelowski 2000; Guest et al. 2006) had been reached for participants who had experience practicing within a specific context representing a combination of factors (for example, participants who were co-located with other providers with whom they worked and utilized an EMR system). Saturation is defined by Strauss and Corbin (1998) as the point “when no new information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data” (p. 136), or as Sandelowski (2000) describes it, “the point of informational redundancy” (p. 249). In other words, it is the point at which new data can fit into existing codes and the new information collected is judged redundant (Charmaz 2000; Sandelowski 2000).

The rationale for recruiting participants who had experience working in different clinical contexts within the FHT was based on the idea of “theoretical sampling” of participants (Mays and Pope 2000; Yin 2009). This approach, as Mays and Pope (2000) describe, ensures “that an initial sample is drawn to include as many of the factors as possible that might affect variability of behaviour, and then this is extended, as required, in the light of early findings and emergent theory” (p. 52).
3.3.3 Data collection

This section describes the sources and collection methods of the data used in this thesis.

3.3.3.1 Data sources

Data for this thesis were collected from participant interviews, questionnaires filled out by FHT contacts (see Appendix 3) and FHT websites. The information from the questionnaires and FHT websites were used to corroborate and enhance information provided in participant interviews (e.g. information on FHT patient programs).

3.3.3.2 Using multiple data sources: triangulation

In this study, multiple sources of evidence within a method (the interview) were used, an approach that is a form of data “triangulation” (Mays and Pope 2000). Participant interviews were conducted with multiple “interest groups” (Mays and Pope 2000), including health-care providers (both physicians and allied health), administrators and patients. Each interest group has a different participatory role in patient care, and thus it was assumed they would have a different perceived experience of process. It was of interest to see how participant experiences were perceived to be influenced by specific factors, such as co-location and use of EMR, and where the perspectives of participants from different interest groups were similar and where they differed.

A triangulation approach was used in data collection to help ensure credibility (Jackson 2003; Byrne 2001b) and comprehensiveness (Mays and Pope 2000) of the findings. As Bowen (2009) describes, exploring the same phenomenon via different sources is thought to provide “greater confidence in the trustworthiness (credibility) of the findings” (p. 30).
3.3.3.3 Participant interviews

Interviews were the primary method of data collection from both the providers/administrators and the patient participants. Interviews with both providers/administrators and the patients were semi-structured and open-ended, meaning that rather than using rigid, structured questions, they were conducted using an interview guide that contained the main topics and questions to be discussed. This allowed for “changes of sequence and forms of questions in order to follow up the answers given…by the subjects” (Kvale 1996, p. 124).

The PCCM (Stewart et al. 2003) was used as a guiding framework in developing interview questions. Specifically, interview questions and topics reflected tasks within the components of the PCCM. Interview questions were also based on existing literature on contextual factors thought to influence team process (such as the co-location of providers and the use of electronic medical records). Interview guides were developed for both provider and patient interviews and they were reviewed and revised as necessary throughout the data collection process (Kvale 2006) (see Appendices 11 and 12 for interview guides). The revised interview guides reflect the recognition of the importance of context on process (Hackman 2012), which occurred after analysis of early interviews.

Provider and administrator interviews were conducted face-to-face in a location selected by the participant (typically a clinical office within an FHT site). Provider and administrator interviews lasted from 30–60 minutes and were recorded using a digital recording device (Panasonic RR-US430). Minimal written notes were taken during the course of interviews, as this practice was found to be a distraction for the interviewer. Signed consent forms were collected from providers prior to commencement of the interview.

Patient interviews were conducted via telephone. Although the initial intent was to carry out all interviews through face-to-face interaction, the protocol was adapted in response to a University of Toronto Research Ethics Board request, specifically that the principal investigator not conduct patient interviews at the FHT due to confidentiality concerns. Patient interviews were 30–60 minutes in length and were recorded (via speakerphone) with an electronic recording device (Panasonic RR-US430). Consent to participate was received orally
by telephone prior to commencement of the interview, and patients had received the consent form for review from the FHT contact prior to the interview.

Some have raised concerns regarding the use of telephone interviewing in qualitative research (Sturges and Hanrahan 2004; Creswell 1998; Kvale 1996), particularly with respect to the absence of non-verbal information, such as the expressions and gestures of the participant (Kvale 1996, p. 125). It also has been argued, however, that using the telephone for interviews has an advantage, in that it is perceived to be a more anonymous form of interviewing for the respondent (Schwarz et al. 1991) and that it makes the respondent feel safer being in his or her own environment (Tausig and Freeman 1988; Grumet 1979). It is also thought to lessen the potential for social desirability responding, although results for this are mixed (Schwarz et al. 1991). Further, as Sturges and Hanrahan (2004) found in their comparison of qualitative data collected via face-to-face versus telephone interview, “[the] method of interviewing did not influence the responses…[and] the nature and depth of responses did not differ” (p. 112). Others have reported similar findings (Greenfield et al. 2000). Thus, the interview mode was not a concern with respect to the integrity of the data collected in this study.

3.3.3.4 Interview process

The beginning of the interview with both providers and patients often marked the first extended interaction between interviewer and participant. As there was only limited time to conduct each interview, there was an attempt by the interviewer (the principal investigator) to quickly establish rapport and trust with the participant, a process considered “paramount” to gaining informative data (Fontana and Frey 2000, p. 655; Kvale 1996; Dicker and Gilbert 1988).

Trust and rapport were pursued by conducting what has been referred to as a “context briefing” at the beginning of each interview, similar to that described by Kvale (1996, p. 128). At the start of each interview, the principal investigator described the study and the purpose of the interview, informed the participant that the interview would be recorded, reassured the participant that all information they provided would be confidential (and that they could
decline to answer any question if they were not comfortable), and answered any questions the participant might have. The formal interview then typically started with a more general question, referred to by Kvale (1996, p. 133) as an “introducing question.” For example, providers were asked to describe their role within the FHT, followed by questions about the structure of the FHT. A variety of questioning strategies such as “follow-up” and “probing” questions (Kvale 1996, p. 133) were employed.

As mentioned above, interview questions and topics were designed based on tasks within the components of the PCCM framework (Stewart et al. 2003) and the context in which these tasks were operationalized (Hackman 2012). For example, patient participants were asked to describe a situation where they saw two or more health-care providers from the FHT for a common health condition. They then were asked about how decisions were made regarding direction of treatment with two or more providers, what their role was in the process, if (and how) their questions were answered and how they felt about the process (component three: “Finding Common Ground”; see 1.3.3, above).

Demographic questions were asked at the end of the interviews. Participants were informed that they could choose not to answer any demographic questions. The interviews concluded with an opportunity for the participant to ask the principal investigator questions. Britten (1995) recommends that a participant save questions for the conclusion of the interview because the researcher’s perspective may be introduce to the discussion when he or she answers questions earlier in the interview.

3.3.4 Data analysis of interview transcripts

Data analysis was a continuous and iterative process that occurred concurrently with data collection. The rationale for this, as Miles and Huberman (1994) explain, is so new data can be collected to “fill in gaps…[and it] helps the [researcher] cycle back and forth between thinking about the existing data and generating strategies for collecting new, often better, data” (p. 50).

The analysis framework described by Miles and Huberman (1994) was used as a guide for the data analysis in this project. They define analysis as consisting of “three concurrent flows of
activity: data reduction, data display and conclusion drawing/verification” (p. 10). These steps in the context of this project are discussed below.

### 3.3.4.1 Data reduction

The first step in the data analysis for this study was data reduction. According to Miles and Huberman (1994), “data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions...[and] occurs continuously throughout the life of any qualitatively oriented project” (p. 10, emphasis original). Data reduction began with the participant interview transcription process, where judgments and decisions about what should or should not be included in the written transcription were made (Kvale 1996; McLellan et al 2003; Miles and Huberman 1994). Miles and Huberman (1994) refer to this as the “refinement” of the raw recordings. Data reduction also occurred during the data coding processes, where transcript segments were judged and labeled with codes, first written and then via a computer software program (NVIVO 8, QSR® International, Doncaster, Australia). The following section describes the process of data reduction via interview transcription and coding.

### 3.3.4.2 Interview transcription process

All interviews (except one) were transcribed verbatim by the same professional transcriber; the remaining interview was transcribed by the principal investigator. Having a single professional

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4 The process of “data reduction” is now referred to as “data condensation” as Miles et al. (2014) explain: “data reduction...implies we’re weakening or losing something in the process” (p. 12; emphasis mine). The term “data reduction” will be used in this thesis to reflect the terminology used in the second edition (Miles and Huberman 1994), which was the edition available during the analysis process of this thesis.
transcriber is recommended (McLellan et al. 2003), as it helps to ensure presentation consistency across interview transcripts.

Select transcripts were proofread (in whole or in part) by the principal investigator against the audiotape, a process recommended to check for accuracy (McLellan et al. 2003). This was done for the first two professionally transcribed transcripts, and then for a selection of “troubled” transcripts (e.g. transcripts from interviews that occurred in an area with significant background noise).

It was left to the judgment of the professional transcriber to determine how much non-verbal detail to include in the interview transcripts (e.g. “ums,” pauses, interruptions and exclamation marks). As the purpose of this thesis was focused on clinical processes in context as experienced by the participants, nonverbal and verbal nuances were judged to be less critical than they might for a more sensitive and psychologically focused topic (Kvale 1996).

The context in which participant experiences occurred, however, was important. Thus, interview transcripts were transcribed verbatim for verbal content, and participants were categorized according to clinical context(s) in which they practiced (specifically whether or not they were co-located with other providers and whether they used an electronic or paper medical record system). Some providers practiced in more than one clinical context within an FHT and were therefore placed in more than one category.

### 3.3.4.3 Coding transcript data

Data were further reduced by coding of the transcripts, which consisted of applying labels or codes\(^5\) to defined text segments or chunks (Miles and Huberman 1994) within the transcripts.

\(^5\) Different authors use various terms interchangeably with “codes” (such as “themes,” “categories,” and “labels”)—Ryan and Bernard (2003) provide a summary of the various terms.
Codes are the written labels given to describe a segment of text (Miles and Huberman 1994). This process of coding interview transcripts is referred to as “content analysis” (Priest et al. 2002).

Some text segments were labeled with more than one code (when appropriate), which is a process called “simultaneous coding” (Saldana 2013). Codes were either “descriptive” (i.e. used to summarize the main topic of a text, such as “provider roles”) or “process-focused” (i.e. used to describe an action, such as a referral between providers) (Saldana 2013). Codes were conceived both inductively (from the data), and (when appropriate) a priori from an understanding of relevant theory (Ryan and Bernard 2003).

All transcripts were independently coded by both the principal investigator and her thesis supervisor. Independently coded transcripts were then compared to check for agreement (Mays and Pope 1995). Final codes were determined by a process of negotiated consensus between the principal investigator and her thesis supervisor, similar to the approach reported by Harry et al. (2005). The codes were organized into a “visual index tree” (Priest et al. 2002), which provided a visual depiction of the relationships between them. Higher-level codes were often divided into several layers of lower-level codes (see Appendix 13).

A record of code definitions was prepared in a simplified “codebook” format (MacQueen et al. 1998) by the principal investigator, and codes and their definitions were revised by the principal investigator and her supervisor during the coding process, as necessary. Borrowing from MacQueen et al. (1998)’s codebook framework, the codebook included all the codes, organized by code and subcode, and their definitions (see Appendix 14). The codebook was reviewed throughout the data analysis process to ensure code utility.

An attempt was made to complete coding from one FHT before beginning interviews at another one (an approach strongly advocated by Miles and Huberman 1994, p. 65). This was not always possible, however, particularly with patient interview transcripts, as patient recruitment was reliant on FHT contacts and gatekeepers. As such, patient interviews from all three FHTs were conducted in a somewhat random order.
3.3.4.4 Use of computer software (NVIVO 8)

When consensus on coding was achieved between the principal investigator and her supervisor for each transcript, the coding process was then replicated in NVIVO 8 (QSR® International, Doncaster, Australia) qualitative data management software. By coding transcripts in NVIVO 8, all chunks or segments related to a particular code within the collected transcripts could be easily located and retrieved.

3.3.5. Data display

Miles and Huberman (1994) describe a “data display” as “an organized, compressed assembly of information that permits conclusion drawing and action” (p. 11). Three types of data displays were utilized in this thesis: context diagrams, matrices and comprehensive code reports.

Context diagrams are a type of graphic representation of data, similar to “context charts” described by Miles and Huberman (1984). In this project, they were used to understand and explain the FHT contexts. Coded data from interviews, augmented by information from FHT websites and questionnaires, were used to form a pictorial representation of each FHT. Each pictorial representation included the sites of the FHT, their location by community and their EMR status. These pictorial representations provided a simplified visual of the FHT contexts, which facilitated written explanation of those contexts and a comparison between FHTs. They also were a point of reference throughout the analysis in order to situate data in context. Context diagrams are presented in Chapter Four (Figures 1, 2 and 3).

Matrices, modeled after those discussed by Miles and Huberman (1994), were used to organize some of the data. A multipage matrix was prepared for each FHT, with codes along the y axis and participants (i.e. patient or provider/administrator) along the x axis. Coded text segments were abbreviated or summarized and then listed in each cell, along with the participant code identifier. These matrices enabled easy access to organized information from both providers/administrators and patients, and they also made it possible to compare data between FHTs (see Appendix 15 for sample matrix).
Code reports used in this thesis were an organized display of extended text for a particular code. (see Appendix 16 for sample). Printed code reports provided easy access to text segments within a particular code and allowed for multiple readings of similarly coded text. During this process, frequent referral was made to the context diagrams to understand the text within the context of where the participant was located.

Code reports were a very useful format of data display. Although there were benefits to the other formats (such as matrices), there often was insufficient information within the matrix data cells because the data might be abbreviated. As Miles and Huberman (1994) argue, “when in doubt, make the [cell] entries ‘thicker’.” (p. 242) The code reports allowed for sufficient detail to be included so that the meaning remained intact, which proved to be critical for the data analysis process (reported in Miles and Huberman 1994).

3.3.6. Conclusion drawing and verification

The process of “conclusion drawing and verification” was ongoing, beginning at the start of data collection and continuing throughout analysis. It was a process of assigning meaning to the data through pattern identification and understanding relationships within the data (Miles and Huberman 1994).

This process involved multiple readings of the data displays, comparing both perspectives of different participants (e.g. patients versus providers; participants using EMR versus paper-based patient charts). This was done to look for patterns or areas where there was alignment or disagreement.

Relationships between participants, processes and contextual factors were explored visually by drawing (and redrawing) the relationships and by constantly exploring the data to try to understand the meaning behind the relationships. Finding verification included investigating “outliers” (Miles et al. 2014) in the data (i.e. findings that contradicted the main themes). As this stage was ongoing, further clarification and verification was sought by presenting findings found in earlier interviews to subsequent participants in order to gain their perspective and experience regarding a specific scenario.
3.4 Enhancing methodological rigour of the study

In this section, several methodological issues related to this study—some which have been previously highlighted throughout this chapter—are discussed with an explanation of how they were addressed in order to enhance the methodological rigour of the study. The issues have been organized into four categories: the “credibility” of findings, “transferability” of findings, “dependability” of methods and “confirmability” (Shenton 2004; Sandelowski 1986; Guba 1981).

3.4.1 Credibility of findings (truth value of data)

Like internal validity, credibility of qualitative findings refers to the confidence that one has in the “truth value” of the data—that is, that the data accurately reflect the perspectives provided by the participants so that they would “immediately recognize it from those descriptions or interpretations as their own” (Sandelowski 1986, p. 30). The credibility (or truth value) of the interview data collected in this thesis was dependent on both the skill of the interviewer (Kvale 1994) and the strategies used to mitigate the potential effects of interviewer bias, the power differential between interviewer and interviewee, and the patient participant social desirability bias, all of which could affect participant responses. These will be discussed next.

The interviewer is considered the data collection “instrument” of the interview (Kvale 1996, p. 125). Thus, there is the potential for “researcher bias” to influence the interview data collected (reported in Appleton 1995). To address this, the principal investigator used an intentional approach to mitigate, as much as possible, the influence of research bias during the data
collection process. In particular, the principal investigator was “reflexive”\(^6\) within her role as interviewer (Mays and Pope 2000); she also was mindful of “bracketing” preconceptions during interviews (Tufford and Newman 2012), a technique borrowed from phenomenology (Creswell 1998), and attempted to, as Kvale (1996) recommends, listen to participants “without prejudice” (p. 135).

The interview guides also served as tools for mitigating interviewer bias in data collection, as there was a common framework of questions and topics for all participants. Furthermore, while it was somewhat flexible, it helped maintain the focus of the interview, thus limiting the potential for the interviewer’s biases to influence the direction of questioning. These strategies assisted in mitigating, rather than eliminating, the potential for researcher bias on participant responses, as some argue that absolute removal of interviewer bias is impossible (Miles and Huberman 1994; Funder 2005).

Some suggest that the presence of the interviewer can influence the type of responses attained from participants. Miles and Huberman (1994) describe how the researcher, or “outsider” to a group under study, may “create social behaviour in others that would not have occurred ordinarily…which can lead to biased observations and inferences…” (p. 265). They describe the researcher as “confounding”. This may be, in part, because of the potential of “unequal

\(^6\) Mays and Pope (2000) define “reflexivity” as “sensitivity to the ways in which the researcher and the research process have shaped and collected data, including the role of prior assumptions and experience…” (p. 51). They recommend considering characteristics and experience of the interviewer that may have the potential to influence the research process.

The principal investigator has a diverse educational and professional background. Her past experience as an undergraduate student in biology majoring in genetics and as a student clinician and naturopathic doctor, and recent experience as a graduate student in health administration provided opportunities to learn about and consider phenomenon from different perspectives. As a graduate student, the principal investigator had opportunities to participate in research projects, as both an interviewer and as a qualitative data analyst, which provided experience “in the field” prior to commencing thesis work. Iterative reflection throughout the research process led to adjustments in interview technique, particularly for patient participants. For example, early on in data collection, the principal investigator recognized the need to substitute specific jargon and concepts with language that many patient participants were more familiar with.
power relationships” assumed between the researcher and researched. As Kvale (1996) explains “the conversation in a research interview is not the reciprocal interaction of two equal partners. There is a definite asymmetry of power: the interviewer defines the situation, introduces the topics of conversation, and through further questions steers the course of the interview” (p. 126).

Asymmetry of power may have been demonstrated in examples of patient participants wanting to please the interviewer, as reflected in patient participant comments such as “am I answering the questions all right...is that [the answer] you're looking for?” (Patient 6). This can be explained by the theory of social desirability bias (Jo et al. 1997; Fisher 1993; Zerbe and Paulhus 1987), which is defined as “respondents’ tendencies to present themselves in a favourable position with regard to social norms” (Reported in Jo et al. 1997, p. 429). Some patient participants also apologized for not having anything “bad” to say. There is the potential that some patient participants were hesitant to discuss negative experiences at their FHT (or that recruitment bias on the part of the FHT meant that only patients with positive experiences were recruited).

### 3.4.2 Transferability of findings

Qualitative research is not context-free, meaning that findings of this study cannot be separated from the context in which the data were collected (Sandelowski 1986; Guba 1981). For that reason, the concept of external validity or generalizability was adapted to evaluate qualitative findings. The concept of “transferability” (Guba 1981; Shenton 2004; Byrne 2001) underscores the importance of context on study findings while acknowledging “the possibility that some transferability between two contexts may occur because of certain essential similarities between them” (Guba 1981, p. 81).

To facilitate the assessment of transferability of the study findings to other contexts, a detailed description of the FHT contexts are presented in Chapter 4 of this thesis. Specific details about the FHTs—such as a description of the community size and provider mix, number and description of sites, including mechanisms of provider communication—was intentionally
solicited from participants to provide information from which others can judge the appropriateness or “fit” of the study findings for their individual contexts (Byrne 2001; Britten et al. 1995; Sandelowski 1986). As Shenton (2004) reports, it is important to “ensure that sufficient contextual information about the fieldwork sites is presented to enable the reader to make such a transfer” (pp. 69-70).

3.4.3 Dependability

Dependability attempts to address in qualitative research what reliability addresses in quantitative work (Shenton 2004). To address dependability, Shenton (2004) recommends providing a detailed report of the study process to allow another researcher “to repeat the work, if not necessarily to gain the same result” (p. 71). In other words, it allows others to “follow the decision trail used by the investigator in the study” (Sandalowski 1986, p. 33). This chapter provides a detailed account of the study methods to allow the reader to follow the study process decision trail and independently audit the research decisions (Sandelowski 1986; Mays and Pope 2000; Richards and Emslie 2000).

3.4.4 Confirmability

Confirmability refers to the “criterion of neutrality in qualitative research” (Sandelowski 1986, p. 33). It attempts to address in qualitative research what “objectivity” addresses in quantitative work in that the research findings should be, as much as possible, “the results of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher” (Shenton 2004, p. 72). It means that two independent researchers should draw similar conclusions when reflecting on the same data. This was addressed by regular telephone and in-person discussions between the principal investigator and her thesis supervisor about the data collection process (and any strategic revisions), the data collected, and the analysis and interpretation of results.
The goal of discussion was for the principal investigator and her thesis supervisor to reach a consensus on issues of data coding and interpretation of results. Byrne (2001b) refers to this process as “peer debriefing” and describes it as a “fresh perspective for analysis and critique” (p. 703). “Enlisting the assistance of a colleague” (Cutcliffe and McKenna 1999, p. 376) to independently code the data, as Burnard (1991) discusses, can “guard against researcher bias” (Burnard 1991, p. 463).

3.5 Ethics

Prior to FHT and participant recruitment and data collection, ethical approval for the study was received from the University of Toronto Research Ethics Board (protocol reference #22248). While anonymity of participant responses was guaranteed, anonymity of participation could not be guaranteed for participants, as the FHT gatekeepers participated in recruitment and provider interviews occurred at the FHT sites.

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7 Formerly protocol reference #20576, #22217
Chapter 4: Results

4 Introduction and overview

This chapter presents the results from data collected from interviews with participants (both providers and patients), FHT questionnaires and FHT websites.

The results are organized into five parts. The first part (Section 4.1: Describing FHTs) is descriptive and presents characteristics of each FHT, highlighting the key similarities and differences between them. This is followed by a summary of participants recruited from all FHTs (Section 4.2: Participants). One purpose of sections 4.1 and 4.2 is to facilitate the assessment of the transferability (Byrne 2001) of study findings to the reader’s own context (as described in Chapter 3).

Section 4.3 presents provider participant interview results, while Section 4.4 presents results from patient participant interviews. The chapter closes with a summary of the results, highlighting key findings (Section 4.5: Chapter summary).

4.1 Describing FHTs

The following section describes each of the three FHTs included in this study. For each FHT, a brief history describing the transition of a physician group to an FHT is presented, followed by a description of the vision and mission statements presented by the FHT. That is followed by an overview of the population served by the FHT, the structure of the FHT itself (i.e. a depiction and overview of the FHT sites and communication mechanisms used), and the providers who practice at the FHT. Each FHT description ends with a summary the programs offered by the FHT.
4.1.1 FHT 1

4.1.1.1 History

Originally, FHT 1 was a group of five physicians who practiced as solo providers, covered for each other on holidays and were paid fee-for-service. The group formalized into a FHN in 2003, with the primary differences being a switch to a capitation form of remuneration and the ability to “utilize the staff that we already had more effectively and increase the scope of our practice” (Provider, FHT 1).

They then decided to become a FHT. Their application for becoming a FHT was approved by the MOHLTC in the spring of 2005. FHT 1 saw its first patient in November 2005. One provider sums up the change from the FHN to the FHT by saying they “were now able to get [allied health-care providers] with much better expertise than the physicians [to do what they do best]” (Provider, FHT 1).

4.1.1.2 Vision and mission statements

FHT 1 has prepared vision and mission statements. These statements were both available on the FHT’s website and were stated orally during provider interviews. These statements articulate a commitment among FHT team members to deliver “comprehensive” and “coordinated family-centred” primary health care to individual patients and their families in an environment of respect, compassion and accountability (FHT 1 website).

4.1.1.3 Location and population served

FHT 1 is located in a medium-sized city in Ontario, Canada, with a population of roughly 200,000. It services a wide range of patients in terms of disease/health profile and demographics.
4.1.1.4 FHT structure, communication and providers

Figure 1. Pictorial representation of FHT 1

FHT 1 is comprised of two distinct sites that both utilize an EMR system for interprovider communication and patient charting; they also share a common EMR server (see Figure 1). All of the providers (except for two physicians) are co-located at the main site. Table 1\(^8\) provides a summary of the characteristics of FHT 1 including providers at each site (see appendix 17 for additional information about providers).

\(^8\) Data for Table 1 were compiled from interview data, FHT questionnaire and the FHT website, and may not be complete.
4.1.1.5 Programs

FHT 1 has developed and implemented a wide variety of patient education and support programs that are designed and delivered by its health-care providers to address specific patient health care needs. These programs include individual counselling sessions and group sessions (FHT 1 website). For example, there is a Diabetes Education Program, a Hypertension Program, a Nutrition Program and a Mental Health Program (among others).

4.1.2 FHT 2

4.1.2.1 History

Before they became a FHT, the 21 participating doctors in FHT 2 were part of two separate FHNs that had a capitation-style remuneration model. The FHNs existed for approximately two years prior to coming together under the FHT umbrella along with the allied health-care
providers. FHT 2 was approved as a FHT by the OMHLTC in April 2006 and became operational in November 2006.

### 4.1.2.2. Vision and mission statements

FHT 2 has formal vision and mission statements. These statements articulate a commitment by FHT 2 to provide “accessible,” “collaborative,” “multi-disciplinary” primary care for patients and the community, with a focus on health promotion, disease prevention and chronic disease management (FHT 2 website).

### 4.1.2.3 Location and population served

FHT 2 is a multisite FHT with a large rural catchment, with the sites spread across two communities. Community 1 is a small city with a population of roughly 30,000 people. Community 2 is a town of roughly 3000 people that is located approximately 25 km away from Community 1.

### 4.1.2.4 Structure, communication and providers

FHT 2 has four distinct sites and four satellite offices across two communities. Figure 2 presents a pictorial representation of FHT 2, while Table 2 provides a summary of the sites and providers of FHT 2. (see appendix 18 for additional information about providers)

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9 Satellite offices are medical offices where a physician practices independently but utilizes the services of the FHT. The physician in a satellite office may refer to allied health-care providers at another site.

10 Data for Table 3 were compiled from interview data, FHT questionnaire and the FHT website, and may not be complete.
Table 2. Summary of FHT 2 sites and providers

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
<th>Number of Providers</th>
<th>Communication mechanism (EMR/paper)</th>
<th>Co-location(^{11}) status of providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>Community 1</td>
<td>6 physicians</td>
<td>EMR (Server A)</td>
<td>Co-located (some full-time, some part-time)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “home base” for many allied health-care providers(^{12})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{11}\) Meaning providers are physically located at the same site at the same time.

Figure 2. Pictorial representation of FHT 2
| Site 2 | Community 2 | 1 physician  
1 nurse educator (3 days/week)  
1 health promoter (1 day/week)  
Dietician (2 days/week) | EMR (Server A)  
Co-located (some full-time, some part-time) |
|--------|-------------|-----------------------------------------------|
| Site 3 | Community 1 | 5 physicians  
1 health promoter (1 day/week)  
Each physician has his/her own reception (non-FHT funded) | EMR (Server B)  
Co-located (some part-time, some full-time) |
| Site 4 | Community 1 | 5 physicians  
1 nurse educator (1 day/week)  
1 health promoter (1 day/week)  
Each physician has his/her own reception (non-FHT funded) | EMR (Server C)  
Co-located (some part-time, some full-time) |

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12 Refers to where an allied health-care provider might have a permanent office (individual or shared), even if part or all of their position involves travelling to one or more of the other sites associated with FHT 2.

13 Refers to reception staff who were hired on as part of the FHT, and therefore are remunerated via FHT funds.

14 Refers to reception staff who are hired directly by a physician and so are remunerated by that physician (and not via FHT funds).
4.1.2.5 Programs

Similar to FHT 1, FHT 2 has developed and implemented a variety of programs for rostered patients that are led and designed by its health-care providers. There are issue-specific/chronic disease-focused programs (such as diabetes) and discipline-focused programs, and they often include assessment and monitoring of disease-specific markers, typically in individual sessions with the appropriate providers. Those programs then provide education, resources and follow-up as indicated (which sometimes includes group education sessions).

Discipline-focused programs highlight the allied health-care provider resources at FHT 2 and what they can provide for patients. An example of this is the Mental Health Program. The stated policy of most programs is that patients must be referred by their family doctors or nurse practitioners to access the program.
4.1.3 FHT 3

4.1.3.1 History

Prior to becoming a FHT, the 21 physicians of FHT 3 were part of a FHO. FHT 3 was approved as a FHT by the OMHLTC in April 2006 and became operational in August 2006.

4.1.3.2 Vision and mission statements

No vision and mission statements were provided in participant interviews and none were found on the FHT 3 website.

4.1.3.3 Location and population served

FHT 3 is a multisite FHT spread across three communities. Community 1 is a town with a population of approximately 10,000 people, Community 2 is a town with a population of about 4,000 people, and Community 3 is a town with a population of around 2,000 people. The total population of the communities and area surrounding the FHT is approximately 33,500. There are no public transportation links between the communities: as one participant explained, “if you don’t have a car you can’t get out of the community. There’s no public transit at all” (Provider, FHT 3).

The FHT services approximately 26,000 rostered patients across the three communities and surrounding area, with a growing senior population. The population served was described as “rural but not remote” (FHT 3 questionnaire).
4.1.3.4 Structure, communication and providers

As depicted in Figure 3, FHT 3 has nine distinct sites across the three communities. There is a Main Site that holds the offices of many of the allied health-care providers; the other eight sites are referred to as FHO offices and hold the offices of the 21 physicians (who are part of a FHO as well as the FHT). Each of these FHO office sites has its own office manager, and they usually have clerical and nursing staff as well. The largest of the three communities of FHT 3 (Community 1) houses the Main Site along with Sites 1, 2, 3, 4 and 5. Sites 6 and 7 are in Community 2, and Site 8 is in Community 3. There is considerable variation among the sites of FHT 3, with some being on EMR and some being paper-based; some have space for allied health-care providers and some do not have designated space. One participant describes this variation by saying

Figure 3. Pictorial representation of FHT 3
the differences between each practice...you know, [you] feel one minute you’re in a practice which is fully electronic, and you can email [providers] and message them, and they can see that you’re in the building and you can facilitate communications that way, to then being in another practice where the only reason you can be there is that the physician has left for the day so there’s room for you to be there. (Provider, FHT 3).

Table 3 provides a summary of the characteristics of FHT 3 sites.\(^\text{15}\) (see appendix 19 for additional information about providers)

Table 3. Summary of FHT 3 sites and providers

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
<th>Providers at site</th>
<th>Communication mechanism (EMR/paper)</th>
<th>Co-location status of providers at site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Site</td>
<td>Community 1</td>
<td>• Dietician (part-time)</td>
<td>EMR (Server A)</td>
<td>Co-located (some full-time, some part-time)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mental health therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurse practitioner (part-time)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 Pharmacist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site 1</td>
<td>Community 1</td>
<td>• 4 physicians</td>
<td>EMR (Server B)</td>
<td>Co-located (some full-time, some part-time)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 Dietician (part-time)</td>
<td></td>
<td>Referrals to Main Site for some allied health care providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 Mental health therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site 2</td>
<td>Community 1</td>
<td>• 2 physicians</td>
<td>Paper-based</td>
<td>Co-located (some full-time, some part-time, some not co-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 Mental health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{15}\) Data for Table 5 were compiled from interview data, FHT questionnaire and the FHT website, and may not be complete.
<table>
<thead>
<tr>
<th>Site</th>
<th>Community</th>
<th>Number of Physicians</th>
<th>EMR System</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>1</td>
<td>4</td>
<td>EMR (Server C)</td>
<td>4 physicians are co-located; referrals to Main Site for Allied Health Care Providers</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3</td>
<td>EMR (Server C)</td>
<td>Co-located (physicians, full-time; mental health therapist, part-time); referrals to Main Site for Allied Health Care Providers</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1</td>
<td>Paper-based</td>
<td>Co-located (some full-time, some part-time); referrals to Main Site for Allied Health Care Providers</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>3</td>
<td>EMR (Server D; has remote access)</td>
<td>Not all co-located; referrals to Main Site</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>3</td>
<td>Paper-based</td>
<td>Co-located (some full-time, some part-time); referrals to Main Site</td>
</tr>
</tbody>
</table>
Site 8 | Community 3 | • 1 physician | Paper-based | Not co-located
| | | | | Referrals to Main Site for all allied health care providers

### 4.1.3.5 Programs

Similar to FHTs 1 and 2, FHT 3 has developed and implemented a variety of unique and focused programs for rostered patients that are led and designed by its health-care providers. There are wellness and health promotion programs on topics such as stress management, healthy lifestyles (e.g. cooking classes) and smoking cessation; there also are disease-specific programs that often focusing on specific issues or chronic diseases (such as diabetes and cancer support), and there are discipline-focused services. The programs often include a combination of group education and support classes, and one-to-one patient counselling with the appropriate provider. Patients are often pre-screened by designated providers to see if a specific program is appropriate for them.

The discipline-focused services refer to and highlight the allied health-care provider resources that are available to rostered patients at FHT 3. The services specifically refer to the scope of practice of each of the allied health-care providers. For example, the mental health therapists provide mental health treatment and follow-up, and they act as a liaison with the mental health system at large (FHT 3 website). The stated policy for patients accessing these services is that a physician’s referral is required (FHT 3 website).
4.1.4 Similarities and differences across FHTs

Although they all were designated as FHTs, the three FHTs included in this study differed from one another in several ways. The most notable difference was in the quantity and contextual diversity of sites that comprise each of them. FHT 1, although officially dual-site, had most of its providers co-located at its main site, where they used a shared electronic communication system (see Table 1). FHT 2 had four sites and four satellite physician offices (see Table 2), and FHT 3 had nine sites (see Table 3). The co-location status of providers at FHTs 2 and 3 varied by site, even within a given site. This results in several possible co-location dynamics:

1. All providers were co-located on-site full-time.
2. Some providers were located on-site full-time and others only part-time (and they may possibly be part-time at two or more sites within the FHT).
3. One or more providers would be stationed on-site, but other providers with whom they might work would not be co-located with them.
4. Providers were not co-located.

FHTs 2 and 3 also utilized a mix of communication strategies that varied by site, with FHT 3 demonstrating the greatest variation across sites. Specifically, some sites utilized an electronic communication system, referred to as “Net Medical”\(^\text{16}\) that allowed providers to document and share patient information with other providers via the patient’s EMR and an internal messaging system (which included capabilities for referring to one another through an electronic referral template called a “stamp”). At all electronic-based sites, there was a single EMR for each patient, shared by all providers caring for that patient. Each provider within the interprofessional team documented their patient notes in the chart; at some sites (but not all), these were immediately available to all other providers on the interprofessional team who were

\(^{16}\)Note that Net Medical is now MD Physician Services (email communication with company June 29, 2010).
also logged in to the shared server at the time of documentation. However, there were situations where provider access to a patient’s EMR was challenging.

In contrast, other sites utilized a paper-based charting system and often relied on other mechanisms of communication, such as traditional paper-based notes, fax and face-to-face communication (if the providers were co-located). As some provider participants travelled between different sites that used different communication mechanisms (i.e. one might use paper-based charts while the next used an EMR system), they were able to provide comparative experiences regarding different mechanisms of interprovider communication.

Common across all three FHTs, however, were specific factors that participants described as acting as either barriers or enablers to operationalizing processes and accomplishing certain tasks. For example, a provider who practiced part-time out of two sites within an FHT might describe receiving a referral through the electronic communication system at one site; this would differ from a process perspective from a referral received from a paper-based site. Each has novel advantages or challenges, but the mechanism of communication available to the provider’s team(s) at each site and the provider’s co-location status at each site was described as impacting the process of receiving a referral.

Thus, the factors defining the contextual boundary within which a process occurred were used by participants to help explain each process and why it occurred the way it did. This, in turn, helped answer the question, succinctly articulated by Perlow et al. (2004), about why “similar work get[s] done differently in different places” (p. 520).

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17 To connect via an EMR system, the two providers must be able to access the system (the server). This is typically accomplished by both providers being present and using the computers on-site. If a provider was at one site and wanted to connect electronically with a provider who was at a second site, the provider at the first site must be able to connect to the server of the second site. In other words, for the two providers to communicate electronically, either (a) the provider at the first site would need external access to the server of the second site or (b) the two sites would have to share a common server. Only if one of those conditions were met would the two providers be able to communicate via the EMR system.
4.2 Participants

As described in Chapter 3, an attempt was made to recruit participants who had experience in the following situations: (a) where providers were co-located, (b) where providers were not co-located, (c) where an EMR system was used for patient charting and communication, and (d) where a paper-based system was used for patient charting and communication. Co-location status of the provider and mechanism of communication were only two of the many factors identified by participants as influencing process, but they were a simple and obvious way to recruit participants because they ensured that participants participated in a diversity of clinical contexts, as outlined in the participant selection criteria (described in Chapter 3).

Forty participants were recruited from the three FHTs between March 2008 and January 2009. This included 16 patient participants and 24 provider participants. Patient participant demographics are summarized in Table 4.\textsuperscript{18}

\textsuperscript{18} Where information isn’t presented, participants declined to answer question or data were not applicable/not available.
Table 4. Patient participant demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>FHT 1 (n=5)</th>
<th>FHT 2 (n=3)</th>
<th>FHT 3 (n=8)</th>
<th>Total (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>n=4</td>
<td>n=2</td>
<td>n=6</td>
<td>75% (n=12)</td>
</tr>
<tr>
<td>Male</td>
<td>n=1</td>
<td>n=1</td>
<td>n=2</td>
<td>25% (n=4)</td>
</tr>
<tr>
<td>Age range (years)</td>
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<td></td>
</tr>
<tr>
<td>30–39</td>
<td>n=1</td>
<td>n=1</td>
<td>-</td>
<td>12.5% (n=2)</td>
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<tr>
<td>40–49</td>
<td>n=1</td>
<td>n=2</td>
<td>n=3</td>
<td>37.5% (n=6)</td>
</tr>
<tr>
<td>50–59</td>
<td>n=2</td>
<td>-</td>
<td>n=3</td>
<td>31% (n=5)</td>
</tr>
<tr>
<td>60+</td>
<td>n=1</td>
<td>-</td>
<td>n=2</td>
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<tr>
<td>Marital status</td>
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<td></td>
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<tr>
<td>Married</td>
<td>n=4</td>
<td>n=2</td>
<td>n=6</td>
<td>75% (n=12)</td>
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<tr>
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<td>-</td>
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<tr>
<td>Divorced</td>
<td>-</td>
<td>n=1</td>
<td>n=1</td>
<td>12.5% (n=12)</td>
</tr>
<tr>
<td>Common law</td>
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<td>-</td>
</tr>
<tr>
<td>Level of education attended</td>
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<td></td>
</tr>
<tr>
<td>High school</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>College/ apprenticeship</td>
<td>n=2</td>
<td>n=3</td>
<td>n=3</td>
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</tr>
<tr>
<td>University (undergraduate)</td>
<td>n=2</td>
<td>-</td>
<td>n=2</td>
<td>25% (n=4)</td>
</tr>
<tr>
<td>Other</td>
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<td>-</td>
<td>n=1</td>
<td>12.5% (n=2)</td>
</tr>
<tr>
<td>Household income (yearly)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $30,000</td>
<td>-</td>
<td>-</td>
<td>n=1</td>
<td>6.25% (n=1)</td>
</tr>
<tr>
<td>$30,000–59,999</td>
<td>-</td>
<td>n=1</td>
<td>n=1</td>
<td>12.5% (n=2)</td>
</tr>
<tr>
<td>$60,000–89,999</td>
<td>-</td>
<td>n=1</td>
<td>n=1</td>
<td>12.5% (n=2)</td>
</tr>
<tr>
<td>Over $90,000</td>
<td>n=4</td>
<td>n=1</td>
<td>n=4</td>
<td>56.25% (n=9)</td>
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<tr>
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<td>n=1</td>
<td>-</td>
<td>n=1</td>
<td>12.5% (n=2)</td>
</tr>
<tr>
<td>Number providers patient sees at FHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2 providers</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3–5 providers</td>
<td>n=2</td>
<td>n=3</td>
<td>n=7</td>
<td>75% (n=12)</td>
</tr>
<tr>
<td>6 or more providers</td>
<td>n=1</td>
<td>-</td>
<td>n=1</td>
<td>12.5% (n=2)</td>
</tr>
<tr>
<td>Not available</td>
<td>n=2</td>
<td>-</td>
<td>-</td>
<td>12.5% (n=2)</td>
</tr>
</tbody>
</table>
A total of 24 provider participants were included in this study (FHT 1, n=6; FHT 2, n=9; FHT 3, n=9). Provider participants from all three FHTs included a range of health-care professions, including seven physicians, two nurse practitioners, two nurse educators, four dieticians, two pharmacists, one mental health therapist, one social worker, one health promoter and four administrators. Among the providers, 58% (n=14) were female and 42% (n=10) were male. Providers ranged in age from 25 years to 59 years old.\(^\text{19}\)

In presenting the results, providers were categorized and presented as either a physician or an allied health-care provider (which included administrators). The rationale for this decision was that there were distinct differences between physicians and all other providers in FHTs, both with respect to their roles in the FHT and how participants described physician practices. Furthermore, most patients are rostered to a physician within the FHT and were typically described as being the physician’s patient; physicians also were stationed at one site and did not travel to see patients between sites (unlike like many allied health-care providers). As such, sites were typically described in terms of the physicians who were stationed there.

Provider participants are not distinguished by FHT, as providers from all three FHTs described similar contextually-influenced experiences that were not FHT-specific, but rather were specific to the context in which the experience occurred (and there were many similar contexts described across all three FHTs). Further, distinguishing provider by FHT would have raised breach of confidentiality concerns given the number of participants from each FHT in the study. Allied health-care providers and administrators also are not distinguished by profession, as this would have raised breach of confidentiality concerns (some professions only had one provider participant).

Patient participants are presented separately, which allows for exploring areas of similarity and difference between patient and provider perspectives. Patient participants are not distinguished

\(^\text{19}\) Age range only includes providers who provided age information.
by FHT as patients reported similar experiences across all FHTs, and this would have also had confidentiality implications given the number of patients recruited from each FHT.

4.3 Provider results

The following section presents results from physicians and allied health-care providers from across all three FHTs. Presented first are themes that describe how provider participants conceptualize the interprofessional team and factors that are perceived to enable formation of such teams: availability of providers, provider buy-in, provider understanding of roles and interprofessional trust. This is followed by examples of multiple providers caring for a shared patient that describe specific processes, such as recognizing and prioritizing patient care needs, care decision-making and referrals. Finally, facilitators and barriers that are perceived to shape process—such as co-location status of providers and instant access to patient notes—are presented.

4.3.1 Describing the interprofessional team: the “wider provider”

Both physicians and allied health-care providers described a patient’s interprofessional team as a collective unit—or “wider provider”—where the team would collectively be responsible for a patient’s care, with each team member addressing role-appropriate concerns:

I just see it [the team] as a wider provider, the provider becomes a group...we would like to have the most appropriate person at the most appropriate time in the most appropriate way...help the patient find some resolution for whatever problem they have.
(Provider 1, physician)

In other words, the cumulative expertise of the group or team (the “wider provider”) replaces the individual provider in patient care. Members of the team may change depending on the needs of the patient (“the most appropriate person at the most appropriate time”), but together, they would fulfill responsibilities of this “wider provider.” Another physician articulates this idea of team as unit, saying “you are actually spending more time [with each patient], but it’s not actually you but—it’s part of the team” (Provider 12, physician).
It is the cumulative time and efforts of a patient’s interprofessional team of health-care providers that defines the time spent with—and the care given to—a patient. Thus, it would be the team as a whole that would be responsible for caring for the patient, or as these following two quotes from allied health-care providers describe, providing patient-centred care:

*When we talk about patient-centred care and just the practitioner and the patient—like one-on-one—well, not all of those things may be covered in that one-on-one assessment by one person, right? But it may be covered by the entire team and everyone has access to seeing it in the chart, so in that sense we [the team] are looking at everything.*
(Provider 2, allied health)

*I think theoretically [each provider] should be providing patient-centred care and should be assessing every single facet of client-centred care in every interaction that we have, but sometimes you just can’t do that: sometimes it’s not appropriate, I guess...So in a team environment if there’s someone that’s more appropriate to do it and can chart it for others to be able to see—as long as it’s done in you know the whole privacy confidentiality way—then I think...that makes it a lot easier...It’s not always appropriate for—it wouldn’t be appropriate for the dietician to start talking about past sexual abuse.*
(Provider 4, allied health)

Thus, the provider becomes a “group” or “wider provider.”

The next quote, from a physician, describes how the concept of the group providing care changes the way this physician approaches patient visits:

*I’m not having to focus my time as much on lifestyle, education, talking to them about all the things that are going to make their cholesterol go up...[be]cause I know that’s going to be dealt with, in a full hour, which I can’t give the patients...I know it’s going to be dealt with in much, much more detail, by the nurse or the educator or the therapist, or whoever it may be, so...I do tend to kind of gloss over that a little bit more, cause I know it’s going to be dealt with, and that way I can deal with a few other issues... .* (Provider 7, physician)

### 4.4.2 Availability of provider resources and meeting patient needs

Providers talked about the goal of addressing patient needs and the value they placed on having access to providers with expertise and scopes of practice different from their own. In particular, they discussed how different team members are able to address scope-appropriate patient needs:
The patient’s needs or issues are being fully addressed, very holistically, so, um, because you feel that you have the backup and you have support with other people on the team, I think that, I know for me...is that if I’m seeing somebody and I’m concerned about medication issues or medical things or whatever, I’m going to flag those things...and I think the same for the physicians and other team members so that when they’re meeting with a patient if there are other issues that are coming up beyond their scope of practice, they have the ability to kind of refer that person down the hall or to pull in other team members... . (Provider 3, allied health)

I really think that good care, I guess it can be, um, provided by one person, but I don’t think it can be...provided as well by, like it needs to be provided by a team. Again, that sort of idea of everybody bringing in their expertise and putting that together to really provide client-centred care...because of the different amount of professions here...we’re dealing with different things with the client, you know the psychosocial needs, and the financial needs, and the, you know, the home needs...not just the medical science needs... FHTs are providing holistic care, just because of all the different disciplines and all the ways that we can address the needs of the client. (Provider 4, allied health)

As these quotes describe, the diverse expertise of different providers being brought together allows different needs of the patients to be addressed—from medical and psychosocial to financial and home needs.

Other providers described access to resources as defining patient-centred care:

[The patient] has access to the whole team and he knows he’s got access. Maybe that’s patient-centred—if they know what they have access to and are comfortable utilizing those resources or are directed to those resources when necessary.... . (Provider 4, allied health)

Patient-centred care...as a team, it’s that collaborative piece and that communication and having access to all different types of practitioners and services to best benefit the patient. So that you’re really maximizing all the venues so you have more of the clinical medical perspective, and then you also have the preventative health promotion piece and the lifestyle piece. (Provider 2, allied health)

However, not all scenarios described by providers reflected the “wider provider,” as described above. There were certain factors that provider participants described as important in order to form an interprofessional team. These included physician buy-in, provider understanding of roles and trust. These factors will be described next.
4.3.3 Buy-in

Although a physician may have been a member of a FHT, it did not automatically mean that other providers within the FHT had access to him or her. Only certain physicians were described as being open to participating in interprofessional teams with allied health-care providers from their FHT. Those who did participate in interprofessional team activities, however, were said to have “buy-in,” a term used by providers to describe the perceived degree to which physicians participated in interprofessional activities within the team (e.g. inter-referrals and interprofessional communication). In other words, buy-in indicated how much a physician was perceived to have embraced the FHT’s philosophy of team practice. Physician buy-in was perceived to be “number one...if there isn’t physician buy-in then don’t waste anybody’s time” (Provider 23, allied health). The concept of buy-in was described almost exclusively in relation to physicians.

In all three FHTs, both physician and allied health-care provider participants described physicians who they felt did not have buy-in. The next two quotes describe the perception that physician buy-in is important for interprofessional referrals (first quote) and interprofessional communication (second quote):

*There are some physicians that don’t, um, you know; you do get the sense which ones do buy in and which ones don’t...and when they don’t buy in, not only do you feel it from a referral standpoint, but you do, I think, also from their staff as well...so you feel very—I don’t want to say, isolated, but almost like segregated a little bit.* (Provider 23, allied health)

*Well, sending e-mails is only as good as people reading them, right? You know. And I think that part of the challenge of that is that not [every physician] has bought into the same level. If you’re really keen on the FHT, then if you see a notice come from the FHT, you might pay more attention than if you’re not keen on it. But, uh, the ability to communicate to those [physicians] that are not keen and try to get them moved towards this side is really, really difficult.* (Provider 18, physician)

Some provider participants described physicians who did not have buy-in as being resistant to change, while others associated buy-in with trust:

*[Physicians] seem to express a sentiment that they’re losing control of their patients and that they are used to being, you know, having the monopoly on the care of their patient, and it’s hard for them to kind of let go and realize that other people in the FHT*
have some expertise that you could rely on. Um, so I would say the trust within the physicians to kind of let go of some of that care is huge. (Provider 16, allied health)

Another allied health-care provider described the perceived frustration and inefficiency of “working around” a physician who is not felt to have buy-in:

Well, for the rest of us, it can be exhausting, trying to bring [the physicians] on board. And it gets frustrating, and sometimes I wonder if it’s worth the effort. So it makes, it can take a very strong team and totally destroy it. If you don’t have the key, the physician holds the greatest power, other than the patient. I think the patient should hold the most power, but next is the physician because they have a larger scope and if they don’t help, then it can make, it can really impact on the quality of your patient care. I don’t think we let it because I think we’ll work around that, and as I say, it’s... a lot of time and energy is spent from the rest of the providers doing these work rounds to make sure the patient has quality care, working around a physician who is not on board. (Provider 17, allied health)

The differences in provider buy-in status within a FHT was explained in part by the fact that the physicians joining an FHT typically did so as an existing FHO or FHN group, regardless of their individual philosophy of practice regarding interprofessional team care. Thus, some physicians embraced the FHT model of practice from the start and were perceived to be open to referring to, and communicating with, providers from other health-care professions (i.e. they had buy-in). Other physicians, however, were described as being either hesitant toward, or resistant to, their FHT’s philosophy of practice, and they were perceived to be less participatory in referral and communication activities than their counterparts who were felt to have buy-in. Allied health-care providers, on the other hand, were hired by the FHT under the understanding that they already embraced the FHT’s philosophy of practice upon joining the FHT and thus were open to participating in interprofessional teams and other FHT activities.

4.3.4 Professional role

Provider participants articulated the importance of understanding one another’s scope, but more specifically, their role. As one provider explains, “scope is one thing but role is different. So scope is what you can do, role is what you’re going to be responsible for doing” (Provider 4, allied health). Understanding what one is “going to be responsible for doing” was perceived to be important in order to best utilize each provider’s skill set in patient care:
I think everybody needs to be aware of what everybody has to offer. I think that’s fundamental. It sounds really basic, but a lot of people have no idea what different people on the [FHT] can bring to the table...So you really need to make sure everybody understands what the level of expertise is so that the skills can get utilized best. (Provider 5, allied health)

Another provider (physician) describes this as a role requirement:

My role on the team as a physician is first of all to be aware of what services the [FHT] staff can offer...So my role has been to refer patients to the allied health professionals, be a resource to them and also take the information that they give me together with the patient making the adjustments in their management that seem to be appropriate. (Provider 8, physician)

Awareness and understanding of provider roles also was considered to be important for referrals between providers, as this allied health-care provider explains:

I think definitely [team members should] put some effort into team building and becoming familiar with each other’s scope of practice and roles and personalities and you know, just what each provider can bring to the team. Because if you don’t really even understand what the other people can do or are capable of doing, you’re not going to make referrals or you’re not going to pull other team members in, so I think that’s pretty key. (Provider 3, allied health)

In addition to having physician buy-in and an understanding one another’s roles, participants described the importance of trusting individual providers within their FHT and how trust is perceived to impact other aspects of team functioning and process. This will be described next.

**4.3.5 Interprofessional relationships and trust**

Interprofessional trust, described by participants as “confidence in skills” that one provider has of another provider, was described as affecting process in three key areas: (1) occurrence of referrals between providers, (2) physician referral practices and (3) whether a provider (typically physicians or mental health providers) allowed other providers on a patient’s team open access to his/her patient clinical notes.
4.3.5.1 Occurrence of referrals

These next two quotes, both from allied health-care providers, articulate their perception that referrals from one provider to another are associated with how much “trust” one provider has in the other:

[What facilitates inter-referrals is] confidence. Trust...it’s once [physicians] feel confident in our skills as being competent [allied health-care] practitioners and able to identify specific issues that need further assistance. It’s just the trust relationship needs to be bonded, developed I mean, a little bit more. (Provider 10, allied health)

I think if people are familiar with each other and, you know, have a working relationship, they’re more likely to seek each other or refer to on to each other if there’s some mutual trust... (Provider 3, allied health)

4.3.5.2 Physician inter-referral practice

A physician’s trust of individual allied health-care providers was also felt to be reflected by each physician’s inter-referral practice. A physician’s inter-referral practice reflects his or her unwritten protocol for how an allied health-care provider can refer one of the physician’s rostered patients to another provider within the FHT. Physician inter-referral practices are informally established by each physician and are understood by allied health-care providers working with that particular physician.

Physician inter-referral practices can be “open” or “closed.” An open inter-referral policy means that an allied health-care provider can refer the physician’s patients to another provider without involving the physician in the referral process (i.e. without getting the physician to make the referral). With this type of practice, some physicians want to be informed of the pending inter-referral (by way of a message), and others do not require any notification from the allied health-care providers prior to the inter-referral. With a closed referral policy, a physician requires a request/recommendation for referral from an allied health-care provider so that he or she can personally make the referral to the other provider.

Physicians who had a more open inter-referral practice were considered to be more trusting, while physicians who had a more closed inter-referral practice were felt to have less trust for
allied health-care providers. Typically, but not always, physicians practicing within a common site in a FHT had similar inter-referral practices. The following quotes, one from an allied health-care provider and one from a physician, illustrate the various levels of trust and how they are perceived to relate to physician inter-referral practices:

[Physician inter-referral practice] depends on the [site]. At this particular site our physicians are comfortable with us inter-referring to the other practitioners, but typically at our other [sites] within this FHT they still, we have to bounce the referral back to the physician, and they have to make the referral to the other practitioner...[At this site] I think our doctors are a little bit more, just more comfortable with, I'm not sure...Some of the other doctors, I mean they're all on board obviously with the FHT but they’re not quite as comfortable with our roles in their practices!...Um, yeah, so they’re not comfortable with me making a referral to mental health or the nurse...for hypertension. They still want to be involved in that process, so...I think it’s just again maybe with time. You know, getting their comfort level with how we practice and you know, just the sort of, trusting maybe, kind of letting loose a little bit... (Provider 11, allied health)

In one of the [sites], what they’ll do is that the doctors have been—are much more—comfortable, and what they’ll do is allow the [allied] health-care professionals to make their own referrals to other individuals in the team. Uh, [at our site] we’re just starting. [At our site] we’re just starting and there’s been a bit of resistance, uh, to that, so they all want [referrals] to funnel through the doc, so currently what happens if the nutritionist says this person should see a mental health [therapist], uh, then it goes to the doc that has to approve it, make a formal referral type of thing, where in other [sites], uh, because just the nature of things, how they’re set up, and how they’re comfortable... so [the doctors will] say, yeah, go for it, type of thing, and you don’t have to have the doctor to make, bless the whole [referral]...[The doctors] are responsible and they will get feedback, but they don’t have to say, yah, that sounds like a good idea, so I think their trust level might be a little different. (Provider 12, physician)

Although a physician could have bought into the team’s philosophy of practice, he or she may only have begun to develop trusting interprofessional relationships with the other providers on the team, resulting in a more closed inter-referral practice, which is felt to impact inter-referral processes.

The next quote, from a physician, presents a rationale for a more closed inter-referral practice:

I think physicians like to keep track of what’s going on because, as family docs, it’s been knocked into our heads from the moment of training that we’re supposed to be, we’re trained to be the coordinators, and so that if we’re coordinating care, we need to know what’s going on with the patients rather than losing sight of the patient and then
having some intervention done that we don’t know about, then we find out and it
doesn’t make sense. It may or may not make sense to us or, you know, so I think it’s
better all around if referrals between the allied health professionals get bounced to the
family doctors...we’re supposed to know everything about...everything. (Provider 8,
physician)

This quote highlights the importance of understanding provider roles. The physician is
articulating a role—that of “coordinator.” The closed inter-referral practice is understood by
the physician as part of his or her role, where another provider may interpret it as a lack of
trust.

A closed physician inter-referral practice also was described as a barrier to “efficient practice,”
as this next quote from an allied health-care provider indicates:

[The referral] has to go back through the physician each time, so if [another allied
health-care provider] wants to refer to me, they have to go back to the physician, make
sure that that is appropriate and then refer to me and vice versa…it kinda cuts down
the efficiency of the whole process. (Provider 21, allied health)

4.3.5.3 Notes status

Finally, the ability of a provider to access patient information, by way of the patient’s clinical
notes, was perceived to impact process. Restricted access to patient information occurred when
an individual provider (particularly physicians, mental health-care providers and social
workers) restricted access to the clinical files (or notes) of their patients (i.e. the notes were
“closed”). If a provider had closed notes, other health-care providers required approval from
that provider in order to access them. This is in contrast to “open notes”, where all providers
within a patient’s interprofessional primary health-care team would have had unrestricted
access to that patient’s clinical notes.

Having closed notes was perceived by some providers to be a barrier to providing care as an
interprofessional team, and notes status (open or closed) was perceived to be related to the
level of trust between providers:

There is some trust, definitely not for me, but within I know this organization with some
of the social workers and some of the [physicians], they block their notes so there’s
access issues with feeling like you’ve got all the information to be able to offer your services, and I know that is an issue for [one of the other allied health-care providers] with one of her practices that she doesn’t always feel that she’s got the information she needs with her. And that’s a bit of a, um, that’s definitely a trust factor, I think, from the social worker’s perspective of just kind of protecting her notes and her client. (Provider 16, allied health)

The next quote, also from an allied health-care provider, describes the impact of closed notes on clinical practice:

I noticed that with the mental health [therapists] the notes have been hidden and so...just with the circle of care for collaboration, that definitely impacts the care, because there have been situations when I have been seeing the same patient...and again not that I want to know [all the details]...and there is, absolutely there’s a lot of sensitive stuff I’m sure that is recorded, but, you know it impacts our circle of care which I don’t think is fair. Um, and especially I would like to know, you know, if one of my patients broke up with her husband—I mean, that’s going to impact...my care because she’s in a state where she’s homeless, and how can I provide the best services at that point in time if I don’t know that information. So...if it’s hidden, the only way that can be accessed is through the physician or through the social worker and I don’t see the social worker cause she’s or he is on... a different site...and I don’t have time to make phone calls every single time that they see, and I don’t know when they’re seeing their patients, the same patients as I am. And then, too, um, you know, with the physicians as well, they’re not going to have time to answer every question, whereas if it was just in the note, I could take a peak in and out and, you know, then that would...save everybody time and grief. I think.... (Provider 23, allied health)

The previous section presented factors that providers described as impacting interprofessional team care. The next section presents interprofessional team processes (as described by providers), ranging from recognizing patient needs to care decision-making.

4.3.6 Recognizing and prioritizing patient needs

The interprofessional teams described by participants did not have a static, defined membership. Their membership instead was determined in response to a patient’s individual needs—team membership changes as patient needs change. This following quote from a physician illustrates how providers were recruited to join a patient’s interprofessional team as needs were recognized:
I’ve got a guy who’s 62, a fairly heavy smoker—pack and a half a day—comes in to see me because he’s short of breath...let’s do some tests and see where we’re at. We do some tests and he’s also got high blood pressure. He’s also got high cholesterol, so there’s a number of different ways I can go, but he came in to see me because he’s short of breath, so I have to treat his shortness of breath. So I send him to see our nurse...who can do a spirometry test on him, talk to him to make sure he’s using his puffers that I prescribed for his shortness of breath properly. He starts feeling better, she says, “Okay, yes, you need to quit smoking, let me send you to see our smoking counsellor.” He sees our smoking counsellor; he’s now on a medication to be able to help him quit smoking. He comes back to see me, and his blood work and his cholesterol is high, ok, now I can send him to the dietician, who can talk to him about diet, as well as how to manage his blood pressure: diet, reduce his salt...the conversation goes back and forth between the four of us...the nurse..., the dietician, the smoking counsellor and myself. The guy comes back, he’s not short of breath anymore, smoking is cut down... . (Provider 7, physician)

The next quote, also from a physician, describes another situation where a patient “life stressor” was recognized and addressed:

So I can think of a patient that has a history of cancer and who is struggling with quitting smoking. So despite my multiple pleas, I have not had any impact on her smoking behaviour, so she got seen by our wellness nurse who runs a smoking program, and with that nurse was able to overcome the smoking issue—transiently, unfortunately, but at least there was some inroads made. ...Through that nurse, it became apparent that some of her smoking was a means of coping with multiple stressors in her life, so a referral was made to the mental health counsellor to give her increased coping skills. That to me is good team care, where the patient is being benefited by the whole team as opposed to one individual trying to do it all. (Provider 18, physician)

The final quote, which is from an allied health-care provider, illustrates how a patient’s interprofessional team can change with the addition of not only providers, but also referrals to FHT programs if that program addresses a patient need:

A patient was referred to me because her blood sugars were high...she had hypertension, morbid obesity...about three months into our trying to get a handle on her sugar and hypertension, she kind of broke down in my office one day and all this other stuff came spilling out. And I’m like, you know what, you really should go see [our mental health therapist], and he happened to be [on site], and I called him to say, “Have you got any time in the next couple of weeks?...I’ve got somebody in my office who really would be interested in seeing you.” So she went and saw [him]. She dealt with a couple of things she was able to overcome. She then went and did a group [program] that we run on “healthy you”...[and she’s doing great]...So that’s a case for me of the benefits to having all this stuff in place, is that you have other strengths, other people to pull on when you...can’t do anything for this person sitting in front of you,
and you were the person they were referred to, but you have the ability to offer them other services at the same time...that’s something I could never have done as a solo practitioner. (Provider 16, allied health)

The three preceding quotes both describe a similar process: a patient need is recognized, the provider recognizes that he or she is not best able to address that need (i.e. the provider recognizes his or her role and limitations) and a referral is made to another provider or a program (thus reinforcing the importance of a provider having “knowledge of roles”). Information also is shared between the providers. Each scope-specific patient need is therefore addressed by the appropriate provider (or program): providers join the patient’s team through a referral process, and together, the team addresses the cumulative needs of a patient. As one physician said, “[we use] the right person at the right place at the right time to do the most expediently with the problems the patients present to us” (Provider 1, physician).

4.3.7 Decision-making and defining roles

As presented above, when a patient need is identified, a referral may be made to a provider or program; a care plan is then decided on to best address that need. This may be a shared decision by the patient and provider(s):

You’re identifying the needs of that patient so, for example, I may get a referral where we meet for the first time, and you kind of sit there and go: “You know what, yes, you do have this issue but this really isn’t your primary issue right now.” And it’s letting that patient decide that “Yeah, they want me to get my cholesterol under control, but I really want to work on this [other issue first].” And you know, sure, I’ll refer you to [the mental health therapist], and when you feel like you’re ready to cope with [cholesterol], come back [and see me]. (Provider 16, allied health)

Providers described different types of roles that they assumed in the decision-making process, ranging from an educator/facilitator at one end of the spectrum to an expert/decision-maker at the other. As an educator/facilitator, providers discussed their expectation that the patient would take on an active decision-making role:

No, I’m not going to tell you [the patient] what to do, but I’m going to help you make a good decision for you...we’re not making your decisions any more. We’re giving you
tools to help you change your life. We will support you. But we’re not telling you what to do. (Provider 17, allied health)

Your role [as a provider] is more of a facilitator...flush the issues out...provide them with options as opposed to me telling you...this is what you have to do...ultimately it’s [the patient’s] decision. (Provider 7, physician)

The “wider provider” can fulfill the role of educator/facilitator, because the provider involved in the decision-making process can refer to another provider to provide patient education, as this next quote describes:

So [patients] have to have some degree of education...before they can smartly take part in decision-making. So our task is to provide them with necessary tools for learning about the disease, and if they don’t get the information in five minutes with me in the office, then I can refer them to someone on the team who will give them a lot more information than I can. (Provider 8, physician)

The role of educator/facilitator was described as being in tension with that of expert/decision-maker:

It’s bringing the patient around to the fact that they’re in control of the destiny of their health care and...have ability to set [their] own goals...have access to information if they want it...you’re identifying the needs of the patient...and that’s tough as professionals, I think, to let go of the fact that you can’t impose control and impose education and impose change. And we all want to fix everyone. (Provider 16, allied health)

There’s frustrations sometimes because...ultimately...[you] want to tell the patient what to do, you want to say what’s best for [the patient, and he or she] should be listening to me, I have the medical expertise.... (Provider 4, allied health)

Providers also recognized patient participants who preferred a more passive role in decision-making:

I mean, you can’t force someone to want to be making their own decisions and that kind of thing, because some people just don’t want to or some people, you know...aren’t at that level where they can set goals for themselves or where they can make those decisions for themselves, and they do need more guidance, more structure around that. (Provider 2, allied health)

Patients don’t want to be in control particularly of their health care—they come to us...looking for answers. (Provider 4, allied health)
Some providers talked about decision-making as more of a “balance,” where the patient can be involved in decision-making “within certain parameters” (Provider 1, physician), referring to health concerns that the providers consider to be of an urgent nature:

> Well, a good example would be somebody that wants to manage their, let’s say, hypertension. Their blood pressure is elevated, they’re really negative about being on medications, and you know even if you prescribe, they’re not going to take them anyhow—they’re not going to probably even fill them. So what you then have to say, well, what other approaches are there, and that’s where you start looking at things like lifestyle. You start looking at things like exercise, weight reduction, sodium restriction, and you try to support their approach to the problem. It becomes more of a challenge when somebody has...an example of very high blood pressure, then it becomes a real challenge to try and convince them to, all those lifestyle things are important, but the way I would handle that one would be, let’s get your pressure normal and diffuse the bomb, if you like...Lifestyle change is going to take a long time, so you try to not say negate the way they’re approaching the problem, but you’re trying to support them, uh, but on the other hand you don’t want to put them at risk. So sometimes that’s what I’ll do is say, well right now your blood pressure is too high, let’s get it down, when you lose, whatever, fifteen pounds, you stop smoking or whatever lifestyle issues are, then we can revisit your medications, maybe reduce the dose, maybe even stop it. So again that’s one example where you have a patient who’s doing this as far as trying to deal with the problem, or their scope is narrow or they don’t, you want to support that, on the other hand trying to balance it out, knowing, yeah, if I don’t do anything, this guy is going to have a stroke. (Provider 12, physician)

Finally, decision-making was described in terms of educating for patient buy-in or compliance:

> Doing whatever we can to enlist, enroll, have patients buy into treatment or recommendations...share information with patients, sharing, educating them about the targets of therapy...this is why I’m making my recommendations for changes and management changes...simply because this is what the evidence is...[and] giving them the option to buy in for whatever part of the treatment they want. (Provider 8, physician)

This next section presents contextual factors that providers perceive to be either facilitators or barriers to interprofessional team processes. These include provider co-location status and access to patient information.
Co-location of providers was perceived by both physicians and allied health-care providers to be a facilitator for fostering the development of trusting interprofessional relationships. Co-location was defined as providers being located at the same place at the same time:

[With co-location] you just build a rapport [with other providers], and you build a comfort level that really, really helps the day-to-day stuff. If you never get that face-to-face contact, then that’s a real challenge. (Provider 21, allied health)

When people are on site, there’s certainly a greater degree of collaboration, and I think there’s an increased probability of trusting...relationships being formed. ...It becomes difficult to establish rapport with somebody that you never, that you don’t even know what they look like. (Provider 18, physician)

Providers distinguished between part-time and full-time co-location status and the development of trusting interprofessional relationships. In the following quotes, allied health providers describe how part-time co-location status affected their ability to develop trusting interprofessional relationships with other providers:

[Providers at a particular site] are very established and are very comfortable with each other. I feel like an outsider, and I don’t know what exactly causes that but, uh, other than just not working with some and as part of their team for so long. I think you have to be a part of their team. Even though you might be out here and still trying to do the same thing as them, um, you’re not with them every single day to develop that relationship. So I just don’t think like seeing me one day a week is enough, just walking through the hall. (Provider 15, allied health)

Well, I believe that it’s very good to stay at one site, if possible, because you form a working relationship with all of those people there. You get to know each other professionally and personally, um, and a bond does grow...for professional relationships, I think it’s a lot more difficult if you’re moving, if you’re going to different locations. (Provider 10, allied health)

The development of trusting interprofessional relationships—facilitated by co-location of providers—is also felt to be associated with inter-referrals, as one physician said: “I think being on the same site really increases the chance to establish trusting relationships...and more referrals because of that” (Provider 8, physician).
However, once “quality” interprofessional relationships were established, co-location of providers may not be essential for members of an interprofessional primary health-care team caring for a shared patient:

*I think it’s ideal when it’s under one roof…but I guess I would say that I don’t think it’s essential [be] cause you can have good working relationships even if you’re not under the same roof. I think it’s probably the quality of the working relationship more than proximity. I think [that] … when you are in close proximity, you probably just have more ability to have those hallway chats and things that you don’t have otherwise, but… I think that if there’s a rapport there or an ability to work together around the patient care, then it’s doable [if not co-located].* (Provider 3, allied health)

Some provider participants reported that co-location enabled immediate access to provider expertise, which was described as “efficient” and an “easier” way to provide patient-centred care:

*The whole point of the FHT is being able to have those corridor conversations in the hallways, so if you see [a provider] walking by…to be able to say, “Hey, like I have a question—do you have five minutes?”...So then you can get those questions answered where, you know, if we were in different sites, it would be constant messages or phone calls through the EMR, and it wouldn’t be very effective use of our time. So I think trying to be in the building, you know, just kind of getting back to the advantages would be as far as you know, trying to save us time, providing the best quality care obviously for patient.* (Provider 23, allied health)

*If I see a patient and there’s a recommendation I want to make to the doc, I could grab the doc, ask him about it, they okay it—I, you know, print off the prescription, doc signs it, patient leaves. [At the site that is not co-located], it’s like I would see the patient, you know, I have to write up a whole assessment to the doctor again because I don’t know the doctors as well, so that’s part of it too, um, and then fax it off to the doc; the doc has to act upon it, bring the patient in perhaps, see the patient, present the patient with this scenario, um, you know. It’s just less efficient for sure.* (Provider 21, allied health)

*It’s much easier to provide patient-centred care in a group setting where you’re interacting with the other allied health professionals…it takes a little bit more work if you have to correspond with someone who is even a kilometer away.* (Provider 8, physician)

Furthermore, “travelling” providers described their part-time co-location status at multiple sites as a barrier to efficient use of their time:

*It’s also the travel that’s kind of, I mean even though [the site] is, you know, 10–15 minutes, it’s still half an hour out of my day by the time I go there and back, and I just*
really don’t have that time, unfortunately, so I mean the travel does cut into it as well...and it takes away time that I wish I could have had for other things as well.

(Provider 23, allied health)

4.3.9 Access to patient information

Earlier in this section, results were presented that described restricted access to patient information in relation to “closed notes” and interprofessional trust. Restricted access to patient information among providers was perceived to be a barrier to caring for a patient as an interprofessional team or “wider provider.” Access to patient information also was described in relation to type of medical record system used (i.e. paper-based or EMR), the co-location status of providers and (for electronic systems) the set-up of the server. The following two quotes provide contrasting experiences with respect to access to patient information. The first quote describes a situation where the provider has instant access to patient notes entered by other providers through the use of an EMR system:

A lot of us see the same patients because, you know, there’s usually multiple different issues. So the mental health worker sees the patient earlier in the day. She charts on it [in the EMR] right away, and I’m seeing [the patient] in the afternoon. If there are any issues that I should know about that are pertinent to what I’m doing, they’re right there [in the EMR], right then! She doesn’t have to give me a file, you know; we don’t have separate files. (Provider 10, allied health)

The second quote describes a situation using paper-based charting where the providers are not co-located, which results in access to information challenges:

A limitation to the paper chart is that...I’ve asked them to fax me labs over, but that’s all I get, so if there’s medical histories in the past, not all their meds are listed. [Patients] don’t always have them with them when they come to see me, so there’s definitely an information gap now with respect to feeling connected to the whole history of the patient. (Provider 16, allied health)

Access to patient information was described as facilitating the ability of multiple providers to care for a shared patient. The next quote articulates the importance of access to patient information, as the provider, facilitated by an EMR system, was able to use sensitive information collected by others in the context of caring for a shared patient:
I think [mental-emotional aspects, stress, etc. are] touched on by different people...and, again back to the electronic records, you can put that sort of stuff in. [If they were] married but then they got divorced, [a provider] could update that in there so you can see. You know, if I was seeing the patient, I could see that so I wouldn’t ask something stupid, like a “how’s your husband” type thing. So the electronic charting helps that in a sense. Social workers certainly are the ones that get more into the psychosocial, although we all try and address it. The problem is when you have so many health-care providers and the patient is new to you, you don’t particularly want to pry into some of that stuff unless they’re forthcoming with it. You do want to ask, you know, “is this medication going to be affordable for you or is there any sort of barriers to taking this medication,” but you don’t want to get into the past history of abuse the very first time that you meet them, so having some of that information on the chart...[is] very helpful for me to know... . (Provider 4, allied health)

In this example, the provider valued having access to sensitive information about the patient’s life finding it “helpful”.

In contrast, limited or restricted access to patient information—as well as limited interprovider communication—was felt to be a barrier to patient care. While this included notes status and type of medical record system, there was another scenario described by provider participants where interprovider communication and access to patient information was limited: restricted across-FHT access to electronic patient information. This occurred because (a) not every site within a FHT utilized an EMR system and (b) only a few of the FHT sites that did utilize an EMR system shared a server with another site or offered external EMR access to their providers. The latter is an issue because a provider must be logged in to a server housing the EMR system in order to view and utilize it.  

20 For example Sites 1 and 2 of FHT 2 used a shared server (as described earlier in this chapter). This means that any provider at Site 1 or 2 can utilize the shared EMR system and communicate with another provider, as long as both providers are at either Sites 1 or 2 and are logged into the system. Although Site 3 of FHT 2 utilizes the same EMR system, it use an independent server without external server access, so providers physically at Site 3 cannot communicate with providers at another site. A provider who travels between Sites 2 and 3, for example, would have to travel to the specific site to access electronic patient information from that site.
The lack of consistency across FHTs regarding utilization of an EMR system was described by providers as a source of great frustration and “wasted time.”21 Although all electronic sites within a FHT may use the same EMR system, only a small number of them were connected via a common server. For those not connected via a shared server, the EMR systems were described as “standalone” and “a different system”:

The [providers from the different sites] communicate differently...Even though they both have [the same type of EMR system], it operates—or they use the system—slightly different. It’s a different system. The systems are kind of like standalone...so even though [we all use the same type of system], there’s no access to [my charts from the other site]...I can’t see the patient’s [notes]. I couldn’t be here and receive a referral from a doctor over at [the other site]. I’d have to wait until the day I got [to the other site] and log into their system to see it. So I can’t follow up and make an appointment until I’m actually physically there...So that’s one of the disadvantages. (Provider 9, allied health)

As this quote describes, the provider has to be on-site to receive electronic patient information and communicate with other providers regarding such things as inter-referrals, even though the sites both utilized the same type of EMR system.

Providers described a desire for across-FHT access to patient information. As the following quote describes, that access could be achieved by establishing a server that is shared across the FHT or by enabling external/remote access to the EMR system.22

If we had, like I say...external electronic access [to the EMR system], it wouldn’t matter where you worked right? Because you communicate instantly. But since we don’t have that, it makes it very challenging to communicate with the other offices. (Provider 17, allied health)

21 These issues were described only by providers; patients may not be aware of what occurred behind the scenes. As such, their perspective on interprofessional communication would reflect only what they experience as providers work around these issues.

22 External/remote access gives a provider the ability to log in to a patient’s EMR while off-site.
The next quote raises an issue particular to more rural communities, which historically have not had infrastructure to support technology such as external access to an EMR system:

For me, [having electronic charts] has meant spending a lot more hours at the office, cause I...used to take home reports and read them at home, and now I’ve got to be connected to the server to be able to read the reports. ...I can’t get access from home because...there's no high speed internet. ....So that’s a barrier. (Provider 18, physician)

4.4 Patient results

The previous section presented results from providers from all three FHTs. This section presents results from patient participants who were rostered at one of the three participating FHTs and who had seen two or more providers from their FHT. Presented first is a description of how patients conceptualize their interprofessional team and how having access to provider resources (such as allied health-care providers) enables their care needs to be met. This is followed by patients describing their awareness of interprofessional relationships and communication, and how these are perceived to impact their care experience. Next, examples of a patient being cared for by multiple providers are presented, with patients describing the communication that occurs between themselves and their providers, as well as their role in decision-making. Finally, facilitators and barriers that are felt to impact the patient care experience are described (such as co-location status of providers and provider access to patient information).

4.4.1 Describing the interprofessional team and trust-by-proxy

Similar to the provider perspective, some patients described their providers in the FHT as a cohesive unit, where everyone “is on the same page.” In the first quote, the patient describes the “the team feeling,” where one provider can pick up where the other left off:

[The providers] work in conjunction with each other...if your doctor’s out, the other doctor can pick up exactly where this one left off...without seeing that one person,
you’re not stuck, so it’s a team environment. So, you know, you’re not being looked after by one person, you’re being looked after by multiple...I mean, you get the team feeling because everybody [on my team] is kind of on the same page with what’s going on... . (Patient 6)

In the second quote, the patient describes the providers as being “on the same track” and expresses an awareness that the providers acknowledge their scope limitations and know when to refer:

Everybody’s on the same track, let’s put it that way; everybody’s on the same page. It’s a combination of things, combination of computers and [the providers] basically knowing, “Ok, this is out of my league; it’s time we got you to someone who know a little bit more about it.” That in itself is a challenge, like, [providers] not having too big a head, thinking... “I’m going to drag this on and try and solve it. Well no, it’s out of my league. Hand it off to someone who knows a little more.” (Patient 14)

In the next quote, the patient describes the health-care providers as a “cohesive unit” and explains how having “faith” in the doctor transfers to other providers in the group:

There seems to be a more cohesive unit [with all the providers] where, you know, where if [my doctor] recommends that I go see somebody or whatever that’s within his group, it’s a lot easier than...how would you put it?...basically if I have a lot of faith in my doctor—quite honestly, he’s been very good to me—and uh, if he, whoever he’s recommending me to, what I’m trying to say is, he obviously wouldn’t do it if, you know, this person would not be in his group if he did not agree with sort of his practices and everything. (Patient 14)

There is an assumption made by this patient that a provider would not be in the physician’s group “if he did not agree with sort of his practices,” which may imply that the providers share a philosophy of practice. This quote demonstrates the importance of a patient–provider relationship and how that may enable the patient’s relationship with other providers: the relationship that this patient has with his or her doctor translates into a “trust-by-proxy” for the other providers within the FHT that are recommended by physician.

4.4.2 Access to provider resources and meeting needs

All of the patient participants were aware that their FHT offered services from allied health-care providers such as dieticians and social workers, although their level of awareness varied.
Similar to the provider perspective, having access to providers with different expertise was perceived by some patients to enable their individual care needs to be met:

_In my experience, I feel that [the providers] are meeting those individual needs, for sure—even, if I may say, even more than I might have expected. Like, when I went to the doctor and found my blood sugar was a little bit high, I did not expect him to send me to a dietician. I was thrilled that he did, that he went that extra step, so it’s been my experience that I feel like my individual needs are definitely being met._ (Patient 4)

Another patient describes how her lifestyle preferences were considered in the treatment options presented and how having access to a nurse and dietician enabled this.

_I don’t like taking pills for things. So I like the fact that, especially like with the [FHT], instead of going on like high cholesterol pills, I went to a dietician instead. Same thing for blood pressure: instead of taking high blood pressure pills, went to the nurse...to try to control blood pressure naturally._ (Patient 2)

Having access to allied health-care providers made it easier for patients to have their needs met, even facilitating “following through” on appointments:

_Often when you go to see a doctor and you talk about your health, they will say “well maybe you ought to go see a dietician.”...In the past, that might have been what happened, and you probably would have just sloughed that off, but they actually had someone there to set up an appointment for your to go and see them, so it was kind of like, kind of like following through on the concern, right? So that, I thought, was a way better approach than, than just, uh, you know, sending you a form saying, you really ought to go see a dietician._ (Patient 5)

_When I went for my physical, with the high blood pressure and the cholesterol, I wanted to see the dietician, and the doctor actually took me over to meet the nurses and the dietician and everything, and she arranged everything for me. So it wasn’t something that was kind of a hassle on my part—it was just, you know, part of the visit!_ (Patient 6)

In both of these examples, the patients were referred by their physician to another provider to address a specific care need. Having access to the other providers facilitated this process, although the physician would also have to be aware of which providers could refer to address specific needs (i.e. the physician would require knowledge of roles).
4.4.3 Awareness of interprofessional relationships and communication

Some patients described an awareness of interprovider relationships and communication between their providers and how these impacted their care experience:

I see a lot more courtesy between professionals [at this clinic]...I’ve seen where, um, from past experiences with other doctors that I’ve had and dealing with outside, you know...I’ve had a couple of times, not just one doc but a couple of different doctors who have commented...[the other doctor is] wrong. He doesn’t know what he’s talking about. And it’s like, well, hold on. He is the professional, just like you. He may have a different opinion but, you know, there seems to be competition, you know, as to what they think is right and wrong and I do not find that...in the group that I deal with [at the FHT]. There is a lot of courtesy and, um, a lot of interest. They express interest in the points, in the different perspectives. And I love that—I love it when, and the nice thing about it is, is that everybody listens to the patient. (Patient 15)

You know that [your providers are] talking back and forth...I have more confidence in the care that I’m getting. [In the past], you go to some of these people and you know, it’s pretty obvious first of all that they just don’t give a shit, you know—you are just like cattle going through a line to them. But I find with this setup, the way it is now, I think that because [the providers] communicate with each other, you’re not just a number...I find that’s a lot more personable. (Patient 8)

The perceived “talking back and forth,” “courtesy” and “interest...in different perspectives” between providers are perceived to influence patient “confidence” in or “love” of their care, thus emphasizing the importance of interprofessional relationships and communication from the patient’s perspective.

4.4.4 Communication and decision-making

Patients described scenarios where there was discussion between patients and providers—and between providers themselves—which resulted in inclusive decision-making regarding patient treatment plans. As described above, patients are aware of the communication that occurs between their providers in the FHT, and this was perceived to be a central part of the decision-making process.

The following quote emphasizes the perceived importance of interprofessional communication when it comes to supporting inclusive decision-making processes regarding patient care:
[The other providers] have at least a little blurb from your family doctor that has been sent over, why you're going and stuff like that, so they already have kind of like a heads-up. So I think that is pretty important, too...[and the providers] just e-mail back and forth...that I've been there and all that stuff, and [my family doctor] knows what [the other providers and I] talked about and then says “What do you think? What course of actions do you think we should take” or stuff like that...[It makes me feel] like [I'm] part of the group figuring it out...part of the decision making process. (Patient 12)

Here, the patient was referred to allied health-care providers who communicated their findings and suggestions to the patient’s family physician via an EMR system. The physician and patient then discussed the options together to figure out a mutually agreed upon course of action.

The next example describes a process of patient involvement in the decision to address a recognized need (a referral to the social worker) and the communication that occurred between the physician, social worker and the patient:

I had an issue and...[my doctor] asked me if I wanted to talk to the social worker. I said “sure.” Then I started talking to the social worker and my doctor oversees everything so...You know, we discussed, um, what the social worker’s role would be and...between the two of them, it works really good [because] if the social worker feels that I need, that I may need some medication or looking at different types of medications or something, then she talks to me about it and she’ll talk to the doctor about it. Then the doctor will sit down with me and talk about it and see whether in the change of medication might be right or should I, you know, whether different therapies might be in line, stuff like that. And it’s really good communication. That’s one of the things I like about it...there’s open communication. It’s not one business talking to another business. It’s one associate talking to another associate. It’s really, really good that way. (Patient 15)

The “open communication” between the patient, the physician and the social worker was the central theme of this quote. The patient felt included in the discussion regarding the social worker’s role and treatment options, and was aware that the two providers were talking back and forth about ways to address the patient’s care needs.

Although some patients did perceive a “responsibility to be involved in their own care” (Patient 6), in the next quote, a patient describes being content with his providers deciding on his care plan:
I mean, I kind of trust my doctors. I’m not one to go on the Internet and do research on my own [be]cause...I just don’t. Like if there’s something wrong, I don’t want to read too much into it or whatever so...I trust my doctor and, you know...whatever they would want to do for treatment options. (Patient 3)

Different patients have different preferences for decision-making regarding their care, and, as this last quote highlights, the patient’s preference may be met by not being involved.

4.4.5 Co-location of providers

Patients considered co-location of the providers on their team to be an enabler for getting their questions answered:

*If I’m talking to one [provider] and I ask a question that that [provider] can’t answer but...let’s say somebody else in the office can answer, then I can be steered in the right direction and I can get, again, a resolution. I don’t have to wait for an appointment. I don’t have to wait weeks or months...depending on what the situation is, I can get a resolution in a couple of days or a couple of hours. (Patient 15)*

Some patients also share the opinion of some providers that co-location of providers enables efficient use of time. From the perspective of patients, having all of the members of their interprofessional team at one site was associated with efficient use of patient time:

*I prefer everything in the same location...convenience, one-stop shop, efficient...everything gets done in one spot so it’s not over multiple appointments. I don’t have to take as much time off work to get the same amount of stuff done. (Patient 6)*

*I was in with the, um, the psychologist and...she had asked [the physician] to come in at one point, so he came in just for a few seconds until, you know, they had worked that out, and then he left again and then I just continued on with her. ...He was available to, you know, help out at the same time. So it was nice that you didn’t have to make another appointment. (Patient 11)*

*I’m overweight, so [my doctor] has constantly said, “well you should, maybe you should go see a dietician.” [And I said] “You know, um, and I’ll go, yeah, yeah, well, we’ll talk about that later.” You know. Um, and then he’d just sit there and [I said] “I’ll go, okay, give me a referral.” But because I have to drive somewhere to go, in another town to get it, there’s no motivation to do it, you know...I don’t go over to that other town other than to see a dietician, why would I do it—You know, waste my time just going for one thing? “Now that the dietician is in the office,” he says. Well, let’s*
set an appointment up to see the dietician. Okay, fine. And no problem. And then I go see the dietician because the dietician is right there. All right. And I’ll sit there, and okay, I’ll make an appointment to see the dietician at the same time that I’m going to be seeing the social worker. You know, so I can see both of them and get both issues done at once. (Patient 15)

As these quotes suggest, patients perceive that co-location of their providers saves them time and may facilitate their follow-through with referrals since it’s a one-stop shop (and requires less time off work). Co-location of providers was perceived to be particularly valuable in a rural community context, where a FHT may have multiple sites spread over two or more communities with limited public transit between them. Describing a situation where providers are not co-located, one provider explains that “[a patient] might be commuting 45 minutes in order to come see one of us…it’s a little bit of a barrier” (Provider 15).

4.4.6 Access to patient information

Patients reported that they felt their providers having access to their information to be valuable:23

Yes, [all my providers] have access [to my electronic chart]. Um, and no, um, [not having access] to me would be counterproductive to your therapy. Okay, well, um, health to me is, everything is interrelated…from your mental state to your physical state, they work hand-in-hand. All right, so, um, if something is stressing me, [and I’m talking] with a social worker, and that [stress is] going to cause physical symptoms. Now, if my doctor doesn’t [have access to the social workers notes and he doesn’t] know I am having issues [with stress], then he’s going to be looking for different things. Now he’s going to waste his time…But, [having access to the social workers notes is] going to help him diagnose me. And it’s the same way…if I’ve just broken a collar bone or broke a bone or um, banged myself up, and sitting there fidgeting in a chair, [the social worker is] going to know, okay, yah, he’s hurt himself, that’s why he’s fidgeting. He’s not fidgeting because of something that’s bugging him. Do you understand? It’s

23 All patients interviewed had their care provided in sites with EMRs, so the patient examples are regarding that technology.
all relative information. The dietician will need to know if I’m under stress. Because if I’m under stress, of course my diet going to go to heck…! You know I tend to eat when I’m under pressure or under stress. Well, it helps her, you know and the way the medical field is, the more you know, the more information the better. (Patient 15)

I don’t mind [all the providers having access to my chart], honestly. I find it to be a preferable aspect that they all kind of know the history, and something that I would consider to be a negligible detail, I might have told one but not the other is ready in my file. So they might say “Okay, well that would have been nice to know!” But since it’s kind of like a complete story, using one chart basically, it’s an advantage. (Patient 6)

The above quotes also demonstrate the perceived importance, from the patient perspective, of all providers who are providing care having access to patient information.

Some patient participants reported particularly valuing how their providers shared a single electronic chart and had instant access to their information:

I think it’s really important. This sounds kind of corny, but the entire electronic focus in the office...the fact they’re sharing the files is much easier. So you have an appointment—they’re able to pull up all your information. So that coordinated effort behind the scene with files I think is essential, because it’s much easier to come up-to-date when you walk in to meet the new service provider; they can pull up your record instantly, have read them and are ready to hit the ground running, kind of thing.

...Absolutely [it’s a timesaver]. If I had to recount my entire life history every time, it wouldn’t be worth my while. (Patient 1)

Well, I mean [not having to repeat my information to different providers], I think you just deal with, it helps you to get to the uh, the root of the matter, I think, a little quicker, right?...I just think it’s more efficient from a visit perspective even. (Patient 5)

So from my primary care giver I went to, um, the dietician and to the counsellor, and...upon seeing those, both those other two, they knew fully what was going on [because they had access to my EMR]. ....It saved a lot of grief of going over the same thing over and over again. (Patient 8)

Thus, patients feel that providers having instant access to patient information via a shared chart EMR system saves them time by not only ensuring that their provider is up-to-date with their health history, but also because it helps the patient avoid the necessity of repeating information to each provider. Furthermore, patients believe that providers on their interprofessional primary health-care team utilize the information gathered about them by other members of their team during the provision of care. This supports the concept of the “wider provider.” As another
patient put it, “sometimes [when you are talking to one provider] you forget something crucial [that you had already told another provider]...[but] they just look it up on the computer” (Patient 9).

4.5 Chapter summary

All three FHTs were different with respect to number of sites, mix of communication strategies and provider distribution. Patient and provider participants from across all three sites, however, described similar contextually bound experiences and perspectives. Both patients and providers conceptualized the interprofessional team as a unit, formed through referrals from one provider to another as patient needs are jointly (when appropriate) recognized and prioritized, with each provider on the team meeting scope-appropriate patient needs and using patient information collected by one another to inform care process. This unit, whose membership changes as patient needs change, was referred to as a “wider provider,” where the expertise of the providers and the time each provider spends with the patient is “cumulative.” Both patients and provider participants felt that having access to providers with different expertise (through referral) enabled diverse patient care needs to be met, from physical to psychosocial to financial and home needs.

Participants reported examples describing referrals and communication occurring between providers, emphasizing the role that trust (or interprofessional relationships) were believed to play in these processes. From the patient’s perspective, the exchange of information and professional relationship between providers directly impacted their care experience: it resulted in more confidence in the care they receive, a sense that all of their providers were “on the same page,” and possibly a trust-by-proxy mechanism where trust for one provider is transferred to other providers within the FHT.

The relationships or trust between providers also was perceived to influence team functioning and processes from the provider’s perspective. Trust that one provider had for another was felt to be associated with whether one provider allowed other providers to access patient clinical notes. Trust also was associated with an open physician referral practice—specifically, that a
physician permitted allied health-care providers to independently refer that physician’s rostered patients to other providers. This is compared to a restricted (or closed) referral practice, where the referral was required to filter back through the physician. Alternatively, having a restricted referral practice was, from a physician perspective, not considered to be a sign of a lack of trust, but rather as a part of the physician’s role as coordinator or gatekeeper. This highlights why it is important that providers understand the roles of their colleagues within the FHT: not only does it help them understand the rationale behind physician referral practices, but it also enables them to identify to whom they should refer a patient when the need arises.

Although an understanding of provider roles was considered to be important, it was not sufficient for interprovider referral and communication. Provider participants distinguished between physicians who had buy-in (i.e. those engaged in FHT activities, including interprofessional communication and referrals) and those who did not. Lack of buy-in was perceived to impact inter-referrals and communication, and participants felt that time and energy where required in order to work around a physician who was not “on board.”

Finally, both providers and patients perceived that co-location of providers and instant access to patient clinical notes enabled providers to work together efficiently, act as facilitators for meeting patient needs, save patients time by coordinating multiple provider visits and reduce the necessity of repeating information. From the provider perspective, co-location also facilitated the development of interprofessional trusting relationships, although once interprofessional relationships are developed, co-location may not be essential to deliver interprofessional team-based primary care.

In closing, there are some key findings that should be highlighted:

1. The interprofessional primary health-care team, described as a “wider provider,” is formed through referrals. Members may leverage information collected by one another and address scope appropriate patient needs.

2. Provider understanding of roles, buy-in and trust may enable activities such as inter-referral and communication, which are described as key team processes.

3. Patients have a clear perception of their preferred role in need prioritization and care decision-making, and they value alignment of provider roles.
4. Interprofessional interactions and relationships may influence the patient experience.

5. Co-location of providers (particularly those who are full-time) may enable team processes and may improve efficiency for both patients and providers, but may not be essential for team care.

6. Instant and open access to patient information may be a critical enabler of interprofessional team care.
Chapter 5: Discussion and Conclusion

5 Introduction

This study is one of the first to explore components of the PCCM in an interprofessional primary health-care team context. It also is one of the few to include both provider and patient perspectives on specific processes of team and patient-centred care, although the importance of including the patient perspective in research has been previously acknowledged (Black and Jenkinson 2009; Domecq et al. 2014). Including both the patient and provider perspective provided unique and valuable insights into team practices and contexts that further our understanding of these processes and may evolve the way in which these practices are conceptualized, operationalized and evaluated.

This study explored how patient-centred care is defined and operationalized in an interprofessional primary health-care team context. Although providers and patients may share common goals for care, they also may report different experiences in reaching those goals. In aiming to produce a seamless care experience for patients, providers may have to regularly adjust workflow in order to overcome unintentional and intentional blocks, many of which may not be apparent to patients. Patients, on the other hand, may be aware of—and impacted by—interprovider interactions that the providers themselves may not consider to be essential or obvious elements in their care processes. The findings of this thesis begin to untangle elements at the crossroads of interprofessional teamwork and patient-centred care.

This chapter begins by describing the interprofessional primary health-care team within a FHT context and the factors that may affect interprofessional team formation and workflow. Following this is a discussion of how obstacles, or “blocks” to workflow may impact both the provider and patient experience, and how this experience is thought to patient-centred care. A preliminary framework of patient-centred interprofessional primary team care also is presented. The chapter concludes with a discussion of study implications, future directions, study strengths and limitations, and some concluding remarks.
5.1 The interprofessional primary health-care team

The findings of this study suggest that a patient interprofessional primary health-care team (“patient team”) is a group of two or more providers from different health-care professions that forms around an individual patient. A patient team is conceptualized by its patient and provider members as an entity—similar to Cohen and Bailey’s (1997) “work team”—and it is distinguished from the FHT as a whole. The patient team is responsible for meeting patient needs and providing patient care. This means that the time spent with the patient is defined as the total time the team members collectively spend with the patient, as the patient team is conceptualized as a collective unit or “wider provider.” To efficiently function as a “wider provider,” work and information have to easily flow back and forth between team members in a reciprocal, interdependent workflow pattern (Tesluk et al. 1997).

5.2 Teaming

Although recognized as a “wider provider” or collective unit by its members, a patient team was also described as dynamic: its membership evolves over time as referrals are made to new providers in order to address emerging patient needs. A provider may be a member of numerous patient teams simultaneously and spend his or her work day participating transitioning in and out of different patient teams, similar to the activity of “teaming” (Edmondson 2012). Edmondson (2012) defines teaming as “teamwork on the fly” (p. 13), an active process of forming teams as needed that requires members to possess specific skills to enable them to form and participate in teams.

Edmondson (2012) explains that there are characteristics of both individuals and organizations that enable teaming; there also are some that act as barriers to teaming. In other words, certain factors define an environment that allows for effective teaming. Other studies (e.g. Lewis et al. 2014; Gittell and Weiss 2004) have described this in the context of inter-organizational networks, suggesting that factors particular to each network member—such as information
systems, electronic records and culture—may impact network function. Gittell and Weiss (2004) emphasize the importance of including factors at multiple levels to reflect “real life” situations.

In this study, the impact of multilevel factors was demonstrated in the multitude of ways that teaming was operationalized and influenced by the behaviours of the providers involved and the clinical contexts in which they operated. For example, a specific behaviour of one provider could result in a major shift in workflow and have implications for the experience of both the other providers on the team delivering care and the patient receiving care.

5.3 FHT referral groups

Within the FHTs studied, every provider is formally associated with one or more physician sites or groups whose members are designated to participate in teaming with the other providers in that group. There may be one or multiple such “referral” groups within a FHT. Referral groups can be described as a type of network (Powell 1987; Lewis et al. 2014) of provider and program resources within a FHT, each with specific knowledge and skills that may be leveraged through teaming to join a patient team to inform or address specific patient care needs. Edmondson (2012) describes a “fluid network of interconnected individuals” (p. 2) who work together in temporary teams.

In this study, the members of these referral groups self-identify and are recognized by others as members of the referral group. Membership in a referral group, however, does not indicate participation in the group. All provider members of a referral group do not participate equally in teaming activities (such as referral and communication); rather, each provider is distinguished by his or her level of participation or engagement in a referral group, as described next.
5.4 “Copresence” and the engagement continuum: differentiating referral ingroups and referral outgroups

Providers within a referral group can potentially connect with one another, either virtually (as with electronic modes of communication) or in-person (as with physical co-location). Despite this, as Zhao and Elesh (2008)—drawing from Goffman (1966)—explain, “being ‘within range’ is not the same as being available to each other for contact…so even though within range, the person can in fact be out of reach” (p. 569). Being available for contact is what Zhao and Elesh (2008), leveraging Goffman (1966), term “copresence.” The concept of “copresence” is useful here for explaining referral ingroups and referral outgroups.

The concept of “copresence” (Zhao and Elesh 2008) describes providers who are mutually accessible to other providers within their referral group for patient referrals and intercommunication; that is, they are engaged and willing to participate in teaming with other providers in their referral group. These providers form the referral “ingroup” (Tajfel 1982) and are distinguished from those providers who may be formal members of the referral group, but who are generally not accessible to other group members for referrals and communication. These non-accessible providers, who are not actively engaged in teaming, form the referral “outgroup” (Tajfel 1982). The results of this study suggest that there may be providers who are not engaged in teaming and are clearly members of their referral outgroup; and there may be providers who are fully engaged in teaming and are clearly members of their referral ingroup. However, there may also be providers who participate to varying degrees in teaming activities and fall somewhere in the middle—along a referral group engagement continuum. Provider members recognize how engaged each of the other members of their referral group are. The engagement continuum is discussed in more detail below (see section 5.5).

The findings of this study suggest that several factors may predict level of provider engagement in a referral group. These factors include provider “buy-in” (meaning whether or not a provider agrees with an FHT’s interprofessional team philosophy or model of practice) and provider understanding of, and confidence in, the skills of other referral group members (classified as knowledge of roles and trust, respectively). Traditionally discussed as provider team “competencies” (Lichtenstein et al. 1997; Mitchel et al. 2011; Worchel et al. 1998;
MacDonald et al. 2010; Solheim et al. 2007; Sargent et al. 2008; Stephan and Stephan 1984; Stewart et al. 2003; Belanger and Rodriguez 2008; Wagner 2000; Arksey et al. 2007; Dieleman et al. 2004; Pullon 2008; Mickan and Rodgers 2005), these factors were presented in this study as the rationale for specific provider behaviours, which in turn indicated the level of provider engagement in a referral group.

To participate in teaming, providers need to develop specific skills or behaviours (Edmondson 2012). Edmondson (2012) suggests that specific behaviours drive effective teaming, such as having a collaborative mindset and speaking up in an environment of trust and respect, or “psychological safety”. The results of this study highlight the importance of developing knowledge of roles and confidence in skills (“trust”) and having buy-in, which is similar to a collaborative mindset (Edmondson 2012). Participation in teaming may require referral group members to develop a set of teaming skills, and a provider with those skills would be more engaged in the referral group, which is indicated by specific provider behaviours, discussed next.

5.5 Indicators of provider engagement: physician referral practice and provider notes status

As introduced above, the level of engagement of each provider within a referral group may vary. Figure 4 depicts a continuum of provider engagement. Providers who are not engaged sit at the far left of the continuum in the “referral outgroup”. Providers who are more engaged sit toward the right of the continuum in the “referral ingroup”. Providers who sit somewhere in the middle of the continuum demonstrate varying levels of engagement. The results of this study suggest that there may be two main indicators of provider engagement in FHT referral groups: physician referral practice and provider notes status.
Physician referral practice refers to the rules each physician has regarding allied health-care providers referring his or her rostered patients to other providers within the referral group:

1. An *open* referral practice means that the allied health-care provider can refer independently of the physician.

2. A *restricted* referral practice means that the allied health-care provider can refer but must inform and/or receive permission from the physician.

3. A *closed* referral practice means that the allied health-care provider is required to refer the patient back to the physician to make the referral.

As depicted in the provider engagement continuum (Figure 4), a physician with a closed referral practice is considered less engaged in the referral group and sits more toward the left side of the continuum. A physician with a restricted referral practice sits in the middle, and a physician with an open referral practice is considered to be more engaged and sits at the far right of the engagement continuum.

Provider notes status refers to whether a provider’s patient notes are available for viewing by other members of a patient’s interprofessional team or if they are restricted. A *closed* notes status means that the provider has restricted the access to his or her patient notes so that other providers cannot access them. An *open* notes status implies the opposite: the providers’ patient notes are available. Referring to the provider engagement continuum (Figure 4), a provider
with closed notes sits more toward the left of the continuum, and a provider with open notes is considered most engaged and sits at the far right of the continuum.

### 5.6 Level of provider engagement and workflow: implications of intentional workflow blocks

Although engaged referral group providers may be teaming throughout the work day, the pattern of workflow may differ between each patient’s interprofessional team. This is because, as the findings of this study suggest, provider behaviours, such as referral practice and notes status, impact workflow processes. A less engaged provider means that he or she may demonstrate a behaviour that acts as a barrier or “block” and causes workflow patterns to shift in order for teaming to occur.

A workflow “block” is something that is considered a disruption in workflow (Halbesleben et al. 2008). However, recognizing a block as a disruption depends on perspective. What one provider considers an intentional change in workflow or an intentional block (Halbesleben et al. 2008) in order to ensure patient safety or confidentiality (such as closed or restricted physician referral practice or a closed provider notes status) may be considered by another provider to reflect a lack of trust and low provider engagement that results in a block to ideal workflow. Furthermore, the block may have unintended implications for patient experience. Thus, the provider instituting the intentional block may not recognize it as a block to ideal workflow, but rather as a necessary teaming practice, unaware of the implications that this practice has on the workflow of the interprofessional team and the experience of the patient; he or she also may be unaware of what these practices indicate to the rest of the interprofessional team with respect to engagement in the referral ingroup. These intentional blocks and their implications are described in more detail next.
5.6.1 Closed or restricted physician referral practice

A physician who has a closed or restricted referral practice may do so with the intention of supporting his or her role of “gatekeeper” (Franks et al 1992; Bodenheimer et al. 1999; Grumbach et al. 1999; Starfield 1994). This is contrary to others who perceived a closed or restricted referral practice as indicating a lower level of trust and therefore lower level of engagement of the physician in the referral group. The findings of this study suggest that a closed or restricted referral practice intentionally changes the workflow pattern of the interprofessional team to allow the physician to oversee all patient referrals. The consequence of this practice may be that it requires extra patient visits and/or provider time compared to workflow with an open physician referral practice. Specifically, an allied health-care provider to whom this practice applies would either have to refer the patient back to the physician to make a referral (closed referral practice) or attain permission from the physician to refer the patient (restricted referral practice). The implication of a closed or restricted referral practice may be extra steps in the referral process and thus reduced efficiency.

5.6.2 Closed provider notes status

Similar to closed or restricted referral practice, closed notes status is an intentional block (Halbesleben et al. 2008) and has implications for workflow. With closed notes, a provider intentionally blocks access to his or her patient notes for other providers who share care for that patient. The rationale for closed notes from the provider implementing the practice may be to protect patient confidentiality with respect to sensitive information (such as mental health notes), as suggested from the findings of others (e.g. Salomon et al. 2009; Reitz et al. 2012). However, as described earlier in the chapter, the findings of this study suggest an alternative perception of closed notes—specifically, that they are an indicator of low provider engagement in the referral ingroup (explained as a lack of trust). Regardless of the rationale, closed notes may have implications for both interprofessional team workflow and patient experience.

When a provider implements closed notes, other providers on a patient’s interprofessional team cannot access patient information collected by that provider. From the perspective of providers
in this study, not being able to access potentially important and useful clinical notes is considered inefficient and may limit the team’s ability to function as a “wider provider.” Along similar lines, Ragaz et al. (2010) report that having access to the full history of each patient was something that interprofessional healthcare providers in FHTs “particularly valued” (p. 42) and Lingard et al (2007) describe “interprofessional informational workaround[s]” to describe shifts in provider process to access patient information in internal medicine teams (p. 664). From the patient’s perspective, clinical notes collected by one provider may help another provider on their team by informing the other provider of critical information (including both physical and mental-emotional information) that the patient may have told the first provider but missed telling the second provider. It may also prevent the patient from having to repeat the same information to multiple providers. Patients expect their providers to be aware of—and use—the information collected by others on their interprofessional primary health-care team. That patient perception, as expressed by participants in this study, is in direct contrast with that of providers who close their notes to protect patient confidentiality.

5.7 Unintentional blocks: co-location and technology system blocks

Two other factors act as blocks to workflow: providers not being co-located at the same time and inaccessible electronic medical record (EMR) and communication systems. These are defined as unintentional blocks, which are blocks that are not designed to intentionally disrupt workflow (Halbesleben et al. 2008). Without co-location, providers may not have the opportunity to participate in ad hoc informal communication and consults, practices considered to be efficient for quick discussions of patient matters or for acquiring professional opinions. Without co-location, providers must rely more heavily on alternate mechanisms of communication (such as electronic methods). Thus, if there is an appropriate electronic communication infrastructure in place to support timely access to patient information, the fact that providers are not co-located may not be a true block to workflow from the perspective of providers. This is assuming that providers already have previously established relationships
and knowledge of roles, which “ongoing interaction over time,” enabled by co-location, has been shown to facilitate (Lewis et al. 2014, p. 91).

Access to patient information, as with open notes, is important for providers to function as a “wider provider.” What this study has found (and which is supported by other studies) is that timely access to patient information may be particularly critical (Stille et al. 2005; Weiner et al. 2005; Lingard et al. 2007). Access to information, however, requires more than just an electronic mode of communication. Independent from notes status, timely access to patient information may be blocked by lack of provider off-site access to a patient’s EMR. Electronic systems in different sites within a FHT have to be connected (i.e. they must share a server), and providers who are not co-located need external access to the system in order to access patient information while off-site.

From the provider perspective, blocked EMR systems may have several implications for workflow of the wider provider. First, without external access to the team’s clinical notes, one provider cannot utilize information collected by another provider if he or she is stationed at a different site. Second, providers who do not have external access to the electronic system are unable to access referrals from other providers unless they are on-site, which may add additional blocks and inefficiencies to efforts to participate in teaming and function as a wider provider, as providers have to travel to the relevant site to receive a referral.

5.8 Workflow blocks and workarounds: provider versus patient perspective

As blocks are encountered by team members, they adjust their workflow practices to accommodate—or workaround—the block in order to reach their goal. Morath and Turnbull (2005) define “work-arounds” as “work patterns an individual or a group of individuals create in order to accomplish a crucial work goal within a system of dysfunctional work processes that prohibits the accomplishment of that goal or makes it difficult” (p. 52). Similarly, Tucker and Edmondson (2003) discuss workarounds as problem-solving around an obstacle in order to continue patient care. They emphasize that workarounds do not address the underlying problem
but are more short-term patch solutions (Tucker and Edmondson 2003). Workarounds due to unintended process blocks have been linked to negative consequences, such as medical errors (Spear and Schmidhofer 2005), although workarounds have also been reported to have both positive and negative impacts on process and patient care (Debono et al. 2013; Lingard et al. 2007).

Providers in this study discussed workarounds as inefficient, creating additional work to maintain patient care. They represent extra work in the form of additional referrals and time (as with closed physician referral practice) or extra travel for providers who have to travel to different sites to receive referrals (as with technology system blocks), each of which may result in challenges to practice, changes to workflow, and extra time and energy spent by providers.

Patients, however, may have a different experience of certain workflow blocks. The intention of workarounds by providers is to minimize the impact of a block on the patient experience. Thus, with an effective workaround, a workflow block may have a minimal impact on patient experience or even go unnoticed. For example, a patient may not notice if a provider worked around technology system blocks and had to travel between sites to receive a referral or patient information or to prepare for a patient visit.

The results of this study, however, suggest that (from the patient’s perspective) specific blocks do impact the patient’s experience. Specifically, if providers are not co-located, patients may have to travel to different sites for appointments and be unable to book sequential appointments with multiple providers—a scenario that requires some patients to take extra time off work, which they consider to be an inefficient use of their time. Providers not being co-located also may deter patient follow-up on referrals due to the hassle and extra time associated with travel.

Similarly, without interprofessional primary health-care team access to patient notes (as a result of either technology system blocks or the intentional block that results from closed notes), there may be an impact on patient time and efficiency. Specifically, patients may have to repeat the same information to multiple providers, with the risk that they may forget something or not realize the importance of information that they shared with some providers but not others. Patients having to repeat information has been described as “difficult for
everyone” (Brown et al. 2016). As noted above, patients report that they expect all their health-care providers to have access to their clinical notes and to use the information gathered by others on the care team during their care.

5.9 The convergence of interprofessional teamwork and patient-centred care

Fox and Reeves (2015) present interprofessional teamwork and patient-centred care as two independent but related discourses, which—although discrete—may be operationalized simultaneously (or “repackaged”), thus creating a new phenomenon that leverages elements of each (Fox and Reeves 2015), an example of which is collaborative patient-centred care (Herbert 2005; Fox and Reeves 2015). Having an interprofessional primary health-care team operationalizing patient-centred care obliges consideration of elements defining patient-centred care, but in the context of elements novel to an interprofessional primary health-care team context.

With this in mind, both patient and provider participants in this study described operational and contextual elements required for meeting patient needs by an interprofessional team. These elements have been distilled into five major themes, presented as a proposed framework for interprofessional patient-centred primary team care, described next.

5.10 Framework of patient-centred care in an interprofessional primary health care team context

An interprofessional primary health-care team introduces elements—including multiple providers, the interactions between them, and the context in which they operate—into the discourse of patient-centred care. These elements not only impact the provider’s process and experience of providing care, but they also influence the patient’s experience. Thus it is proposed that indicators of patient-centred care in an interprofessional primary health-care
team context should focus not only on patient outcomes, but on outcomes reflecting provider interaction and engagement in teaming, along with the context in which they operate.

Table 5, which is based on findings from this study, introduces both patient- and provider-focused indicators of five themes defining patient-centred care specific to an interprofessional primary health care team context. These themes represent congruence between patient and provider perspectives.

Table 5. Framework of interprofessional patient-centred primary care

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
<th>Provider Indicators</th>
<th>Patient Indicators</th>
</tr>
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<tbody>
<tr>
<td>(1) Access to resources</td>
<td>Resources (providers and patient programs) are available and accessible to address a patient’s broad and complex needs. Patient needs are acknowledged and responded to.</td>
<td>• Resources exist in the referral group  • Open physician referral practice</td>
<td>• Appropriate response to patient needs (e.g. referral, patient experience measure)  • Not repeating information</td>
</tr>
<tr>
<td>(2) Timely access to full patient information</td>
<td>Patient information is accessible in a timely fashion to all providers in an interprofessional primary health care team.</td>
<td>• Open notes  • Sufficient communication infrastructure</td>
<td>• Provider co-location  • Not repeating information</td>
</tr>
<tr>
<td>(3) Convenience and efficiency</td>
<td>Patient and provider time is valued and respected, as demonstrated by convenience and efficiency of practice. Time is used wisely.</td>
<td>• Open physician referral practice  • Open notes  • Co-location or sufficient communication infrastructure</td>
<td>• Provider role complements patient role  • Patient role complements provider role</td>
</tr>
<tr>
<td>(4) Alignment of patient and provider/team decision-making roles</td>
<td>Alignment of patient and team roles in decision-making regarding care.</td>
<td>• Interprovider referrals  • Interprovider communication</td>
<td>• Awareness of interprovider respect  • Awareness of interprovider communication</td>
</tr>
<tr>
<td>(5) Interprofessional team culture of respect</td>
<td>Patients recognize an interprofessional team culture where providers demonstrate overt respect and courtesy.</td>
<td></td>
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</tr>
</tbody>
</table>

Table 5. Framework of interprofessional patient-centred primary care

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition</th>
<th>Provider Indicators</th>
<th>Patient Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Access to resources</td>
<td>Resources (providers and patient programs) are available and accessible to address a patient’s broad and complex needs. Patient needs are acknowledged and responded to.</td>
<td>• Resources exist in the referral group  • Open physician referral practice</td>
<td>• Appropriate response to patient needs (e.g. referral, patient experience measure)  • Not repeating information</td>
</tr>
<tr>
<td>(2) Timely access to full patient information</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
5.10.1 Access to resources

Shifting from a dyadic to an interprofessional primary health-care team context introduces multiple resources in the form of the “wider provider,” whose members may each address scope-appropriate patient needs. As the findings of this study and others (Brown et al. 2016) suggest, providers appreciate having access to other providers with complementary scopes of practice and also to patient programs as this not only provides a source of peer support for providers, but it allows for a greater range of patient needs to be met (such as physical, mental-emotional, health promotion and education needs). This supports the notion that an interprofessional team may be advantageous or even essential for meeting complex patient needs (Stewart et al. 2003). Similarly, the findings of this study suggest that patients recognize and appreciate having access to providers to address their individual needs. To the patient, awareness of their access to provider and program resources means that their diverse needs can be addressed, which may positively influence their experience of care. The assumption is that available resources in a FHT referral group align with community needs (OMHLTC 2005; OMHLTC 2016).

As described earlier in this chapter, however, accessibility not only means that the resources are present in the referral group, but that there is “copresence” (Zhao and Elesh 2008) of providers, which may be indicated by level of provider engagement within the referral group. In other words, accessible providers may be engaged in the referral group to participate in teaming and to address patient needs as they arise. This is reflected in Theme 1 (access to resources; see Table 5), which is defined as having resources available and accessible to address a patient’s broad and complex needs (i.e. acknowledge and respond to patient needs). This theme is measured by a patient experience indicator that defines whether their needs are responded to (this can be documented evidence of a referral or a prescribed treatment; or a patient experience measure); and also by provider-focused indicators that reflect provider engagement in teaming, specifically physician referral practice.
5.10.2 Timely access to full patient information

Timely access to full patient information is the second area of alignment between patients and providers. This can occur if providers have open notes and, if they are not co-located, have access to adequate infrastructure that supports between-site and external provider access to a patient’s EMR. As discussed earlier in this chapter, providers may value how shared clinical notes can provide them with pertinent information that the patient may not have shared with them directly. For their part, patients may value how timely access to their information for their providers saves them time and the frustration of having to continuously repeat themselves to different providers. Timely access also may mitigate the effects of patients neglecting or forgetting information that they may have shared with one provider but not with others. Patients report being aware of interprovider sharing and communication, and that they expect providers to use patient information collected by other members of the their team in advancing their care process. Thus, indicators for Theme 2 (timely access to full patient information) include patient-focused, provider-focused and context-focused measures (as defined in Table 5).

5.10.3 Convenience and efficiency

Convenience and efficiency is the third area of alignment between patients and providers. From the perspective of providers, convenience and efficiency suggests that workflow occurs in the most straightforward and timely manner possible. This may be enabled by co-location of providers—preferably full-time co-location—as it allows for ad hoc meeting and discussion which is suggested, by participants, to be more efficient than other forms of interprovider communication (including electronic-based methods). From the provider’s perspective, co-location may be beneficial but not essential for interprofessional practice, particularly when there already are established interprofessional relationships and suitable interprofessional communication infrastructure. What may be more salient for efficiency, from the provider’s perspective, is provider “copresence” (Zhao and Elesh 2008).
From the perspective of patients, however, the convenience and efficiency of their care experience may be impacted by co-location. Co-location of providers allows for sequential patient clinical visits, enables ad hoc patient consults (for example, in situations where one provider calls in another provider to consult during a patient visit) and supports patient follow-through after referrals. This one-stop shop is considered by patients to be efficient and convenient and values their time. Further, as presented in the section above, timely access to patient information also may save time for both providers and patients, so there is some overlap of indicators between Themes 2 and 3.

5.10.4 Alignment of patient and provider/team decision-making roles

The fourth area of alignment between patients and providers is regarding the role of patients as decision-making partners in care. Most patient participants in this study preferred to receive information and advice from their providers and to be active participants in decision-making regarding their care (although some preferred to yield decision-making to their health-care providers and assume the role of passive recipient). Stewart et al. (2003) talk about the importance of alignment between patient and provider roles with respect to decision-making in Component 3 of the PCCM (finding common ground). They emphasize that roles within the team are mutually agreed upon, meaning that the patient’s preferred role in decision-making should complement the decision-making roles of his or her providers. This may require role “shifts” on the part of providers when patient role requirements change (Stewart et al. 2014; Scott et al. 2008).

In this study, advocating the patient role in decision-making and self-management may be central to patient-centred care from the provider perspective. While some providers supported complementary patient and provider roles determined by patient preference, however, others articulated their expectation of the appropriate patient and provider roles in decision-making, revealing conflicting motivations for the patient role as decision-maker. These roles are depicted in Figure 5 below.
Referring to Figure 5, on the far right of the continuum is provider as educator/facilitator. The role for the provider in this scenario is one of providing information and options to the patient, but with the purpose of leaving the decision to the patient. This is similar to the “informative model” described by Emanuel and Emanuel (1992). The assumption here is that the provider does not omit options that he or she considers to be less favorable, a practice that would bias patient choice (van Mossel et al. 2010). In this scenario, providers may not agree with the patient’s decision, but they nonetheless respect, consider and support patient preference when recommending care.

The far left of the continuum describes the patient in a passive decision/recipient role and the provider/team as expert/decision-maker. In this scenario, the provider makes care decisions on behalf of the patient. This is similar to the “paternalistic model” described by Emanuel and Emanuel (1992). These roles were described by both patients and providers, reflecting the notion put forward by Stewart et al. (2003) that advocates alignment and agreement between patient and provider roles.
Two other role scenarios were described by providers in this study, reflecting a profession-centric perspective. This means that decisions should be yielded to professionals, such as providers, particularly under more urgent care situations. Berwick (2009) refers to the work of Freidson (1970) in reporting that a profession-centric perspective assumes that professionals are altruistic, that they self-regulate, and that they have a special, non-accessible expertise (Berwick 2009 referencing Freidson 1970). The first role scenario, second from the right, describes the patient role in decision-making as being within parameters: the more critical or urgent the provider defines the problem, the less of a role the patient would have in decision-making and the provider or team would take on the role of decision-maker. This may assume that the patient is not capable of understanding information and decision-making in a situation defined as more urgent or serious by the provider (van Mossel et al. 2011).

The other scenario described (second from the left in Figure 5) was one where the provider was educator/expert. In this role, the provider/team educates the patient to agree to what the provider feels is the right decision. The emphasis here is on educating the patient as to why a certain course of treatment is appropriate, with the goal of attaining patient buy-in or informed consent. Thus, the purpose of this scenario is one of achieving compliance.

The scenario of education for compliance defining patient-centred care has been discussed previously (Grob 2013; Fox and Reeves 2015; Jones et al. 2004). Grob (2013) refers to it as the “compliance paradigm in patient-centred care,” where patients are engaged in order to “increase the chances that they will follow instructions” (p. 461). This paradigm, whether it stems from a profession-centric perspective or, as some suggest, a commitment to evidence-based care (Berwick 2009; Sanders and Skevington 2004), is in opposition to what patients in this study perceived as participation in decision-making, which was receiving information and then participating in a choice. It also may contradict the fundamental tenets of patient-centred care described by others: understanding and considering patients’ context, needs and preferences (Stewart et al. 2003; Gerteis 1993; Laine and Davidoff 1996).
5.10.5 Patient awareness of interprovider interactions and communication

The findings of this study suggest that patients are aware of the interactions that occur between their providers and the way in which they occur. A patient’s perception of these interactions, including interprovider communication, may influence the patient’s experience of care. From the patient’s perspective, providers are performing in a way that enhances the patient’s perception of his or her care experience when they (1) act with courtesy and respect toward other providers, (2) listen to and express interest in other provider’s perspectives (when appropriate), and (3) are able to concede and acknowledge when a patient need requires skills beyond their scope of practice and refer to another provider. This, in turn, may instill confidence in patients about the care they receive.

According to Stewart et al. (2003) “collaborative interdisciplinary practice is a negotiated process among equals, characterized by mutuality, respect and trust that enables appropriate self-disclosure without discomfort…[team members] have shared values, goals and vision enhanced by an understanding and valuing of each team member’s perspective and scope of practice” (p. 137). The importance of interprovider respect has also been acknowledged by others (Herbert 2005; Mickan and Rodger 2005). What is missing, however, is acknowledgment of the patient’s awareness of the interactions among his or her team members and a recognition of the impact this has on patient experience. Patient recognition of interprofessional respect and courtesy, then, presents a novel element of patient-centred care in an interprofessional primary health-care team context.

5.11 Congruence and divergence between the proposed framework of interprofessional patient-centred primary care and the PCCM

The PCCM directs its focus on the patient–provider dyadic interaction and relationship, operationalizing the components in the context of “being realistic” with wise utilization of available resources (Stewart et al. 2003). Although the PCCM reflects a broad and
comprehensive model of care, it does not sufficiently expand to consider clinical context and the interprovider interactions and processes that define the interprofessional primary healthcare team. It also limited in its reflection of the impact these factors have on patient experience of care. The proposed framework, however, addresses these limitations.

The definition of the Theme 1 (access to resources) in the proposed framework states that resources are available and accessible to address patient primary care needs, assuming that patient needs may be broad and complex (which may include everything from physical and emotional needs, to health promotion needs). This theme draws on Components 1 and 2 of the PCCM, in that these components articulate the importance of addressing and considering the broadness and complexity of patient needs. In particular, it highlights the importance of exploring both different aspects of disease and the patient’s experience of it (Component 1), while also considering the patient context and particulars that shape patient experience and perspective (Component 2) (Stewart et al. 2003). What is novel in the proposed framework is the emphasis on resource accessibility: that resource are available and accessible to refer to, address and respond to patient needs. This is what patients and providers in this study valued. Thus, the findings of this study recognize and expand Components 1 and 2 of the PCCM (Stewart et al. 2003) and emphasize the importance of not only having appropriate resources engaged and accessible, but also of making both providers and patients aware that resources are available to address patient needs.

Component 3 of the PCCM (finding common ground) emphasizes the importance of fostering a comfortable environment where the patient can ask questions and discuss their care. This is done with the goal of reaching agreement on treatment priorities, goals and direction of care, while still respecting patient preferences (Stewart et al. 2003). Stewart et al. (2003) present this with the recognition that a patient’s preferred role in decision-making varies and has to be both respected and aligned with the role of the provider.

Component 3 of the PCCM is reflected in Theme 4 of the proposed framework: alignment of patient and provider/team and patient decision-making roles. The proposed framework, however, focuses on role alignment, a prerequisite to patient-provider agreement on decisions (Stewart et al. 2014). The proposed framework furthers the discussion on role alignment with the inclusion of multiple providers in the equation, and also with the proposal of a continuum...
of patient–provider/team complementary roles. However, provider motivation for assuming certain roles—such as when they want to educate to achieve patient compliance (Grob 2013; Fox and Reeves 2015; Jones et al. 2004)—may not always be explicit and may be in tension with the role of supporting the patient in a decision-making choice.

Component 4 of the PCCM (incorporating prevention and health promotion) was not explicitly included in the proposed framework. Theme 1 (access to resources), however, includes resources to address patient needs—such as those promoting health and preventing disease complications—that are addressed by the patient programs implemented by each FHT. Thus, prevention and health promotion are included as potential patient needs in the proposed framework.

In Component 5 of the PCCM (enhancing the patient–provider relationship), the focus is on developing a trusting relationship between a patient and provider during the clinical encounter. What the PCCM is missing, however, is the recognition that patient experience may be impacted by not only the relationships between the patient and each of his or her providers, but also by the relationship and interactions between each of the providers on the interprofessional primary health-care team. This is reflected in Theme 5 of the proposed framework: interprofessional team culture of respect. This theme articulates the notion that the relationship and exchanges between providers is important, particularly in how they overtly treat and value one another, as demonstrated by inter-referrals and communication. The critical piece, however, is patient recognition of the interprovider respect demonstrated by his or her health care team.

Component 6 of the PCCM (being realistic) is the final component, and it emphasizes the importance of considering patient and provider expectations in the context of health care environmental constraints (i.e. what can be realistically accomplished under certain constraints, being mindful of judicious resource use) (Stewart et al. 2003).

Although none of the themes of the proposed framework directly align with Component 6, efficient use of time was a central aspect of Theme 3: convenience and efficiency. The emphasis in the proposed framework then, is less on being realistic with available resources than it is on the value that patients and providers placed on wise use of their time, and that
there should be resources and infrastructure in place to support wise and efficient use of their time, as reflected in Theme 1 (access to resources) and Theme 2 (timely access to information).

Theme 2 (timely access to information) is relevant in an interprofessional primary health-care team context and is not explicitly reflected in the PCCM components. Without timely access to patient information by all team members, the ability of the team (or “wider provider”) to provide patient-centred care is challenged and impacts wise use of both patient and provider time.

Thus, a novel definition of interprofessional patient-centred primary care is proposed based on the findings from this study, with consideration of definitions proposed by others (Stewart et al. 2003; Herbert 2005):

Interprofessional patient-centred primary care focuses on addressing the broad and complex primary care needs of a patient, with alignment of patient and team decision-making roles in care. It relies on all team members having access to appropriate resources and patient information, while valuing and supporting efficient use of patient and provider time, and practicing in a culture of overt respect.

Since the completion of this study, the PCCM was updated by its authors and now reflects a more streamlined model of patient-centred care (Stewart et al. 2014). Two of the original components—“Health Promotion and Disease Prevention” and “Being Realistic” —were incorporated elsewhere in the model, resulting in a new four-component model of patient-centred care (see Stewart et al. 2014, p. 8). Specifically, Health Promotion was incorporated into a revised component one, “Exploring Health, Disease, and the Illness Experience”. There is alignment between the framework presented in this study and the revised PCCM (Stewart et al. 2014) in that health promotion is not a stand-alone theme, but is instead identified as a patient need and included in the proposed framework as a patient need (along with physical needs, mental-emotional needs, etc.) that all require access to appropriate resources to address them (Theme 1, table 5).

“Being Realistic”, as Stewart et al. (2014) explain, “was thought to be not so much a component as a comment on the context within which the patient-centred clinical method is
enacted” (p. 5). The health care team, they say, is the “most immediate” context to consider, and they emphasize the importance of investing in the creation of a sustainable team whose members treat one another in a “team-centred” manner (i.e., following the same principles of patient-centred care) and share a common patient-centred philosophy of practice. This, they say, “may be positive for patient-centred care” (p. 313). Stewart et al (2014) further emphasize the importance of having resources to support a patient-centred team approach. The findings of this study similarly recognize the importance of interprofessional relationships in patient-centred team care. The findings of this study, however, further this discussion by acknowledging the importance of interprofessional relationships from the patients’ perspective; and also emphasize the critical role individual and contextual factors play in shaping team processes and thus the operationalization of patient-centred care.

5.12 Implications of study and future directions

This study introduces a framework of interprofessional primary patient-centred team care that aligns both patient and provider perspectives. It also acknowledges that patient experience is influenced by an array of factors beyond the patient’s relationship and interaction with a particular provider. These factors include the interprofessional relationships and interactions between providers caring for a shared patient, the specific practices of providers and the context in which they practice.

The recognition that interprovider relationships matter not only to the providers themselves but also to the patient experience of care is a critical finding of this study. This finding expands the importance of interprovider interactions and relationships beyond that of just enabling teaming activities. The impact of interprovider relationships on patient perception of care experience has implications of defining patient experience measures beyond those focused on the patient–provider interaction. For this reason, patient awareness of interprovider respect and communication were included as indicators reflecting Theme 5 (interprofessional team culture of respect) in the proposed framework. More work should be done to further explore aspects of interprovider interaction and behaviours recognized by patients that may impact their experience of care.
The impact of intentional and unintentional workflow blocks (Halbesleben et al. 2008) on patient experience of care represented another critical finding of this study. Intentional blocks (Halbesleben et al. 2008), such as closed provider notes, may not only have implications for provider teaming (Edmondson 2012) and practicing as a “wider provider,” but they may also create a situation of inefficiency due to information repetition by patients and possibly suboptimal care from providers who don’t have access to patient notes. As intentional blocks are provider-generated practices, they may be amenable to change with interventions of interprofessional education, interprofessional relationship-building and other behaviour modification strategies. Future work should focus on exploration of intentional blocks to teaming and strategies to educate providers on their impact on teaming and patient care, with the goal of behaviour change and reduction of intentional blocks.

Unintentional blocks (Halbesleben et al. 2008)—specifically insufficient communication infrastructure and providers not being co-located—may also impact teaming (Edmondson 2012) and patient experience. Interprovider communication may be critical to teaming and patient-centred care, so securing sufficient communication infrastructure should be prioritized upon formation of a FHT referral group. This aligns with recent information technology recommendations for proposed Patient Care Groups in Ontario (Price et al. 2015). The upfront investment in communication infrastructure, including dedicated support for EMR (Ragaz et al. 2010) may mitigate resource waste (such as provider travel time) and ensure that providers who are not co-located can effectively participate in teaming through timely receipt of referrals and patient information. Delayed receipt of patient information between members of an interprofessional primary health-care team may have implications for providing care and, ultimately, for patient experience.

Consideration also should be given to prioritizing co-location of providers within a referral group (Gocan et al. 2014). Although beneficial (Dinh et al. 2014), but possibly not essential for provider teaming where there is sufficient communication infrastructure (as demonstrated by functioning virtual teams [Brahm and Kunze 2012; Robert Jr et al 2009]), the findings of this study suggest that co-location of providers may be critical from a patient experience perspective. Co-location of providers allows for consecutive patient consults with providers, indicating convenience and one-stop shopping; from the patient perspective, this may provide
an efficient experience that values their time. Others have described “one-stop shopping” as defining continuity of care in FHTs (Brown et al. 2016) and being convenient for patients (Dinh et al. 2014). There may be considerable resource and infrastructure implications to enable co-location of providers, however, as an appropriate physical site is required to house all referral group providers.

Intentional and unintentional blocks are sometimes seemingly small factors (such as a physician having closed notes) that may have a large impact on downstream workflow and patient experience. This feature is a characteristic of complex adaptive systems (Begun et al. 2003), where actions of individuals in the system “are interconnected so that one’s actions changes the context for others” (Plesk and Greenhalgh 2001, p. 625).

Although this study did not formally explore the phenomenon of interest through a complexity lens, this approach should be considered for future research on teaming and patient-centred care, aligning with a growing literature conceptualizing health-care systems as complex adaptive systems (Tsasis et al. 2012; Martinez-Garcia and Hernández-Lemus 2013; Matlow et al. 2006; Shiel et al. 2008; McDaniel Jr et al. 2009; Sturmberg et al. 2014; Edmondson et al. 2012; Gotlib Conn et al. 2010). It is increasingly being recognized that processes of operationalizing phenomenon such as patient-centred interprofessional teamwork may not be simply following a linear path; rather, it depends on a host of factors at multiple levels that may influence one another in various ways. The proposed framework provides a starting point requiring further investigation in similar and diverse contexts. Work furthering this framework should proceed through a complexity lens, as this acknowledges that novel indicators of patient-centred interprofessional team care may be interconnected, yet obscure, factors. Future work should not only focus on validating the framework, but also designing a companion evaluation tool, including both patient and provider experience and patient health outcome measures.
5.13 Strengths and limitations of this study

This was a qualitative study, with an advantage of having a flexible design (Yin 2009). That flexibility allowed for protocol adaptation throughout the study process. Due to this, multisite FHTs were recruited to participate, which allowed for rich comparison of process in a variety of clinical contexts. That contextual diversity is a strength of this study. Specifically, some providers were able to compare and contrast their experiences while accomplishing a similar task (for example, accessing patient clinical information) within different clinical contexts (such as one that utilized paper-based patient charts compared to one that utilized an EMR). This allowed for increased understanding of how factors such as mechanisms of provider communication were perceived to influence processes of teaming. This may enhance transferability of findings, as readers can identify with various described factors that are relevant to their context.

This study has several limitations. First, this study included three FHTs, none of which were located in a large urban centre. This may limit transferability of findings to FHTs located in larger urban centres. Further, at the time of data collection, recruited FHTs had been operational and seeing patients for between 1.5-2.5 years, which may limit transferability of study findings to more mature FHTs.

At the request of FHT gatekeepers, a list of potential participants (for both patients and providers) were provided to the principal investigator by the FHT contacts. The main concern with this protocol is that although participant selection was based on selection and inclusion criteria set by the principal investigator, it may have been subjected to bias on the part of the FHT contact/gatekeeper. It is possible that the FHT contact or gatekeeper selected participants who they thought would provide responses to the interview questions that were favorable to their FHT. Participants, however, were generally open to sharing both successes and challenges, so the risk of bias was thought to be minimal.

Provider interviews were also restricted to a limited number of days, which meant that only providers that were available on one of those days were interviewed and may not reflect the views of all providers at the FHTs. Although some providers were not included because of the interview date restrictions, provider selection criteria were satisfied as reflected by the wide
range of providers from different professions that were available and included as participants. Therefore, the impact of this limitation was thought to be minimal.

An attempt was made to recruit participants who participated in different clinical contexts. However, patient participants were mainly recruited from clinical contexts where providers were co-located and that used an EMR system. Patients were, however, able to compare past experience (which mirrored features of the other clinical contexts, such as providers not being co-located or providers using a paper-based system) with their current experience at their FHT so the impact of this limitation may be minimal as it was still possible to compare patient experiences across different clinical contexts, although not directly within FHTs. Patient participants did, however, represented a group of educated, higher income individuals, and therefore, their experiences may not reflect those of all patients at the FHTs.

Finally, data for the study was collected in 2008 and 2009, which may limit current relevance of study findings. After a review of recent literature in the field, this issue was discussed at length with the thesis supervisor and committee, and it was agreed that key study findings were still relevant in the current healthcare context.

5.14 Concluding remarks

In closing, patient-centred care in an interprofessional primary health-care team context is broader than meeting the wants, needs and preferences of patients. As this study suggests, the patient experience of care may be influenced by the interactions and relationships between providers and by the context in which these interactions occur. This study makes a valuable contribution to the integrated field of patient-centred interprofessional teamwork in primary care.
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Appendices
Appendix 1: Study Information Sheet – Clinic Director/Contact Person

Title of Research Project:
Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context

Dear Madam or Sir:

I am writing to ask for your help. I am a student at the University of Toronto conducting a qualitative study exploring the views of patients and health care providers on patient-centred care in inter-professional primary health care teams for my PhD thesis. I would like to talk to you about my study and discuss the participation of your clinic.

What is the purpose of the study?
The purpose of this study is to explore what patient-centred care could look like in an inter-professional primary health care team and how it can be achieved. This project is the thesis requirement for my PhD.
When and where will the study take place? 24
The study will take place at Family health Teams (FHTs), Community Health Centred (CHCs) and Private Inter-professional Primary Health Care Teams (PCs) located in the Greater Toronto Area. Data for the study will be collected between August 2007 and August 2008. 25

Who is being asked to take part and what will they do?
Health care providers working in your clinic and patients attending your clinic will be asked to participate in this study.

I am looking for approximately three to five health care providers from different professions who have been working at your clinic for at least six months. Health care providers will be asked to describe how they envision patient-centred care in their inter-professional team environment and what factors affect their ability to be patient-centred. Each provider will take part in an individual interview lasting about 40-60 minutes conducted by the principal investigator. Further, I will be sending a questionnaire to all

24 Initially, there were some challenges with FHT recruitment so an ethics amendment (appendix 20) was submitted to include Community Health Centres (CHCs) and private clinics. The clinic director study information sheet reflects this amendment. However, 3 FHTs were recruited right after the ethics amendment approval so there was no need to recruit CHCs or private clinics and therefore the original protocol was followed.

25 The data collection completion date changed as it took longer to recruit FHTs than expected.
health care providers at your clinic asking them about collaborative practice at the clinic.26

Patients attending your clinic will also be asked to participate in this study. I am looking for patients, 18 years old or older, who have had consultations with at least two health care providers from different professions at your clinic for the same or a related health concern in the past three months. Patients will be asked to describe how they experience team care at the clinic and what their preferences are toward, for example, participating in decision-making regarding their care.

What is being requested of you?

I am asking you to give formal consent, on behalf your clinic, to participate in this study. I am also requesting your permission to invite health care providers working at your clinic and patients attending your clinic to participate in this study. In addition, I am asking you to fill out a questionnaire to provide background information about your clinic.

What are the risks and benefits of the study?

The study has minimal risk. Participation is voluntary, participants are not required to answer any questions they do not want to and participation or non-participation will not have any affect on individuals’ professional or personal lives.

26 The provider questionnaire assumed that a provider practiced out of one clinical context and therefore was determined not to be appropriate for providers practicing out of two or more clinical contexts within a FHT and was therefore not used.
The study may benefit participants by allowing them to share their feelings about their experiences participating in a primary health care team. A summary of the results of the study will be distributed to all interested participants, which will provide information to them about experiences in similar clinical environments.

**Is the study confidential?**

The decision to participate or not is voluntary and participants can withdraw from the study at any time. All the information collected will be kept strictly confidential. The names of participants will not be used at any stage of the research. Each participant will be identified by a unique study identifier code to ensure privacy and the names of persons identified in interviews will be removed from the transcriptions. All data will be kept on a secure computer and access to the computer will be by use of specific passwords known only to the principal investigator and her supervisor. The completed interview schedules, transcriptions and audiotapes will be stored in a secure, locked cabinet. No information will be released or printed that would disclose any personal identity.

Complete anonymity about participating in this study cannot be guaranteed particularly if interviews take place at the clinic since it is possible for others in the clinic to be aware of an individual’s participation in the study. All participants will be offered the opportunity to be interviewed at a location away from the clinic if desired or by telephone.

The identities of the participating clinics will not be revealed.

**Will there be any compensation for participating in this study?**

There will not be any compensation for your clinic’s participation in this study. Participants consenting to interviews will be compensated for reasonable travel expenses incurred to attend the interview.

**Can I see the final report from the study?**

You may request a copy of the final report from the principal investigator.
What are the rights of participants?
If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by email: jc.parsons@utoronto.ca

Please keep the information letter and a copy of the informed consent for your own records.

Your clinic is important to the study. We hope that you and your team will agree to take part. You will be contacted in approximately one week by the principal investigator to discuss your clinic interest in participating, to request additional information regarding the practitioners at your clinic and to answer any questions or address any concerns that you may have about the study.

If you do choose to participate in this study, a consent form and questionnaire will be sent to you and picked up by the principal investigator at a time that is convenient for you.

Yours sincerely,

Heidi Amernic
Principal Investigator
PhD candidate
Department of Health Policy, Management and Evaluation
Faculty of Medicine
University of Toronto
heidi.amernic@utoronto.ca
Tel: 905-764-9943
Fax: 416-978-1833
Appendix 2: Telephone Script for Clinic Director/Contact Person

**Telephone Script for Clinic Director/Contact Person**

Hi __________.

My name is Heidi Amernic and I am a PhD candidate at the University of Toronto. I recently sent you a letter describing a project that I am conducting for my PhD thesis looking at patient-centredness in inter-professional primary health care teams. I am calling today to follow-up with you to see if your Family Health Team (FHT) would be interested in participating in my study.

**If YES:**

I just have a couple of questions to ask you regarding your FHT to see if you meet our criteria to participate:

1. How long has your FHT been in operation?
   - If they have been in operation for twelve months or more, continue to questions #2;
   - If they have been in operation for less than twelve months say: “We are looking for FHTs that have been in operation for twelve months or more. Thank you very much for your consideration”

2. How many providers work in your FHT? Are they co-located?
   - If they are a team practice with less than 3 different types of providers, say: “We are looking for teams with three or more types of providers so unfortunately your team does not meet our criteria. Thank you very much for your consideration”;
   - If they are a team practice with 3 or more different types of providers all co-located, continue to question #3;

3. What types of health care providers work in your clinic/practice?
   - If they have a mix of provider(s) unique from other clinics already in the study, continue with script;
- If they do not have a mix of provider(s) unique from other clinics already in the study say: “We are looking for teams with different types of health care providers and we have already recruited another team with the same mix of providers as your clinic. Thank you very much for your consideration”.

Thank you for expressing interest in my study. I will be sending you a consent form and questionnaire in the next couple of days. The questionnaire includes space for entering all the names and contact information of the health care providers at your FHT. Would you prefer me to send it by post mail, fax, or email? Could you please suggest a convenient time when I could come and pick these up?

**If NO:**

Thank you for your time and for considering participating in my study. If you don’t mind, could you please let me know why your FHT is unable to participate?

Do you have any questions for me at this time? Do you have any concerns that you would like me to address?

Thank you
Appendix 3: Questionnaire for Clinic Director/Contact Person

Title of Research Project:
Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context

Principal Investigator:
Heidi Amernic
PhD candidate
Department of Health Policy, Management and Evaluation
Faculty of Medicine
University of Toronto
heidi.amernic@utoronto.ca
Tel: 416-946-7840
Fax: 416-978-1833

Clinic Questionnaire

I. CLINIC DEMOGRAPHICS
Please provide the following information about your clinic:

1. Are you a27:
   - Family Health Team (FHT); approximate date approved by Ministry: ______
   - Community Health Centre (CHC); approximate date approved by Ministry: ______
   - Other: ________________________________

2. Approximate date clinic became operational (started accepting patients):
   ____________ (month/year)

3. Which governance type applies to your clinic?
   - n/a
   - Community-based group
   - Provider-led group
   - Mixed provider/community group
   - Other: ________________________________

4. Would you be willing to share any of the following documentation (if applicable) with me as part of this research project?
   a) Intake forms
      - No
      - Yes
      - N/A

27 Initially, there were some challenges with FHT recruitment so an ethics amendment (appendix 20) was submitted to include Community Health Centres (CHCs) and private clinics. The clinic questionnaire reflects this amendment. However, 3 FHTs were recruited right after the ethics amendment approval so there was no need to recruit CHCs or private clinics and therefore the original protocol was followed.
b) Referral forms  
- No  
- Yes  
- N/A

II. PATIENT INFORMATION

5. Please describe specific characteristics (if any) unique to your catchment area and to your clinics patient population (e.g., large geriatric population; large diabetic population).
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

III. CLINIC OPERATIONS

6. Does your clinic have an in-house referral process by which patients are seen by (or move between) different practitioners within the clinic? (For example, formal referral letters)
   - No  
   - Yes, please explain________________________________________
     ___________________________________________________________
     ___________________________________________________________
     ___________________________________________________________
     ___________________________________________________________
     ___________________________________________________________
7. a) Do all practitioners working at the clinic use a single, shared patient chart for documentation?
   - [ ] No
   - [ ] Yes
   - [ ] Sometimes

   Please explain.
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

b) Do you use electronic chart/electronic patient records at the clinic?
   - [ ] No
   - [ ] Yes

8. Does your clinic have a structured intake process? (i.e., is there a formal process to determine which providers a new patient should initially see?)
   - [ ] No
   - [ ] Yes

   If yes, please explain:
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

9. How much do the providers participate in the decisions concerning the operation of the clinic (e.g., clinic policy, evaluation mechanisms)? (please circle)
Very little   A great deal

_________________________

1  2  3  4  5

IV. HEALTH CARE PROVIDER INFORMATION

10. Please enter how many of each provider type is working at your clinic:
   a) Medical doctor: 
   b) Nurse practitioner: 
   c) Registered nurse: 
   d) Pharmacist: 
   e) Mental health/addictions worker: 
   f) Dietitian: 
   g) Social Worker: 
   h) Registered practical nurse: 
   i) Midwife: 
   j) Chiropodist/podiatrist: 
   k) Occupational therapist: 
   l) Chiropractor: 
   m) Physiotherapist: 
   n) Other (please describe): 
   o) Other (please describe):

11. Please provide the following information about the health care providers working at your clinic:

   Total number of health care providers working at your clinic: 

*If you need additional space, please attach extra page(s)

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Profession (include specialty if applicable, for example: medical doctor – pediatrics)</th>
<th>Approximately how many hours do they work there per week?</th>
<th>Do they see patients on-site?</th>
<th>Contact information (phone number and/or email, etc.)</th>
<th>May we contact this provider?</th>
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12. In the next year, are you considering:
a) expanding your clinic’s services?
   - No
   - Yes, please explain
     __________________________________________
     __________________________________________
     __________________________________________

b) decreasing any of your clinic’s services?
   - No
   - Yes, please explain
     __________________________________________
     __________________________________________
     __________________________________________
     __________________________________________

Thank you very much for filling out the questionnaire. If you have any questions or concerns, please contact the number at the top of page 1.
Appendix 4: Clinic Director/Contact Person Consent Form

University of Toronto

CLINIC DIRECTOR/CONTACT PERSON CONSENT FORM

Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context

I have read the accompanying letter of information, have had the nature of the study explained to me and all questions have been answered to my satisfaction.

I agree to (please check all that apply):

☐ Let the principal investigator, Heidi Amernic, contact the health care providers working at my clinic.

☐ Let the principal investigator, Heidi Amernic, distribute a questionnaire on collaborative practice to health care providers working at my clinic  

☐ Let the principal investigator, Heidi Amernic advertise the study to patients at my clinic (posters, brochures and information packages)

28 The provider questionnaire assumed that a provider practiced out of one clinical context and therefore was determined not to be appropriate for providers practicing out of two or more clinical contexts within a FHT and was therefore not used.
Let the principal investigator, Heidi Amernic, provide information and answer questions regarding the study to patients in the waiting room of my clinic for the purpose of recruitment in the study.

Complete a questionnaire providing background information on our clinic.

I understand that the study will be conducted by the principal investigator, Heidi Amernic, a PhD candidate in the Department of Health Policy, Management and Evaluation at the University of Toronto, and that this study is her thesis requirement for her degree.

I understand that participation of my clinic in this study is voluntary and I have the right to withdraw our participation at any time during the course of this study with no adverse consequences.

DATE: _____/_____/_____(to be dated by clinic director/contact person)
    day month year

SIGNATURE OF CLINIC DIRECTOR/CONTACT PERSON: _______________________

PRINTED NAME OF CLINIC DIRECTOR/CONTACT PERSON: _______________________

DATE: _____/_____/_____(to be dated by principal investigator)
    day month year

SIGNATURE OF PRINCIPAL INVESTIGATOR: _______________________
Appendix 5: Study Information Sheet – Health Care Providers

University of Toronto

Study Information Sheet – Health Care Providers

Research Project: Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context.

Dear Sir or Madam:

I am writing to ask for your help. I am conducting a qualitative study exploring the views of patients and health care providers on patient-centred care in inter-professional primary health care teams for my PhD thesis. The Director/contact of your clinic has already been informed of the study and is aware that I am sending you this letter. I would like to talk to you about my study and discuss your participation.

What is the purpose of the study?
The purpose of the study is to explore what patient-centred care could look like in an inter-professional primary health care team and how it can be achieved. This project is the thesis requirement for my PhD.
When and where will the study take place?\(^{29}\)

The study will take place at Family Health Teams (FHTs), Community Health Centres (CHCs), and private primary health care team clinics (PCs) located in the Greater Toronto Area. Data for the study will be collected between August 2007 and August 2008.\(^{30}\)

Who is being asked to take part and what will they do?

Health care providers such as yourself will be asked to participate in this study. I am looking for approximately three to five health care providers from different professions who have been working at your clinic for at least six months. Health care providers will be asked to describe how they envision patient-centred care in their inter-professional team environment and what factors affect their ability to be patient-centred. Each provider will take part in an individual interview lasting about 40-60 minutes conducted by the principal investigator.

Your interview will be audio-recorded. You will also be asked to fill out a questionnaire asking about collaboration at your clinic.\(^{31}\)

---

\(^{29}\) Initially, there were some challenges with FHT recruitment so an ethics amendment (appendix 20) was submitted to include Community Health Centres (CHCs) and private clinics. The provider study information sheet reflects this amendment. However, 3 FHTs were recruited right after the ethics amendment approval so there was no need to recruit CHCs or private clinics and therefore the original protocol was followed.

\(^{30}\) The data collection completion date changed as it took longer to recruit FHTs than expected.

\(^{31}\) The provider questionnaire assumed that a provider practiced out of one clinical context and therefore was determined not to be appropriate for providers practicing out of two or more clinical contexts within a FHT and was therefore not used.
Patients attending your clinic will also be asked to participate in this study. I am looking for patients, 18 years old or older, who have had consultations with at least two health care providers from different professions at your clinic for the same or related health concern in the past three months. Patients will be asked to describe how they experience team care at the clinic and what their preferences are toward, for example, participating in decision-making regarding their care.

**What are the risks and benefits of the study?**

The study has minimal risk. Participation is voluntary, you are not required to answer any questions they do not want to and participation or non-participation will not have any affect on your professional or personal life. **You have the right to withdraw from this study at any time with no adverse consequences.**

The study may benefit you by allowing you to share your experiences in your work environment and activities. A summary of the results of the study will be distributed to all interested participants, which will provide information about experiences in similar clinical environments.

**Is the study confidential?**

The decision to participate or not is voluntary and participants can withdraw from the study at any time. All the information collected will be kept **strictly confidential.** Your name will not be used at any stage of the research. You will be identified by a unique study identifier code to ensure privacy, and the names of persons identified in interviews will be removed from the transcriptions. All data will be kept on a secure computer and access to the computer will be by use of specific passwords known only to myself and my supervisor. The completed interview schedules, transcriptions and audiotapes will be stored in a secure, locked cabinet. No information will be released or printed that would disclose any personal identity.
Quotations from interview transcripts may be used in the final report. To ensure confidentiality, no names or identifying information will be presented with the quotations. The final report may be submitted for publication in a peer-reviewed journal.

Complete anonymity about participating in this study cannot be guaranteed particularly if interviews take place at the clinic since it is possible for others in the clinic to be aware of your participation in the study. Thus you may request an interview at a location away from the clinic if you wish.

The identities of the participating clinics will not be revealed.

What if something new comes up during the study that may affect my participation?
If anything comes to light during the course of this research which may influence your decision to continue, you will be notified.

Will I be compensated for participating in this study?
You will not be compensated for your participation.

What are my rights as a participant?

If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by email: jc.parsons@utoronto.ca

Your participation is important to the study. I hope that you will agree to take part. I will contact you in approximately one week to discuss your participation and to answer any questions or address any concerns that you may have about the study.

Please keep the information sheet and a copy of the informed consent for your own records.
Yours sincerely,

Heidi Amernic  
Principal Investigator  
PhD candidate  
Department of Health Policy, Management and Evaluation  
Faculty of Medicine  
University of Toronto 
heidi.amernic@utoronto.ca  
Tel: 905-764-9943  
Fax: 416-978-1833
Appendix 6: Health Care Provider Consent Form

University of Toronto

HEALTH CARE PROVIDER CONSENT FORM

Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context

I have read the accompanying letter of information, have had the nature of the study explained to me, and I agree to participate in the study described. All questions have been answered to my satisfaction.

I understand that I will be interviewed by the principal investigator, Heidi Amernic, a PhD candidate in the Department of Health Policy, Management and Evaluation at the University of Toronto, and that this study is her thesis requirement for her degree.

I understand that my interview will last approximately 40 minutes to one hour and that it will be audio-recorded.

I understand that any information I provide for the study is strictly confidential and that I will only be identified by a unique code that will only be accessible to the principal investigator and her thesis supervisor. All audio files will be stored on a password-protected computer and transcripts from this study will be stored in a locked cabinet at The University of Toronto. Any identifying names or information will be removed from the interview transcripts.
I understand that complete anonymity about participating in this study cannot be guaranteed particularly if interviews take place at the clinic site since it is possible for others in the clinic to be aware of my participation in the study. I have the right to request the interview at an alternate location.

I understand that my participation in this study is voluntary and that I have the right to withdraw at any time.

DATE: _____/_____/_____ (to be dated by practitioner)
   day    month    year

SIGNATURE OF PRACTITIONER: __________________________

PRINTED NAME OF PRACTITIONER: __________________________

Consent for audio-recording:

I consent to audio-recording of the interview

SIGNATURE OF PRACTITIONER: __________________________

DATE: _____/_____/_____ (to be dated by practitioner)

DATE: _____/_____/_____ (to be dated by principal investigator)
   day    month    year

SIGNATURE OF PRINCIPAL INVESTIGATOR: __________________________
Appendix 7: Information Script for Patients

Script for Patients

Hi ________,

My name is Heidi Amernic and I am a PhD candidate at the University of Toronto. I am conducting a project for my PhD thesis looking at the care experience of patients in primary health care team clinics such as this one. I would like to tell you a bit about my study and I am hoping that you might be interested in participating.32

This study will look at patients’ experience of care at their primary health care clinic. Participants will be invited to participate in a telephone interview lasting approximately 40-60 minutes scheduled at a time that is convenient for them.

We are looking for people who have been attending this clinic for at least six months, who have seen at least two health care providers from this clinic for the same (or related) health concern in the past two months. For example, someone with diabetes may have seen both their medical doctor and dietician for diabetes care), and who are at least 18 years old. If you meet these criteria and are interested in participating in the study, we would welcome your help.

Here is an information package describing my study (hand the patient information package). Included in this package is an information letter describing the study, a short

32 If clinic reception staff person is recruiting, paragraph one would change to the following: “Heidi Amernic is a PhD candidate at the University of Toronto who is conducting a project for her PhD thesis looking at the care experience of patients in Family Health Teams. Can I give you some information on the study to see if you might be interested in participating?”
questionnaire and a consent form for you to look over. Here is my contact information (point out contact information on information sheet). Please feel free to call me if you have any questions or are interested in participating and we can arrange a date and time for the telephone interview.

Thank you!
Appendix 8: Study Information Sheet - Patients

Study Information Sheet – Patients

Research Project: Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context.

Dear Sir or Madam:

I am writing to ask for your help. I am conducting a study exploring the views of patients and health care providers on their care experience in Primary Health Care Teams for my PhD thesis. Your health care clinic has already been informed of the study and is aware of this letter.

When and where will the study take place?33

The study will take place at Family Health Teams (FHTs), Community Health Centres (CHCs), and Private Primary Health Care Team Clinics (PCs) located in the Greater

33 Initially, there were some challenges with FHT recruitment so an ethics amendment (appendix 20) was submitted to include Community Health Centres (CHCs) and private clinics. The patient study information sheet reflects this amendment. However, 3 FHTs were recruited right after the ethics amendment approval so there was no need to recruit CHCs or private clinics and therefore the original protocol was followed.
Toronto Area. Data for the study will be collected between August 2007 and August 2008.\textsuperscript{34}

\textbf{Who is being asked to take part and what will they do?}

Individuals such as yourself who are patients at a Primary Health Care Team Clinic will be asked to participate in this study. In order to participate, you must be 18 years or older and must have seen at least two health care providers from this clinic in the past three months for the same or related health concern. You will be asked to describe how you experience care at this clinic and what your preferences are toward, for example, participating in decision-making regarding your care.

You will be asked to take part in an individual interview by telephone lasting about 40-60 minutes conducted by the principal investigator Heidi Amernic. The interview will be audio-recorded. You will also be asked to fill out a one-page questionnaire asking about yourself (such as age, gender,).

\textbf{What are the risks and benefits of the study?}

The study has minimal risk. Participation is voluntary, you are not required to answer any questions they do not want to and participation or non-participation will not have any affect on your health care. \textbf{You have the right to withdraw from this study at any time with no adverse consequences.}

The study may benefit you by allowing you to share your experiences in your health care environment. A summary of the results of the study will be distributed to all interested

\textsuperscript{34} The data collection completion date changed as it took longer to recruit FHTs than expected.
participants, which will provide information about experiences in similar clinical environments.

**Is the study confidential?**
The decision to participate or not is voluntary and participants can withdraw from the study at any time. All the information collected will be kept strictly confidential. Your name will not be used at any stage of the research. You will be identified by a unique study identifier code to ensure privacy, and the names of persons identified in interviews will be removed from the transcriptions. All data will be kept on a secure computer and access to the computer will be by use of specific passwords known only to myself and my supervisor. The completed interview schedules, and transcriptions will be stored in a secure, locked cabinet. No information will be released or printed that would disclose any personal identity. Your health care providers will not be informed of your participation.

Quotations from interview transcripts may be used in the final report. To ensure confidentiality, no names or identifying information will be presented with the quotations. The final report may be submitted for publication in a peer-reviewed journal.

**What if something new comes up during the study that may affect my participation?**
If anything comes to light during the course of this research which may influence your decision to continue, you will be notified.

**Will I be compensated for participating in this study?**
You will not be compensated for your participation.

**What are my rights as a participant?**

If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by email: jc.parsons@utoronto.ca
Your participation is important to the study. I hope that you will agree to take part. **If you are interested in participating or have any questions about the study please contact Heidi Amernic at 416-946-7840 or heidi.amernic@utoronto.ca**

Please keep the information sheet and a copy of the informed consent for your own records.

Yours sincerely,

Heidi Amernic  
Principal Investigator  
PhD candidate  
Department of Health Policy, Management and Evaluation  
Faculty of Medicine  
University of Toronto  
heidi.amernic@utoronto.ca  
Tel: 416-946-7840  
Fax: 416-978-1833
Appendix 9: Patient Consent Form

University of Toronto

PATIENT CONSENT FORM

Exploring Perceptions of Patient-Centred Care in an Inter-professional Primary Health Care Team Context

I have read the accompanying letter of information, have had the nature of the study explained to me to my satisfaction, and I agree to participate in the study described. All questions have been answered to my satisfaction.

I understand that I will be interviewed by telephone by the principal investigator, Heidi Amernic, a PhD candidate in the Department of Health Policy, Management and Evaluation at the University of Toronto, and that this study is her thesis requirement for her degree.

I understand that my interview will last approximately 40 minutes to one hour and that it will be audio-recorded.

I understand that any information I provide for the study is strictly confidential and that I will only be identified by a unique code that will only be accessible to the principal investigator and her thesis supervisor. All audio files will be stored on a password-protected computer and transcripts from this study will be stored in a locked cabinet at The University of Toronto and any identifying names or information will be removed from the interview transcripts.

Heidi Amernic, principal investigator
Heidi.amernic@utoronto.ca
Tel: 905-764-9943
Fax: 416-978-1833

Dr. Heather Boon, thesis supervisor
heather.boon@utoronto.ca
Tel: 416-946-5859
Fax: 416-978-1833
I understand that complete anonymity about participating in this study cannot be guaranteed.

I understand that my participation in this study is voluntary and that I have the right to withdraw at any time.

If you have questions about your rights as a research participant, please contact Jill Parsons, Health Sciences Ethics Review Officer, Ethics Review Office, University of Toronto, at telephone 416-946-5806 or by email: jc.parsons@utoronto.ca

DATE: _____/_____/_____ (to be dated by participant)

day   month    year

SIGNATURE OF PARTICIPANT: __________________________

PRINTED NAME OF PARTICIPANT: __________________________

Consent for audio-taping:

I consent to the audio-taping of the interview

SIGNATURE OF PARTICIPANT: __________________________

DATE: _____/_____/_____ (to be dated by principal investigator)

day   month    year

SIGNATURE OF PRINCIPAL INVESTIGATOR: __________________________
Appendix 10: Patient Recruitment Script

Patient Recruitment Script\textsuperscript{35}

Hello _________, I appreciate your interest in this study,

This study will look at patients’ experience of care at their Family Health Teams. You will be invited to participate in a telephone interview lasting approximately 40-60 minutes scheduled at a date and time that is convenient for you.

I am looking for people who have been attending the Family Health Team for at least six months. How long have you been a patient at this Family Health Team?

- If less than 6 months, say: “Unfortunately we are only looking for individuals who have been attending this clinic for at least 6 months or longer, thank you very much for your consideration”
- If 6 months or longer, continue with script

How many different health care providers do you see at this clinic?

- If only one provider, say: “Unfortunately we are only looking for individuals who have seen two or more providers at this Family Health Team, thank you very much for your consideration”
- If 2 or more providers, continue with script

Have you seen more than one provider for the same or related health concern in the past two months at this Family Health Team? (if they want an example, can say: for example, ________________)

\textsuperscript{35} Wording will be adjusted accordingly for email correspondence

Heidi Amernic, principal investigator
Heidi.amernic@utoronto.ca
Tel: 905-764-9943
Fax: 416-978-1833

Dr. Heather Boon, thesis supervisor
heather.boon@utoronto.ca
Tel: 416-946-5859
Fax: 416-978-1833
someone with diabetes may have seen both their medical doctor and dietician for diabetes care)

- If they have not seen more than one provider for a common health concern say: “Unfortunately we are only looking for individuals who have seen more than one health care provider from this Family Health Team for a common health concern, thank you very much for your consideration”
- If they have seen more than one provider for a common health concern, continue with script

If the principal investigator is not confident of their age say: “Are you 18 years or older?

- If under 18 years say: “Unfortunately we are only looking for individuals who are 18 years or older, thank you very much for you consideration”
- If 18 years or older, continue with script

Thank you for your interest in participating. The interview will last approximately 40 minutes to one hour in length. Can we arrange a date/time for the interview that is convenient for you? Would you prefer to call me or have me call you? May I have your telephone number?
Appendix 11: Provider Interview Guide

*ask for examples

1. Could you talk a bit about how this Family Health Team works?
   a. What is your role on the team?
   b. Do you see patients together with other providers?

2. How do you communicate with other providers re: common patients? EMR?
   Hallway chats?
   a. How are patients referred to other providers? Example?
   b. How is it decided which providers a particular patient should see? Example?

3. (if applicable) Can you tell me a bit about how the EMR system works?
   a. When do you have time to review patient charts?
   b. Compared to previous experience/paper charts – what are advantages/disadvantages?

4. (if applicable) How many FHT sites do you practice out of?
   a. Do you think it makes a difference to have all providers co-located?
      Why/why not?
   b. Is each site like a separate ‘team’ or all one big team?
   c. How is communication achieved between sites? What about referrals?
   d. What are some advantages/disadvantages to practicing out of/having multiple sites?

5. Have you had previous experience practicing in another setting?
   a. What was that like?
   b. How was it different from practicing in the FHT setting?

6. What does good care look like? In a team? Is it different from solo practice?

7. How would you describe the style of care that the FHT is trying to provide? Please explain.
   a. …everyone keeps using that term…what does it mean?
   b. …can you give me an example?
8. (if it doesn’t come up in question 7) A lot of people are talking about patient centred care…what does it mean to you? What would it include?
   a. Is this a term that would be appropriate to use to describe your FHT or is another term better? Why? Please explain. Is it a goal of the clinic?
   b. Can you give me an example of what would be an ideal ‘patient centred’ team experience for a patient?
   c. Is patient centred care different in a team than in solo practice? Please explain.
9. Can any type of provider work in a team setting or does it take a certain type of person? Please explain
   a. Can it be taught?
10. How do you learn to work together as a team?
11. Are patients considered members of the team here? Please explain.
12. What is your experience with patients wanting to be involved in the decision-making regarding their care? Examples?
   a. How does this work?
   b. What are your expectations as a provider for patients being involved in the decision making regarding their care? Why?
   c. How do you know how much involvement a patient wants?
   d. What are barriers/facilitators to this?
13. (if it hasn’t come up already) what does holistic care mean to you?
   a. Relationship to patient centred care?
   b. Can you have one without the other? (…the provider inquiring about the patient’s unique experience of illness, understanding of the whole person including mental/emotional aspects, family life, stress, etc.)
14. How would you know if a patient was satisfied with his/her care?
15. How would you know if a patient felt that his/her encounter with the team was patient centred? How would you know if a provider felt it was?
16. How should we measure patient centred care? What would be some good questions to ask patients and providers?

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17. Is there anything else that would make your experience with this team better?
18. Any questions that I haven’t asked that you wish that I would?

**Demographic questions:**
1. Health care profession
2. Specialty
3. How long have been seeing patients at this FHT?
4. Year received license to practice?
5. How often do you practice at this site(s)
6. How are you compensated for your time at the FHT?
7. Gender
8. Age: (under 25, 25-29, 30-39, 40-49, 50-59, 60+)
Appendix 12: Patient Interview Guide

*ask for examples

1. *Read consent form
2. When did you first start coming to the Family Health Team?
3. How many different providers have you seen at the FHT?
4. Maybe you could describe a situation when you saw more than one provider for a related health concern.
   a. Describe the process of how you were referred from one provider to another
   b. How was the referral decided? Discussion? Your request? Joint decision?
   c. Did you have to go back to your doctor for the referral? Please explain.
   d. How are your goals for treatment discussed?
5. Who would you consider is on your personal health care team?
6. Is there one provider that you would consider your main provider at this FHT?
   a. Who do you discuss treatment plans/goals with?
   b. If you have questions, who do you go to?
7. Do your health care providers use a computer during the visit?
   a. Tell me about how the computer is used during the visit
   b. Advantages/disadvantages to computer?
   c. Compared to past experience?
   d. How do you feel about all your providers having access to your chart?
8. Some people have told me that when they see a new provider, they had to repeat a lot of information – what is your experience here when you see a new provider?
9. Some people have said that they like to have a very active role in the direction of their care, and some don’t – how do you feel about it? Why? Example?
   a. How did you decide what role you wanted?
   b. Compared to past experience? Examples?
10. Are all of your providers in one location?
a. What is it like having all your providers in the same location/different location? Compared to past experience? Please explain/example.

11. What do you think about having all these providers available?

12. How would you describe the type of care the FHT provides? Please explain.

13. Do you feel that you have a team of health care providers here or a bunch of individual health care providers?
   a. Do you feel that you are part of a team here? What is your role?
   b. How is this experience the same or different than before you attending this Family Health Team?

14. What are your expectations of this team regarding your care?
   a. Have they been met? Why/why not?

15. Do any of your health care providers at the FHT ask about aspects of your health other than physical symptoms (e.g., how they experience illness, family life, support systems, etc.)?
   a. How is this addressed in your care?
   b. How satisfied are you with this aspect of your care? Why?

16. Is there anything you would like to change about your care here? Specific examples?

17. Is there anything else that would make your experience with this team better? Specific examples?

18. Do you have any questions for me?

19. Demographic questions
   a. Age (under 18; 18-29; 30-39; 40-49; 50-59; 60+)
   b. Education (public school 1-8; high school 9-13; apprenticeship; college/university)
   c. Marital status
   d. Household income (less than 30,000; 30-59,999; 60-89,000; 90+)
Appendix 13: Coding Tree
## Appendix 14: Code Definitions

### TEAM CARE

#### Patient: Codes related to patient care and experience

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient education/empower</td>
</tr>
</tbody>
</table>
| 2.   | Access | a) **Holistic**: access to all types of providers ‘to address all needs of patient – holistic care’  

   b) **Coordination**: appointments with different providers are coordinated – e.g. can see them back to back; can see them in same location (one-stop shop); minimal wait times, etc. – ‘have access to coordinated care’  

| 3.   | Patient control/decision-making | Patient is in control of their health care including decision-making regarding the direction of their care. Patient is involved in the decision making of their care – they have choice. |
| 4.   | Patient role | Patients role in their care – can be as a member of the team, role in decision-making regarding their care; control over their care; preferring not to participate in the decisions regarding their care, etc. |
| 5.   | Addressing patient individual needs (meeting patient needs) | Treating the patient as an individual; addressing the unique needs of the patient through individualized care. Can also refer to demographic characteristics that may contribute to the preferences of each patient regarding aspects of their care (e.g. whether they want to participate in decision-making) |

#### Provider: Codes related to provider process and experience

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Education/training</td>
</tr>
</tbody>
</table>
| 2.   | Communication | a) **Communication general**: anything to do with communication that doesn’t fit in nodes below  

   b) **Informal communication**: hallway discussions, unscheduled meetings, etc.  

   c) **Electronic charts**: anything to do with electronic communication about patients, electronic medical records, etc.  

   i. **Booking appointments/referrals**: anything related to using the EMR to book appointments or make referrals to other providers  

   ii. **Communication bwn providers**: can refer to the EMR being a ‘simple/easy way to communicate’, or anything related to instant messaging bwn providers, how they communicate with each other about common patients (through EMR), etc.  

   iii. **Comparison to other charting**: comparing the EMR to previous methods of charting  

   iv. **Confidentiality**: from patients perspective=any issues around all their providers having access to their information; from providers perspective=any issue around other providers having access to their patient information, etc.  

   v. **Describing system**: describing how the EMR works; describing how they use it, processes related to using the EMR system, etc.  

   vi. **(Instant) access to info**: easy access to patient information, fast/instant access to patient information; also includes being able to do instant searches for information  

   vii. **Learning curve**: the process of learning how to use the EMR – how it was to switch from old charting methods, etc.  

   viii. **Limitations**: limitations to EMR system; what they wish it had
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ix.</td>
<td>Misc: anything that doesn’t fit anywhere else; can include praise for EMR system</td>
</tr>
<tr>
<td>x.</td>
<td>Paper trail-organized: includes comments about the EMR creating better organization, a easy to find record of events (‘paper trail’); also includes reminders to self to follow up on things (organized!); includes data management comments</td>
</tr>
<tr>
<td>xi.</td>
<td>Patient expectations/knowledge of EMR: are patients aware of EMR and that all their providers share information? Also includes what patients expect from their providers now that they have access to the EMR (is it different?) – e.g. do patients expect their providers to be caught up to date/have read everything on their e-chart before the visit?</td>
</tr>
<tr>
<td>xii.</td>
<td>Providers awareness of appointments: providers being aware of their patients appointments with other providers because of the EMR (maybe combine with instant access to info??)</td>
</tr>
<tr>
<td>xiii.</td>
<td>Remote access: for travelling providers – having access (or not) at each location; having access from home; having access from solo providers office, etc.</td>
</tr>
<tr>
<td>xiv.</td>
<td>Repeat: anything to do with whether or not patients have to repeat themselves to different providers who are on EMR</td>
</tr>
<tr>
<td>xv.</td>
<td>Reviewing chart: do providers have time to review chart before patient visits? When do they review charts?</td>
</tr>
<tr>
<td>xvi.</td>
<td>Safety: how the EMR makes practice ‘safer’ – e.g. catches potential drug interactions</td>
</tr>
<tr>
<td>xvii.</td>
<td>Saves time: does EMR save time, make things more efficient? Can be saving time filing, saving time searching for information, saving time from filling out referral forms, etc.</td>
</tr>
<tr>
<td>xviii.</td>
<td>Shared files/common charting: comments related to the fact that providers share a common chart through the EMR</td>
</tr>
<tr>
<td>xix.</td>
<td>Teaching tool: using the EMR as a teaching tool and resource for patients – e.g. show them changes in blood pressure over time</td>
</tr>
<tr>
<td>xx.</td>
<td>Typing during visit: maybe this should be with limitations??</td>
</tr>
<tr>
<td>d)</td>
<td>Referrals: process of referring patients from provider to provider; patterns of referrals, etc.</td>
</tr>
</tbody>
</table>
e) | Formal team meetings: anything about formalized/pre-arranged team meeting |

### 3. Barriers/ facilitators

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Building relationships: providers getting to know each other professionally and personally. Can include anything to do with this process.</td>
</tr>
<tr>
<td>b)</td>
<td>Trust: The value of trust among providers in teams.</td>
</tr>
<tr>
<td>c)</td>
<td>Co-location: Providers working in the same location/clinic site.</td>
</tr>
<tr>
<td>d)</td>
<td>Personality/skill set: Characteristics of providers/clinic staff that are considered essential or detrimental to working in a team environment (e.g. are they controlling? Open to change?)</td>
</tr>
<tr>
<td>e)</td>
<td>Role definition: Team members roles are clearly defined. Can include issues around providers awareness of the roles and expertise of other team members. Issues related to professional boundaries.</td>
</tr>
<tr>
<td>f)</td>
<td>Time: Issues related to time (e.g. enough time to practice how they want?)</td>
</tr>
<tr>
<td>g)</td>
<td>Remuneration: The effect of method of provider/staff payment on teamwork/working together</td>
</tr>
<tr>
<td>h)</td>
<td>Hierarchy: Issues to do with equality of providers in the team. Are all providers considered/respected on the same’ level’? Are some providers more controlling/paternalistic, etc.?</td>
</tr>
<tr>
<td>i)</td>
<td>Liability: Issues related to provider liability and working on a team (e.g. who is ultimately responsible – an individual or the team?)</td>
</tr>
<tr>
<td>j)</td>
<td>Understanding/knowledge of roles: knowing what each other’s profession does. Being aware of other disciplines and when it is appropriate to refer to them.</td>
</tr>
</tbody>
</table>
Understanding of professional boundaries

k) **Physician buy-in/issues**: any issues around physicians not being ‘involved’ in team, not ‘buying in’ to team idea, or ways to improve physician buy-in

l) **Resources**: issues around having/not having access to other resources that would be helpful for the team

m) **Misc**: anything that doesn’t fit in above categories

**Benefits of team: codes related to perceived team benefits**

<table>
<thead>
<tr>
<th>1. Comparing experience</th>
<th>Comparing past clinical experience to current team experience. Describing benefits/issues with each. Can be from provider or patient perspective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Provider benefits</td>
<td>Benefits of team directly related to providers</td>
</tr>
<tr>
<td>3. Patient benefits</td>
<td>Benefits of team directly related to patients</td>
</tr>
<tr>
<td>4. Misc</td>
<td>Any benefits of team practice that do not fit ‘comparing experience’. Can be from provider or patient perspective.</td>
</tr>
</tbody>
</table>

**Goals/vision/model/ shared care**: Includes clinic goals, clinic vision or mission statement, any described ‘model of care’ including ‘shared care’

**Patient-centred care**: How the participant defines patient-centred care

**Holistic care-definition**: How the participant defines holistic care

**FREE NODES**

<table>
<thead>
<tr>
<th>1. Quotes</th>
<th>Any good quotes</th>
</tr>
</thead>
</table>
| 2. **History/demographics of clinics** | a) **General**: Any information describing the history of the clinic – how it started and evolved, etc. Also, how it is changing, what providers are there – any information on the clinic itself  
  b) **Describing roles on team**: Describing the different providers and their roles |
| 3. Outcomes/measure   | Anything to do with measuring outcomes of team care; indicators |
## Appendix 15: Sample Matrix

<table>
<thead>
<tr>
<th>Providers</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNICATION (includes referrals)</strong> overlap with education (with patients)</td>
<td><strong>COMMUNICATION overlap with decision making</strong></td>
</tr>
<tr>
<td>• <strong>Between providers</strong>: easier with EMR PCC (P16)</td>
<td>• Between providers: gives each other updates, can walk over and talk to each other – “love it” CL(Pt15)</td>
</tr>
<tr>
<td>• don’t read email – CL(P14)</td>
<td>• “everybody listens to the patient...takes an interest in you...[friendly] DM(0Pt15)</td>
</tr>
<tr>
<td>• can only communicate within your own ‘team’ – need external electronic access then “it wouldn’t matter where you worked” CL(P17) co-location issues also</td>
<td>• <strong>“He’ll say, well what do you think?</strong> You know, and when he first, the first time he ever did that to me it’s like, whoa, hold on, a doc is actually asking me what I think!...I’m not used to this...I’ve been in shock. I felt like I’m actually, I feel more interested I my treatment and I feel more, um, like I feel in control of my treatment, then the doctor’s the advisor, you know, you’re going to take his opinion but you feel, I would say, you feel more like getting better...I’m involved...and it makes me more inclined to participate in my own recovery.” DM(Pt15)</td>
</tr>
<tr>
<td>• “...there’s still an element of paper trail because we are not all connected...” CL(P16) – paper referrals p9</td>
<td>• <strong>Informed consent</strong>: “…and he’ll sit there and he’ll say, okay, well in this case yes you can, not need the pills or not, you know, or don’t use as much of it, or he’ll sit there and say, well no, you definitely need the medication, you know, you can help the medication by doing this and that and the other, but you have to do it and he explains it...” DM(Pt15)</td>
</tr>
<tr>
<td>• Different versions of netmedication = limiting (P16)</td>
<td>• <strong>Good ex. of teamwork/communication</strong>: EE(Pt15)</td>
</tr>
<tr>
<td>• “...if we were all onsite without the EMR it would still operate as a team.” CL(P16) “...I think the ability to have corridor chats is much more important with the inter-professional part of it because we’re trying to, we’re kind of sharing thoughts and ideas on care and a lot of that stuff is not going to show up in a note anyway.” CL(P16)</td>
<td>• “…the nice think about it is, everybody listens to the patient.” EE(Pt15)</td>
</tr>
<tr>
<td>• Front staff = barrier to communicate with docs CL(P23)</td>
<td>• “...I found out more about what was going on with me and my care and everything than I had ever known before. It was all explained to me, any question I had was explained. It was excellent...they made me feel that it mattered whether they answered my questions or not...huge difference...” EE(Pt10)</td>
</tr>
<tr>
<td>• Part of team vs doctors office CL(P23)</td>
<td>• <strong>Part of the discussion</strong>: “…it made me feel much more that I understood what was going on instead of just something that was way over my head was being talked about and I couldn’t understand it anyway, so,</td>
</tr>
<tr>
<td>• “I really don’t [communicate with providers at other site]...mainly the phone...say can I come see the charts...” CL(P23) also co-location issue</td>
<td>• I was really pleased, it really was a brand new experience for me.” EE(Pt10)</td>
</tr>
<tr>
<td>• Mental health charting separately CL(P20)</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
<tr>
<td>• EMR too expensive for solo provider CL(P20)</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
<tr>
<td>• Should have established means of communication with physicians CL(P18)</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
<tr>
<td>• “…it would be much more functional if every single patient or every single health care provider here had access to every physician’s EMR so that they could interact with the physician pretty seamlessly, um, even off site that could work ok...” CL(P21)</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
<tr>
<td>• “important to get information ahead of time...so can research” IND(P23)</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
<tr>
<td>• “…it’s nice to be able to get other people’s input, especially when it’s</td>
<td>• <strong>Open to questions</strong>: EE(Pt10)</td>
</tr>
</tbody>
</table>
somebody that you know and trust.” AH(P21)

**With patients:** “...they've never been asked the question before...” EE(P16); *EE(P23)

**ACCESS**

- Need designated days and space CL(P16)
- Patients get quicker access to your services AC(P16) – “...a year compared to a week [for mental health services]...” AC(P20); DM(P22); access to services to meet patients needs IND(P18)
- “...wait time since we’ve had the NP has gone down and patients are getting in more quickly...maybe seven days down to two days.” AC(P18)
- Access to providers/expertise bc of being in the team “one stop shopping...much easier to link people up...” AH(P22); AH(P21)

**Co-location:**

- “…the only reason you can be there is that the physician has left for the day so there’s room for you...not going to foster collegiality...” CL(P19)
- Working at multiple locations – “…frenetic...challenging for patients...can only offer them a three hour chunk of time in a week to see them...” CL(P16)
- Advantage of being on site of paper office is get access to charts and doc CL(P16) – if off site of paper office then have to fax and don’t always get what you need – “information gap” p6, also allied health can’t order bloodwork p7
- “…once blood work and orders for that I can do here, I don’t think [co-location] makes a big difference. What will make a difference is the ability to do the quick one-offs that would happen – like a doctor comes by and stays five minutes just to talk to someone about x, y, z. Can’t do that anymore. So that’s a limitation. There’s definitely, the ultimate would be to be in their practice but it was far too frenetic for me, moving all over the place and having three hours here and three hours there and, I don’t know...there’s a lot of teaching tools and stuff that I was lugging around and it was getting bigger and bigger...[and

**Feel ‘listened to’:** EE(Pt12)

- “...they seemed to be on top of what was going on with me and I really like that...” AC(Pt10)
- “…what I really enjoy is they’re all really friendly.” AC(Pt12)

**ACCESS**

- Access to providers – can see NP if minor CL(Pt15)
- “…accessibility...being able to get in touch with them at any time and getting the information or to the person I need to talk to quickly.” AH(Pt12)
- Financial: AC(Pt15); AC(Pt10)
- Less wait time: AC(Pt14); AC(Pt11); AC(Pt12)

**Co-location: (co-location = more ‘compliance’)**

- Saves time CL(Pt15); CL(Pt11) travelling
- “…It’s great because, you can go in there and say listen, I need to see the dietician, the social worker and the doctor and they can look and see if they can schedule all three together.” AC(Pt15)
- “…if I have an issue, if my doctor is actually there then we can get a more quick resolution to an issue or if I’m talking to one person and I get a question that that person can’t answer but my, but let’s say somebody else in the office can answer, then I can be steered in the right direction and I can get, again, a resolution. I don’t have to wait for an appointment. I don’t have to wait weeks or months, I can get a resolution within, you know, depending on what the situation is, I can get a resolution in a couple of days or a couple of hours.” AC(Pt15)
- Can see social worker at any of her offices – flexibility: AC(Pt15)
- “You’re familiar to them. They know your situations and I think you get help a lot quicker.” CL(Pt11)
- Convenient to see everyone under same roof – you are only going to one location – can see all providers one after the other CL(Pt11); *CL(Pt15); CL(Pt16)
- Convenient, don’t have to travel CL(Pt12)
- Great for smaller communities CL(Pt15); CL(Pt10)
- “…the benefits are...if you have everything in one site, they know more or less all your history and so you don’t have to go in and repeat what’s
not having own space, phone, etc]...” CL(P16)
- Have to go early to office to look at charts – time consuming CL(P16)
- Ltd access to charts – respect for time CL(P23)
- Patients could see 2 providers on the same day “…that’s the benefit to being on site…you presence is constantly there reminding them…” CL(P16)
- “…disadvantage to being on-site…[docs have] sense of ownership [think you are not there for them when you are at another site]” CL(P16)
- “…advantages [of being co-located]…being able to speak to the provider right away…downfalls…if I have my day planned…my schedule can be…upside down…” CL(P23)
- “…corridor conversations in hallway…saves time…” CL(P23)
- “…segregation…I really believe it has everything to do with the fact that I’m not there permanently.” CL(P23)
- Meet with colleagues to discuss things CL(P23)
- Financial advantage to being solo practitioner CL(P20)
- Disadvantage to solo – when on holidays, the doc who covers him doesn’t have access to his charts CL(P20)
- “…when people are on site there’s certainly a greater degree of collaboration and I think there’s an increased probability of trusting the relationships being formed…and more referrals because of that.” *CL(P18)
- Can see patients together with doc when co-located CL(P21)
- “…build rapport and…comfort level that really helps the day to day stuff. If you never get that face to face contact, then that’s a real challenge.” CL(P21)
- “…it’s all about relationships…If you know the person and they trust you then everything just works out much better…And that’s why it makes so much more sense to be under the same roof.” CL(P21)

PATIENT AS TEAM MEMBER/ PATIENT TAKING RESPONSIBILITY FOR CARE / PATIENT DECISION MAKING

- *Patients want to be informed before they make decisions – they are the ones in charge – we just give you tools PCC(P17)
- Patient age: PCC(P17); PCC(P21); DM(P20)

PATIENT AS TEAM MEMBER/ DECISION MAKING

- “…it’s very involved, and I love it…I feel more inclined to participate…if there’s something he [doc] suggests, I’m going to be more inclined to do that…” PR(Pt15)
- “I like to be involved, I like to know everything that’s going on…” PR(Pt16)
- Checking in with patients to see if plan is ok – but if acute, more serious condition, then “here is medication and here is why” DM(P17)
- “...that’s tough as professionals, I think, to let go of the fact that you can’t impose control and impose education and impose change. And we all want to fix everybody right?...” DM(P16)
- Patients want to be told what to do DM(P23)
- “...acknowledging their choices but again in the context of a relationship, if they were able to do and help themselves on their own, they wouldn’t be seeing professional consultation.” DM(P22)
- “if they still make that decision [even with opposite advice], then that’s their decision” DM(P21)
- “...it’s trying to give them the ability to make the decisions...” IND(P16)

<table>
<thead>
<tr>
<th>External Use</th>
<th>...I never felt pressured to do something that I didn’t understand...things were explained and I understood what was going on...I was satisfied, very pleased.” DM(Pt10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Use</td>
<td>“...He asks me. I love it when he asks me what I want to do. It just makes me feel good!” EE(Pt15)</td>
</tr>
<tr>
<td>External Use</td>
<td>“...It was left up to me which I thought was good too...I never felt pressured to do something that I didn’t understand...things were explained and I understood what was going on, I was very satisfied, very pleased.” EE(Pt10)</td>
</tr>
</tbody>
</table>
Appendix 16: Example Code Report “Meeting Patient Needs”

“I’ve got a guy who’s 62, a fairly heavy smoker, pack and a half a day, comes in to see me cause he’s short of breath...let’s do some tests and see where we’re at, we do some tests and he’s also got high blood pressure, he’s also got high cholesterol, so there’s a number of different ways I can go, but he came in to see me cause he’s short of breath so I have to treat his shortness of breath so I send him to see our nurse...who can do a spirometry test on him, talk to him to make sure he’s using his puffers that I prescribed for his shortness of breath properly, he starts feeling better, she says ok, yes, you need to quit smoking, let me send you to see our smoking counselor. He sees our smoking counselor, he’s now on a medication to be able to help him quit smoking, he comes back to see me and his blood work and his cholesterol is high, ok, now I can send him to the dietician who can talk to him about diet as well as how to manage his blood pressure – diet, reduce his salt...the conversation goes back and forth between the four of us, so the nurse..., the dietician, the smoking counselor and myself, the guy comes back, he’s not short of breath anymore, smoking is cut down...” (P7)

“A patient was referred to me because her blood sugars were high...she had hypertension, morbid obesity...About halfway through, I’d say about three months into our trying to get a handle on her sugar and hypertension she kind of broke down in my office one day and all this other stuff came spilling out. And I’m like, you know what, you really should go see [our mental health therapist], and he happened to be [on site] and I called him to say, have you got any time in the next couple of weeks because I’ve got somebody in my office who really would be interested in seeing you. So she went and saw [him]. She dealt with a couple of things she was able to overcome. She then went and did a group that we run on ‘healthy you’...[and she’s doing great]...So that’s a case for me of the benefits to having all this stuff in place, is that you have other strengths, other people to pull on when you are kind of, can’t do anything for this person sitting in front of you and you were the person they were referred to but you have the ability to offer then other services in the same time...” (P16).

“...So I can think of a patient that, uh, has a history of cancer and who is struggling with quitting smoking. So despite my multiple pleas I have not had any impact on her smoking behaviour so she got seen by our wellness nurse who runs a smoking program and with that nurse was able to overcome the smoking issue, transiently, unfortunately, but at least there was some inroads made, and, um, through that nurse it became apparent that some of her smoking was a means of coping with multiple stressors in her life so a referral was made to the mental health counsellor to give her increased coping skills. That to me is good team care. Where the patient is being benefited by the whole team as opposed to one individual trying to do it all.” (P18)
“...I think [mental-emotional aspects, patient context issues, etc. are] touched on by different people, um...and, again back to the electronic records you can put that sort-of stuff in, um, so, you know, patient, married but then they got divorced, you could update that in there so you can see, you know if I was seeing the patient I could see that so I wouldn’t ask something stupid like ‘how’s your husband’ type thing, so the electronic charting helps that in a sense, um social workers certainly are the ones that get more into the psychosocial, although we all try and address it, the problem is when you have so many health care providers and the patient is new to you, you don’t particularly want to pry into some of that stuff unless they’re forthcoming with it, you do want to ask, you know, ‘is this medication going to be affordable for you or is there any sort of barriers to taking this medication’ but you don’t want to get into the past history of abuse the very first time that you meet them, so having some of that information on the chart, you know for example...that’s very helpful for me to know, um, it’s not something I ask people...every time right, because I’m just meeting them for the first time, so...” (P4)

um, I think we’re trying to give a holistic approach, um, and, I mean the whole idea of family medicine, which is really ??, the way I see family medicine, is that um, you’re providing multi-disciplinary care, um, really, in the context of the family, you may not have that whole as your cohort in your office but you know there’s people connected to that person, you need to understand where that person fits within their life. I think the family health team helps you with that and a team approach helps you with that, um, it’s a lot easier if you have the whole family in your practice. The team, I think is able to pick up on things that you may not see. If you see someone day in and day out you may not be able to get information necessarily from them either because you’re too close and they don’t want to disappoint you and tell you information, they’re afraid they are going to disappoint you, so they’ll tell someone else instead, so you get information from other different sources, um, or someone else through whatever their expertise is, be able to pull some of that information out that you just weren’t aware of, for example I had a patient ??? who I’d been seeing for years, who’s got a mental health problem, and um recently just went to one of our counselors ??? (minute 32:52) ??? and never told me for years because she didn’t want to disappoint me, she’d been hiding it for so many years, she was worried that she was going to disappoint me and she told me that, so she confided in the counselor and the counselor said is it ok if I speak to Dr. [name] on your behalf and explain the situation, ya (P7)

So we identify very quickly patients that need extra support or whether, you know, for example, if it’s an emotional, you know, someone who is not coping well with illness, a chronic disease, whether it’s chronic pain or Alzheimer’s or with a caregiver of somebody with Alzheimer’s. So we have supports here, we have the social workers and they automatically will get a referral and see the social worker for a short period of time. This is not life long counselling, there’s a limit, but they have those supports
in place where they can see that aspect of the team if they need it. Socioeconomic supports, for example, you know classic, I see many patients who don’t have enough medication, or money for medications, so we try to work through, you know, can we change which medications that they’re on to provide something that’s cheaper. Can we apply for [funding] so we try to address the socioeconomic aspects of their disease to make sure that, you know, get them on medications that are effective, the least expensive, but make them understand how important it is that they take their medications and to understand that if they have a complication, you know, that’s going to cost a whole lot more than what they are on now. So try to make them understand the implications of their disease, to encourage them to stay on track even if it’s financially difficult. So we’re always trying to address, you know, the whole pictures, so you know whether, I personally have not referred somebody to a social worker, but without a doubt I’ve talked to [our nurse practitioner] ...but I will talk to the social workers and say I’ve got a patient, what do you think. Or I’ll talk to [the nurse practitioner] and say, what do you think. And so then we try to address the whole, the whole gamut. (P5)

“Good care to me in a team would be that the person’s, the patient’s needs or issues are being fully addressed, very holistically, so, um, because you feel that you have the backup and you have support with other people on the team, I think that, I know for me...if I’m seeing somebody and I’m concerned about medication issues or medical things or whatever I’m going to flag those things, and so, and I think the same for the physicians and other team members so that when they’re meeting with a patient if there are other issues that are coming up beyond their scope of practice they have the ability to kind of refer that person down the hall or to pull in other team members. So to me good care is about really covering the patient’s needs, um, you know, addressing the patient’s needs, be it whichever provider needs to be involved in that. And communication, I think, is huge, because I think patients feel very frustrated I think when, you know, they get short appointments and things are not addressed or, you know, they go see a specialist and the reports didn’t get there or something, you know, when there’s those kind of communication lags. I think it really becomes frustrating and, you know, people are back pedaling or maybe not getting what they need, you know, not getting the most out of their appointments so I think when there’s good communication I think that really helps.” (P3)

...with the diabetes program we’re seeing patients as kind of joint [successive] visits so after they go through the group sessions they see me for an individual follow up and then that’s followed by an appointment with the nurse practitioner...in that instance we would do more of a case discussion with me, the nurse practitioner and the pharmacist and we would decide, okay, what’s the best course of action, should they have another follow up with the dietician and do more of a lifestyle change, should they do medication, like what should be the next step? (P2)
...a patient who may have problems with emphysema, chronic obstructive pulmonary disease. That individual is referred for lung assessment [with a provider from our FHT] and through that intervention it’s also found that, yah, part of the problem is his smoking and then I’ll get feedback saying that this person would really benefit and is interested in the smoking cessation program, goes to, to one of our health care workers and yah, he’s also have issues with proper nutrition too and should lose some weight. So, and that would help his lungs as well and then a referral is made to the dietician and then she, sometimes the dietician surprisingly they’ll find that there are mental health issues, just from the discussion about eating patterns and yah, I’m not eating because I’m depressed and a referral is made [to the mental health worker]... (P12)

For example, I saw someone recently for smoking counseling, he saw the [smoking] counselor, the counselor reviewed a whole bunch of stuff including one of the medications for smoking, sent me a message saying ‘patient has agreed to do this, have follow-up with you next week, want prescription for this’, so I see him, then great!, you saw the smoking counselor, here’s your prescription, so I don’t have to go through as much of that, that education around it, because they’ve already done it, I’m already aware of the plan because they’ve sent me that message back saying this is what the plan is, the patient knows the plan, I know the plan, the counselor knows the plan, we’re all on the same page.” (P7)
### Appendix 17: Providers at FHT 1

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Number in FHT</th>
<th>Described role</th>
<th>Remuneration</th>
</tr>
</thead>
</table>
| **Physician**                | 9             | • general patient check-ups, physical exams, acute illness case  
|                              |               | • key diagnosticians in the FHT  
|                              |               | • coordinate patient care  
|                              |               | • one physician is the medical director (all staff report to him for medical-related issues)      | Capitation   |
| **Nurse practitioner**       | 2             | • general patient check-ups, physical exams, acute illness, well baby visits (sometimes share care/alternate visits with physicians)  
|                              |               | • chronic disease management (patient education and program administration)  
|                              |               | • unofficial case managers (called “hubs”), which includes (along with physicians) coordinating patient care among allied health-care providers | Salary       |
| **Nurse**                    |               | • 2 registered nurses  
|                              |               | • 3 registered practical nurses  
|                              |               | • patient education  
|                              |               | • take patient vitals and blood work; administer injections  
|                              |               | • assist in development and management of some patient programs | Salary       |
| **Pharmacist**               | 2 (part-time, alternating weeks) | • patient education around medications (through individual patient counselling and via chronic disease management programs)  
|                              |               | • assess and make recommendations regarding specific medication-related issues  
|                              |               | • monitor patient medications during hospital transfers | Salary       |
| **Dietician**                | 2 (part-time) | • provide individual one-on-one counselling sessions with patients on food and nutrition that is specific to their medical situation  
<p>|                              |               | • co-facilitate patient group education sessions (programs) for clinical concerns (like diabetes care) alongside a social worker, nurse practitioner or pharmacist | Fee-for-service |</p>
<table>
<thead>
<tr>
<th>Role</th>
<th>Position Details</th>
<th>Responsibilities</th>
<th>Compensation</th>
</tr>
</thead>
</table>
| Social worker                 | 4 (part-time)    | • assess and make recommendations regarding mental-emotional issues that a patient might be experiencing  
                                    • co-facilitate patient programs                                            | Fee-for-service |
| Respiratory therapist         | 2 (part-time)    | • patient education and support for respiratory-related conditions and treatment                              | Not available |
| Endocrinologist               | 8 hours/month    | • initial assessment and follow-up for endocrine-related issues                   | Not available |
| Administration/Reception Staff| N/A              | • book appointments (including referrals)  
                                    • answer general patient inquiries  
                                    • have full access to patient EMRs  
                                    • coordinate student activities and orientations                              | Salary |
| Executive Director (ED)       | 1                | • oversee many clinical and operational activities and the implementation of strategic goals  
                                    • all staff report to the ED for non-medical matters                                      | Salary |
### Appendix 18: Providers at FHT 2

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Number in FHT</th>
<th>Described role</th>
<th>Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>21</td>
<td>• General patient check-ups, physical exams and acute illness case</td>
<td>Blended model&lt;sup&gt;36&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
| Nurse educator    | 4             | • Educate patients around chronic disease, medication use and addressing quality of life issues  
                    | • Physician’s assistant                                                        | Salary                                      |
| Nurses            | N/A           | • Nurses are employees of individual physicians and their role is not standard across FHT 2  
                    | • They primarily assist their respective physician in clinical activities (such as taking laboratory samples from patients) | Remunerated via salary from individual physicians |
| Dietician         | 2             | • Counsel patients one-on-one for their various nutritional needs, often specific to their particular condition | Salary                                      |
| Mental health worker | 5         | • Counsel patients over 16 years of age on mental-emotional issues              | Salary                                      |
| Respiratory       | 1             | • Not available                                                                | Not available                               |

<sup>36</sup> Under a blended model of payment, physicians are remunerated via a combination of capitation and bonus models. A provider describes this as follows: "to a large extent, our income is based more on our roster size than it is on how many patients we see. So I’d say, 50–60% of our income is based on roster size and the rest of it is based on bonuses, so...if 80% of your old people get flu shots then you get some bonuses, if so many women have their PAP smears you get a bonus..." (Provider FHT 2).
<table>
<thead>
<tr>
<th>Therapist</th>
<th>Quantity</th>
<th>Responsibilities</th>
<th>Employment Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promoter</td>
<td>1</td>
<td>• Counsels patients on smoking cessation and child obesity</td>
<td>Salary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Works alongside dieticians and nurse educators to co-counsel patients and develop programs in those two areas</td>
<td></td>
</tr>
<tr>
<td>Administration/reception staff</td>
<td>N/A</td>
<td>• Those employed by the FHT support some physicians and allied health-care providers</td>
<td>FHT-employed receive salary;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Those employed by individual physicians support their individual physicians only</td>
<td>physician-employed N/A</td>
</tr>
<tr>
<td>Executive Director (ED)</td>
<td>1</td>
<td>• Responsible for transitioning all the sites under the FHT umbrella, renovations, capital purchases, and the hiring and the firing of staff</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 19: Providers at FHT 3

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Number in FHT</th>
<th>Described role</th>
<th>Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>21</td>
<td>• General patient check-ups, physical exams, acute illness case</td>
<td>Blended model&lt;sup&gt;37&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• May assist in program development</td>
<td></td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>2</td>
<td>• Complement the services family doctors provide</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Primary provider for a small group of patients</td>
<td></td>
</tr>
<tr>
<td>Registered nurses</td>
<td>5</td>
<td>• Called “nurse specialists”—each has a specific clinical focus</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Involved in programs</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td>3</td>
<td>• Medication review and education, and participates in some of the organized</td>
<td>Salary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>clinics (such as the Pain Management clinic)</td>
<td></td>
</tr>
<tr>
<td>Mental health therapist</td>
<td>5</td>
<td>• See patients one-on-one for dietary counselling sessions</td>
<td>Salary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Involved in some of the organized health and wellness programs and group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>classes that focus on chronic disease</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>• Receives patient referrals for medication review and education</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Participates in some of the organized clinics</td>
<td></td>
</tr>
</tbody>
</table>

<sup>37</sup> A blended model of payment means that physicians are remunerated via a combination of capitation and bonus models.
<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social worker</td>
<td>1</td>
<td>Has a specific focus in palliative care and geriatric care and provides care to patients though one-on-one and family counselling sessions and support groups</td>
</tr>
</tbody>
</table>
| Specialists                 | 1 child psychiatrist and 1 adult psychiatrist | Child psychiatrist receives referrals from across the FHT and practices out of Main Site once per month  
Adult psychiatrist receives referrals from FHT 3 and practices off-site |
| Administration/reception staff | N/A   | Those employed by the FHT support some physicians and allied health-care providers  
Those employed by individual physicians only support their individual physicians |
| Executive Director (ED)     | N/A   | FHT-employed receive salary; physician-employed N/A |
Appendix 20: Ethics amendments

University of Toronto
Office of the Vice-President, Research
Office of Research Ethics

PROTOCOL REFERENCE #20576 now #22217

February 22, 2008

Dr. Heather Boon
Faculty of Pharmacy
144 College St.
Toronto, ON M5S 3M2

Ms. Heidi Amemic
Health Policy Management & Evaluation
155 College St.
Toronto, ON M5T 3M6

Dear Dr. Boon and Ms. Amemic:

Re: Your research protocol entitled “Exploring perceptions of patient-centred care in an inter-professional primary health care team context”

We are writing to advise you that a member of the Health Sciences Research Ethics Board has granted approval to an amendment (received February 19, 2008) to the above referenced research study under the REB’s expedited review process. This amendment involves including Community Health Centres and Private interprofessional primary health care clinics.

The following consent documents (received February 19, 2008) have been approved for use in this study: Study Information Sheet (clinic directors/contact person, health care providers and patients), Telephone Script (clinic directors/contact person and health care providers), Consent Form (clinic directors/contact person, health care providers and patients), Study Advertisement (poster and pamphlet), Script for patients and Patient recruitment script. Participants should receive a copy of their consent form.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.

Best wishes for the successful completion of your project.

Yours sincerely,

Jenny Peto
Research Ethics Coordinator

McMurrich Building, 12 Queen’s Park Cres. W, 3rd Floor Toronto, ON M5S 1S8
TEL: 416-946-3273 FAX: 416-946-5763 EMAIL: ethics.review@utoronto.ca
University of Toronto  
Office of the Vice-President, Research  
Office of Research Ethics

PROTOCOL REFERENCE #20576, #22217 now #22248

March 3, 2008

Dr. Heather Boon  
Faculty of Pharmacy  
144 College St.  
Toronto, ON M5S 3M2

Ms. Heidi Amernic  
Health Policy Management & Evaluation  
155 College St.  
Toronto, ON M5T 3M6

Dear Dr. Boon and Ms. Amernic:

Re: Your research protocol entitled “Exploring perceptions of patient-centred care in an inter-professional primary health care team context”

We are writing to advise you that a member of the Health Sciences Research Ethics Board has granted approval to an amendment (received February 25, 2008) to the above referenced research study under the REB’s expedited review process. This amendment involves clinic reception staff assisting with recruitment.

The following consent documents have been approved for use in this study: Script for Patients (received February 25, 2008).

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.

Best wishes for the successful completion of your project.

Yours sincerely,

Jenny Peto  
Research Ethics Coordinator