

June 11th Dissemination: Presentation Notes

In this document, you will find the presentation slides along with supporting notes designed to help guide our preparation for the dissemination.

- We have included “additional notes” underneath some of the presentation slides to help provide useful context for individual slides; and
- We have included “potential speaker’s notes” for selected slides where you had requested more information or where it might be helpful to have some suggestions.

You may also wish to review the separate document, “***Preparation for CHRSP Dissemination for Patient Partners***” which outlines our dissemination approach and provides sample questions along with notes for potential responses.

Links to our report materials can be found here:

- SPOR project page: [LINK](#)
- Full report on NLCAHR Website: [LINK](#)

If you have any other questions, please send them along or make a note of them and we can discuss them when we meet on June 8th.

Presentation Notes

Welcome to the dissemination (Rochelle)

- Rochelle to say a few words of welcome in advance of us starting the presentation

Slide 1: Title (Cris)

Patient Perspectives on Team-Based Primary Care



Disseminating the Final Report to Health and Community Partners | June 11, 2026

Cris Carter, Rosemary Lester, Sarah Mackey and Emily Granter



Alliance pour des données probantes de la SRAP



Slide 2: Presentation Overview (Cris)

Presentation Overview

Background

Cris Carter and Rosemary Lester

Research Approach

Sarah Mackey and Emily Granter

Findings from the Literature

Cris Carter and Rosemary Lester

The NL Context

Sarah Mackey and Emily Granter

Discussion



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Slide 3: The Project Team (Cris)

Background: The Project Team

Introducing the Project Team comprising patient and academic researchers

Patient Researchers



Cris Carter, Project Co-Lead Rosemary Lester, Patient Partner

Researchers from NLCAHR/ CHRSP



Sarah Mackey, CHRSP Emily Granter, CHRSP Rick Audas, NLCAHR Director

Additional notes on the background/team:

- NLCAHR = Newfoundland and Labrador Centre for Applied Health Research
 - NLCAHR (pronounced NL-CAR) conducts research and public engagement to improve health and healthcare in Newfoundland and Labrador.
 - The Centre has been informing decisions with evidence, attuning that evidence to the local context, building capacity for research, and forging research collaborations and community partnerships for over 25- years.
 - One of the key programs central to this work is the Contextualized Health Research Synthesis program (CHRSP).
- CHRSP = Contextualized Health Research Synthesis Program
 - Researchers in our Contextualized Health Research Synthesis Program, (CHRSP) locate, assess and report on evidence to answer priority research questions posed by health system leaders, and in this case for this Patient-Led knowledge synthesis (Co-Lead Cris Carter).
 - Working in close collaboration with our partners, CHRSP provides decision support on priority issues that have been identified as essential to the sweeping transformation of health and healthcare now underway in our province

Slide 4: Patient-Oriented Research (Cris)

Background: Patient-Oriented Research



2023: SPOR Evidence Alliance invites Canadian public/patient partners to submit patient-oriented topics to be considered for research funding



A national panel selects 20 topics, including a submission from Cris Carter, a Patient Partner with the NL SUPPORT Patient and Public Advisory Council



As a long-time patient advocate, Cris was interested in research identifying how patients experienced barriers and facilitators to primary care access



NLCAHR, a member of the SPOR-EA, was matched as the research team to work with Cris Carter as the Project Co-Lead and with Rosemary Lester, Patient Partner, to carry out an evidence synthesis.



Additional notes on the project background:

- In 2023, the national Support for Patient-Oriented Research (SPOR) Evidence Alliance hosted a Patient and Public Health Research Topic Priority-Setting exercise in which patients and public partners from across Canada were invited to submit topics on current and pressing healthcare and health system gaps.
- All submitted topics were considered for research funding through the Alliance.
- Final topics were selected by a 15-member steering panel that included patients and public partners alongside health system decision makers.
- The initiative was aimed at connecting patients and members of the public with a dedicated SPOR Evidence Alliance research team “to ensure research outcomes are both scientifically robust and reflect patient experiences and perspectives”.
- Cris’s submission was selected as one of 20 priority topics to receive funding from the SPOR Evidence Alliance.
- NLCAHR was then matched as the research team to work with Cris Carter, Project Co-Lead and with Rosemary Lester, Patient Partner, to carry out an evidence synthesis.
- Once matched, Cris and CHRSP team met to clarify project parameters and outline a workplan. Through this process and some initial background research, we narrowed our focus to patient perspectives on Team-Based primary care.

Slide 5: About our Patient Partners (Cris)

About Our Patient Partners

Cris Carter, Project Co-Lead

- Patient Partner on NL SUPPORT Patient and Public Advisory Council (PPAC)
- Patient Partner with the Health Data Research Network (HDRN)
- Served as the Community representative on the NL Health Research Ethics Board (HREB) and as Patient Partner with the Canadian Institutes of Health Research (CIHR)
- Worked on: *“Through the Looking Glass: The impact of COVID-19 isolation on Long-Term Care facility residents – a visitor’s perspective”* a project funded through NL SUPPORT



Rosemary Lester, Patient Partner

- Patient Partner on NL SUPPORT Patient and Public Advisory Council (PPAC).
- Former nurse with experience in both Canada and the UK
- Worked with SeniorsNL, serving as Executive Director from 1992 to 2008.
- Worked on: *“Through the Looking Glass: The impact of COVID-19 isolation on Long-Term Care facility residents – a visitor’s perspective”*

Slide 6: About our Academic Partners (Cris)

About Our Academic Partners

Researchers from NLCAHR

- Sarah Mackey, Master's of Public Health, Research Officer & Patient Engagement Coordinator with the Contextualized Health Research Synthesis Program (CHRSP)
- Emily Granter, Master's of Public Health, Research Officer with CHRSP
- Dr. Rick Audas, Professor of Health Statistics & Economics in the Division of Population Health and Applied Health Sciences at Memorial University's Faculty of Medicine and the Director of the NL Centre for Applied Health Research.



Project Consultant

- Dr. Sabrina Wong, a professor at the University of British Columbia's Centre for Health Services and Policy Research and the UBC School of Nursing whose research is focused on primary care delivery.

Potential speaker's notes:

- This slide highlights our academic partners who helped carry out this evidence synthesis.
- The research team from the Newfoundland and Labrador Centre for Applied Health Research includes:
 - CHRSP Research Officers Sarah Mackey, Emily Granter, and the Centre's Director, Dr. Rick Audas.
- Our project team also consulted with Dr. Sabrina Wong; a researcher whose work examines primary healthcare delivery and patient-reported quality of care. Dr. Wong is a professor at the University of British Columbia's Centre for Health Services and Policy Research and the UBC School of Nursing.

Slide 7: Project Background (Rosemary)

Project Background



Canada's primary care crisis is affecting patients' ability to access care when and where they need it.



In response, several provinces have introduced primary care teams in which family physicians work with other healthcare professionals to deliver coordinated patient care.



- Rosemary what you presented at the NLSUPPORT PPAC meeting for the background was great. Feel free to use that again!

Additional notes on the project background:

- See p. 7 of our report for the section on “Why is this topic important”
- The 2023 Canadian Community Health Survey:
 - found 83% of adults reported having a regular healthcare provider, leaving approximately 5.4 million (17%) of Canadians without one
 - Across Canada, primary care access was lowest among young adults, lower income groups, residents of the territories, and people living in the Atlantic provinces including NL
- The Switch to Team-Based Primary Care:
 - To address the growing number of Canadians living without a regular primary care provider, several provinces have introduced team-based primary care models as a key strategy for primary care reform
 - Team-based primary care models involve family physicians working collaboratively with nurses, nurse practitioners, pharmacists, social workers, dietitians, and other allied health providers to deliver high-quality, coordinated care.

Slide 8: Why This Topic Matters (Rosemary)

Why This Topic Matters



Team-based primary care models are being implemented across Newfoundland & Labrador as Family Care Teams (FCT).



The FCT model is a strategy to address primary care shortages in Newfoundland & Labrador.



While these new teams aim to improve access and meet patients' primary care needs, understanding how patients experience them is critical to ensuring success and identifying opportunities for improvement.

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Additional notes on Family Care Teams in NL:

How are Family Care Teams in NL defined?

- NLHS website info
 - Family care teams are a new way to provide primary health care in Newfoundland and Labrador.
 - The vision for family care teams is to make it easier for people and families to get the health care they need in their own communities. Family care teams bring together different health-care professionals to work as a team to support people's health and well-being.
 - Each family care team is unique and designed to meet the specific needs of your community. Our family care teams are flexible, inclusive and able to adapt to changes over time.
 - You will be connected to a main provider on your family care team, who will make sure you receive the necessary care from the full team of health-care professionals.
- Family Care Teams: A Health Policy Framework for Newfoundland and Labrador (2023) – [\[LINK\]](#)
 - Provides a useful overview of the goals and vision for Family Care Teams in NL

Slide 9: Our Research Question (Emily)

Our Research Question

“What does the research literature reveal about patient perspectives on community-based primary care delivered by interprofessional teams, specifically regarding access, continuity, and other relevant aspects of quality of care?”



Patient perspectives: The term “patient perspectives” is used in this report as an umbrella term encompassing patient experience (including patient-reported experiences), perceptions, attitudes, preferences, and views related to team-based primary care.


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Additional notes on research question (defining terms):

- **Community-based primary care:**
 - Primary care services delivered within the community—such as in local clinics or practices—rather than in hospitals or specialized facilities.
- **Interprofessional primary care teams:**
 - Healthcare providers with different scopes of practice who collaborate to deliver primary care as a team. For this project, we focused on teams that included at least one primary care physician OR one nurse practitioner working with at least one other healthcare professional.
 - The literature we reviewed used a wide range of definitions and terms to describe these teams, including “team-based primary care,” “multidisciplinary care teams”, and “interprofessional collaborative practice”. If interested, see “Defining Primary Care Teams” on Page 17 for more detail on how care teams are defined in the literature
- **Traditional solo-based primary care model:**
 - The primary care model that most people are used to, in which a single physician practices independently, supported by small administrative staff. In this model, patients would typically see the same physician at each visit.
- **Access:**
 - In this report, “access to care” generally refers to timely, affordable, and appropriate access to health services that promote, maintain, or restore patient health.
- **Continuity of care:**

- Refers to an experience of healthcare that is continuous, connected and well-organized through a patient's care journey, from care provider to care provider, regardless of the healthcare setting.
- **Quality of Care:**
 - Rather than applying a single predefined framework, this report reflects how quality is described and examined in the primary care literature, with a particular focus on patient perspectives. While we emphasize access and continuity, we also include patient perspectives on other relevant aspects of care that contribute to overall care quality.
 - In the literature we reviewed, "quality of care" was understood as a multidimensional concept shaped by factors such as access, continuity, and other aspects of care, including patient-centered and holistic care. Only two primary studies provided explicit definitions of quality of care (13,19).

Slide 10: Study Methodology (Emily)



The diagram consists of five circular icons arranged in a circle, connected by arrows in a clockwise direction. Starting from the top and moving clockwise, the icons are: a blue circle with a white checkmark, an orange circle with a white question mark, a yellow circle with a white list icon, a light blue circle with a white circular arrow icon, and a red circle with a white speech bubble icon.

Study Methodology

This project was conducted as a **CHRSP Rapid Evidence Report (RER)** which:

- supports evidence-based health system decision making on priority topics
- offers decision makers an *overview* of scientific evidence carried out within a defined timeframe, rather than conducting a comprehensive review of all literature/ all contexts
- appraises and synthesizes the best evidence from systematic reviews and recent primary studies
- describes the scope, nature, and key areas of agreement/disagreement in this evidence, along with selected contextual considerations for NL

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Additional notes on study methodology:

- Rapid Evidence Reports (RERs) offer an overview of recent research (typically from the last 5 years) to support evidence-informed health system decision making in NL.
- They synthesize key findings, describe the search strategy and evidence base, and provide a quality assessment of included studies, rather than providing a comprehensive review of all available literature.
- RERs highlight the scope and nature of the evidence, and outline areas of agreement and disagreement among researchers, along with some potentially relevant contextual considerations for decision makers in province.

Slide 11: What we looked for (Sarah)

— What we looked for...

Parameter	Inclusion Criteria	Exclusion Criteria
Population	Adult patients, aged 18 years and older, seeking primary care	Adults not seeking primary care Pediatric patients seeking primary care
Intervention	Interprofessional primary care teams that include at minimum, one primary care physician or one nurse practitioner working collaboratively with at least one other healthcare provider.	Interprofessional teams working outside the primary care setting Interprofessional primary care teams that are not led by a primary care physician or nurse practitioner
Comparator	Solo-based community practice and program-based models of service delivery (if available)	
Outcomes	Patient perspectives on: <ul style="list-style-type: none"> access to primary care, continuity of care, and other relevant aspects of quality of care 	
Setting	Community-based primary care clinics in rural or urban settings	Non primary care clinics
Language	English	
Years	Published in the last 5 years (2020- 2025)	

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Additional notes on our research parameters:

- See p. 11 of our report for the section on “How Did We Select Research Evidence for This Report?”

Slide 12: Characterizing the Literature (Sarah)



Characterizing the Literature

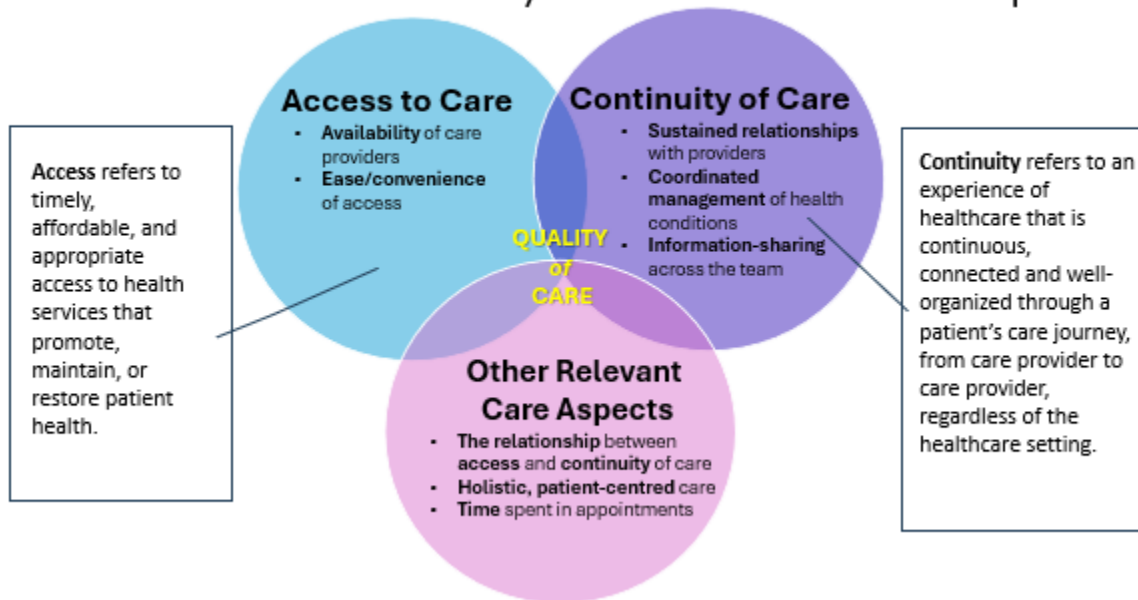
- **Included literature:** In total, we included evidence from one integrative review of 48 primary studies and 14 recently-published primary studies that were not captured in the review literature.
- **Patient populations studied:** Much of the research we found was focused on patients with complex or chronic conditions.
- **Primary Care Teams studied:** We found a variety of descriptions for interprofessional primary care teams. Much of the literature tended to describe the general concept of team-based primary care without offering detailed information on the exact composition of teams.
- **Settings studied:** Studies were conducted in primary care settings across at least 14 different countries.

Additional notes on characterizing the evidence:

- See p. 15 of our report for the section on “Characterizing the Evidence”

Slide 13: What we Found: Key Outcomes in the Report (Cris)

What We Found: Key Outcomes in the Report



Potential speaking points:

- This slide shows Figure 1 from the report, which summarizes the key outcomes from the report.
- The subthemes for each outcome represent the key patient perspectives that came up most often across the literature we reviewed.

Additional notes on how outcomes were characterized in the literature we reviewed:

- See p. 22 of our report for the section on “Included outcomes” and p. 26 of our report for the section with Figure 1 (Venn diagram)
- While the report explores how these terms are defined in more detail, it’s important to note that across the literature we reviewed, access and continuity were not always clearly or consistently defined.
- **Characterizing Access to Care in the literature we reviewed**
 - Based on how access was described in the literature we reviewed, we categorized access in the report as:
 - availability of care (supply and capacity), or
 - accessibility (ease/convenience of access).
 - Defining access to care in the literature:
 - Four recent primary studies applied the **Levesque and colleague’s framework**, which conceptualizes access as a **multi-step process: perceiving the need for care, seeking care, reaching care, obtaining care, and having needs met.**

- The remaining primary studies and the integrative review did not apply a formal framework but examined a range of access-related perspectives.
- Most of the literature we reviewed examined access to care, including the integrative review and 12 recent primary studies
- **Characterizing Continuity of Care in the literature we reviewed**
 - Three of these primary studies explicitly applied **Haggerty’s framework**, a widely used model that distinguishes between three dimensions of continuity. While the integrative review and most recent primary studies did not formally define continuity, the outcomes they reported can still be meaningfully understood within this framework:
 - **Relational continuity**, referring to an ongoing therapeutic relationship between a patient and one or more providers;
 - **Management continuity**, referring to the consistent and coordinated management of care across different services or providers; and
 - **Informational continuity**, referring to the transfer of information from past events and personal circumstances to make current care appropriate for each individual.
 - The majority of the literature also examined patient perspectives on continuity of care, including the integrative review and 11 recent primary studies
- **Characterizing Other Relevant Aspects of Quality of Care in the literature we reviewed**
 - Additionally, some of the literature we reviewed also reported on other relevant aspects that influenced quality of care from the patient perspective:
 - The **relationship between access and continuity** was discussed in five recent primary studies. These studies described how changes in one domain (e.g., access) could impact another (e.g., continuity). – Trade off
 - Outcomes related to **holistic and patient centered** care were examined in the integrative review and three recent primary studies
 - **Appointment length** and **time spent with providers** was examined in the integrative review and five primary studies

What Do We Mean By “Quality of Care”?

- In the literature we reviewed, “quality of care” was understood as a multidimensional concept shaped by factors such as access, continuity, and other aspects of care, including patient-centered and holistic care. Only two primary studies provided explicit definitions of quality of care (13,19).
- Rather than applying a single predefined framework, this report reflects how quality is described and examined in the primary care literature, with a particular focus on patient perspectives. While we emphasize access and continuity, we also include patient perspectives on other relevant aspects of care that contribute to overall care quality.

Slide 14: Key Message #1 (Cris)

**Key Message #1:
Characterizing the Evidence**

- Evidence on this topic was limited.
- Evidence tended to focus on people with chronic/complex conditions
- Study characteristics varied
- Overall, the evidence provided broad and valuable insight into patient perspectives, but characteristics of included studies may limit their generalizability.
- **Our analysis of the literature highlights the value of gathering patient feedback to understand how patients experience team-based care within their local contexts.**

Speaker's notes:

- Rochelle suggested reading the key messages verbatim see below

Full key message from the report: Characterizing the Evidence

- We found limited research examining patient perspectives on access, continuity of care and other relevant aspects of quality of care related to interprofessional team-based primary care.
- The available research evidence focused mostly on the perspectives of those living with chronic or complex conditions.
- Other study characteristics varied, with many studies providing only general descriptions of how primary care teams operated, limited details on team composition and function, and inconsistent definitions of key concepts such as team-based care and patient experience.
- As a result, while the evidence provides broad and valuable insight into patient perspectives, differences in setting and health system contexts may limit the applicability of the findings to other jurisdictions.
- Our analysis of the literature highlights the value of gathering patient feedback to understand how patients experience team-based care within their local contexts.

Additional notes on the key messages

- See p. 9-10 of the report for full list of key messages

Slide 15: Key Message #2 (Cris)

**Key Message #2:
A Variety of
Perspectives**

- The research evidence suggests patients generally have positive experiences with team-based primary care; however, patient perspectives also vary, as some patients report challenges with certain aspects of care.
- Patient perspectives may differ depending on individual needs, the local context in which care is delivered, and how team-based care is organized.
- This variability highlights the importance of flexibility in responding to patients' diverse care needs.
- **Understanding patient perspectives is critical in evolving team-based primary care to support improvements in access, continuity, and overall quality of care.**

Speaker's notes:

- Rochelle suggested reading the key messages verbatim as appears on the slide above

Additional notes on the key messages

- See p. 9-10 of the report for full list of key messages as appears on the slide above

Slide 16: Key Message #3 (Rosemary)

Key Message #3:
Perspectives on
Access to Care

- Patient perspectives on access to team-based primary care reflect both the availability and capacity of their team-care providers, as well as the expansion of their care network beyond the general practitioner (GP).
- Factors that influence the ease and convenience of accessing services include: co-location of professionals and services; multiple modes of access and options for booking appointments; and affordability of healthcare.

Speaker's notes:

- Rochelle suggested reading the key messages verbatim as appears on the slide above

Additional notes on the key messages

- See p. 9-10 of the report for full list of key messages

Slide 17: Access to Care Table (Rosemary)

Access to Care		
Availability of Care: Supply and Capacity	Accessibility: Ease/ Convenience of Access	Multi-level Factors (Recent primary studies) influencing patient perspectives on access
<p>Widening the care network beyond the GP</p>	<p>Co-location of professionals and services</p> <p>Multiple modes of access and booking appointments (e.g., face-to face, telephone, video, email)</p> <p>Affordability of healthcare</p>	<p>Patient-level factors</p> <ul style="list-style-type: none"> • Individual patient characteristics influencing patient perspectives on access to care (e.g., health status, gender, education, social vulnerability, immigration status) <p>Contextual-level factors</p> <ul style="list-style-type: none"> • Local health system characteristics influencing patient perspectives on access to care (e.g., clinic size) <p>Organizational-level factors</p> <ul style="list-style-type: none"> • Clinic-level processes influencing patient perspectives on access to care (e.g., estimating supply/demand, referral algorithms, and consultation strategies)

Potential speaker’s notes for Access to Care Figure:

- This slide presents Figure 2 from the report (Figure 2: Access to Care: Themes and Sub-Themes) outlining the main themes and subthemes related to access to care that emerged from the literature we reviewed.
- Overall, most patient perspectives on access from the literature focused on:
 - Availability of care (i.e., supply and capacity), or
 - Accessibility of care (i.e., ease and convenience of access)
- Beyond these two areas, some recent primary studies highlight that patient perspectives on access to care may also be influenced by factors operating at multiple levels, ranging from individual patient characteristics to broader contextual and organizational-level factors. We refer to these in the report as “Multi-level factors”

Additional notes on Access to Care figure:

- See p. 27 of the report for the section with the Access to Care figure
- **Multi-level factors:** We define multi-level factors as factors that influence outcomes within different levels of a system, for the evidence on access this includes factors at the patient level, the contextual level and the organizational level.

Slide 18: Key Message #4 (Cris)

**Key Message #4:
Perspectives on
Continuity of Care**

- Patient perspectives on continuity of care in team-based primary care emphasize the importance of connecting with professionals to build supportive relationships across the care team, with the GP role being considered a crucial anchor to patient care.
- Patients tend to value support from other team members as well, so long as the relationship with their GP is maintained. This is especially true for patients with complex needs (i.e., patients value what is known as *relational* continuity).
- Patients also value care coordination and having providers who manage chronic conditions collectively as a team, formalize care plans, and structure follow-up (i.e., patients value what is known as *management* continuity).
- Finally, patients value seamless information-sharing across the team to avoid having to repeat themselves (i.e., patients value what is known as *informational* continuity).

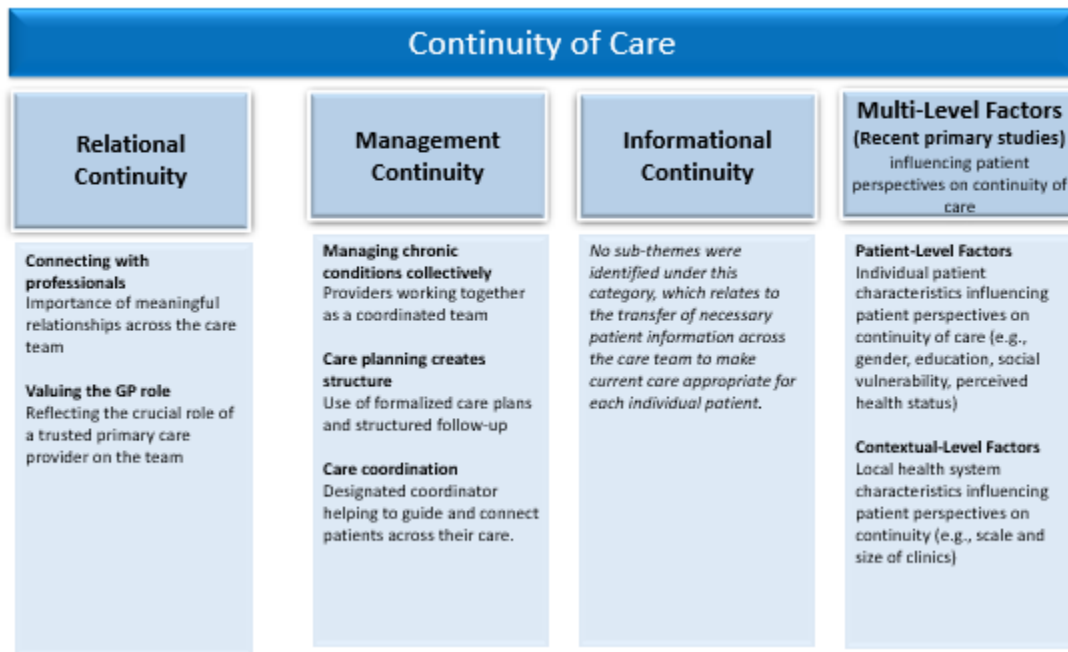
Speaker's notes:

- Rochelle suggested reading the key messages verbatim as appears on the slide above

Additional notes on Continuity of Care key message:

- **Relational continuity**, referring to an ongoing therapeutic relationship between a patient and one or more providers;
- **Management continuity**, referring to the consistent and coordinated management of care across different services or providers; and
- **Informational continuity**, referring to the transfer of information from past events and personal circumstances to make current care appropriate for each individual.
- See p. 9-10 of the report for full list of key messages

Slide 19: Continuity of Care Figure (Cris)



Potential Speaker's notes:

- This slide features Figure 3 from the report (Figure 3: Continuity of Care: Themes and Sub-Themes), which highlights the key areas of continuity of care identified in the literature we reviewed.
- Across the evidence, patient perspectives on continuity of care were most often described across three overlapping dimensions: relational, management, and informational continuity.
- In addition to these dimensions, similar to access, a few recent primary studies suggest that patient perspectives on continuity of care can also be influenced by multi-level factors, particularly those at the patient and contextual level.

Additional notes on Continuity of Care figure:

- See p. 33 of the report for the section with the Continuity of Care figure
- **Multi-level factors:** We define multi-level factors as factors that influence outcomes within different levels of a system, for the evidence included in the report on continuity of care these include factors at the patient level and the contextual level (local health system characteristics).

Slide 20: Key Message #5 (Cris)

**Key Message #5:
Perspectives on
Other Relevant
Aspects of Quality of
Care**

- Patients describe both access and continuity of care as key components of their overall quality of care; however, access and continuity may interact in ways that influence patient perspectives. As an example, having quicker access to a medical appointment may also mean seeing unfamiliar care providers, a trade-off in which access to care may be improved at the expense of relational continuity.
- Patients' overall experience of quality of care is also influenced by whether their care is patient-centered and holistic.
- Patients value being seen as a whole person and having enough time in appointments to feel heard and understood.

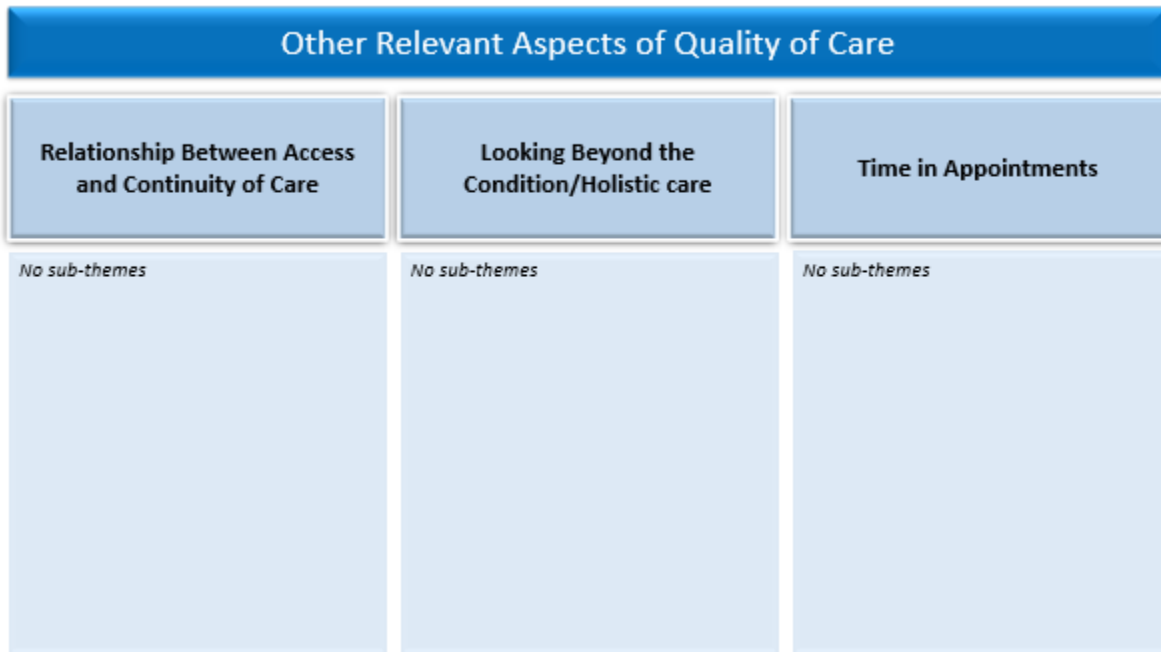
Speaker's notes:

- Rochelle suggested reading the key messages verbatim as appears on the slide above

Additional notes on the key messages:

- See p. 9-10 of the report for full list of key messages

Slide 21: Other Relevant Aspects of Quality of Care Figure (Cris)



Potential speaker’s notes:

- This slide presents another figure from the report (Figure 4: Other Relevant Aspects of Quality of Care).
- For other relevant aspects of quality of care the main themes that patients described in the literature we reviewed include:
 - Relationship between access and continuity of care
 - Looking beyond the condition or holistic care, and
 - Time in appointments

Additional notes on other relevant aspects of quality of care:

- See p. 40 for the section of our report on other relevant aspects of quality of care
- The relationship between access and continuity was discussed in five recent primary studies (Abelsen, 2023; Breton, 2024; Cohen 2024; Goff, 2024; Kayira, 2024). These studies described how changes in one domain (e.g., access) could impact another (e.g., continuity).
- Outcomes related to holistic and patient centered care were examined in the integrative review (Davidson, 2022) and three recent primary studies (Abelsen, 2023; Ashcroft, 2021, Zong, 2021).
- Appointment length and time spent with providers was examined in the integrative review (Davidson, 2022) and five primary studies (Abelsen, 2023; Ashcroft, 2021; Donaghy, 2024 Sweeney, 2024, Vader, 2025).

Slide 22: The NL Context (Emily)



The NL Context

Access to Primary Care: Accessing primary care services in Newfoundland and Labrador continues to be a challenge for many patients. In 2024, only 74.8% of NL patients reported having access to a regular healthcare provider, compared to 82.6% nationally.

Health Workforce Challenges: NL continues to navigate longstanding challenges with the recruitment and retention of family physicians and other healthcare professionals. Since the launch of Family Care Teams in 2023, the province has been actively recruiting physicians, nurse practitioners, registered nurses, licensed practical nurses, social navigators, allied health professionals, and support staff to support team-based care.

An Aging Population with High Burden of Chronic Disease | As of 2025, 25.2% of NL's population were aged 65 and older, compared to 19.5% across Canada. Provincial projections show the median age is expected to rise from 47.8 in 2024 to 49.3 by 2044.

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Additional notes on the NL Context

- See p. 45 in our report for the section on “Considering the NL Context”

Slide 23: The NL Context (Sarah)



The NL Context

Distribution of the Population Across Rural and Urban Communities: Newfoundland and Labrador is geographically distinct, with a small population dispersed across a large geographic area. Access disparities between rural and urban communities are evident as shown by reports showing that only 66.6% of patients in rural/remote communities have a regular health care provider, compared to 83% of patients living in urban areas

Patient Engagement: Meaningful patient engagement is an important component of primary care, as it helps to ensure that services are designed and delivered in ways that genuinely reflect patients' needs, priorities, and lived experiences. Findings from the 2025 OurCare National survey show that while 27.9% of respondents across Canada reported at least one opportunity to participate in improving primary care in their community or region, only 20.1% of respondents in NL reported the same .

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Additional notes on the NL Context

- See p. 45 in our report for the section on “Considering the NL Context”

Slide 24: What Does This Mean? (Cris)

What Does This Mean?

- There is intrinsic value in integrating patient perspectives into healthcare evaluation and planning.
- While the evidence in this report offers helpful insights into patient perspectives on their primary care, research in this area remains limited. More research on patient perspectives is needed.
- Gaining a clearer understanding of patient perspectives on team-based primary care models will be critical to ensuring their current success and identifying opportunities for future improvement.

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Slide 25: Honouring Patient Voices (Cris)

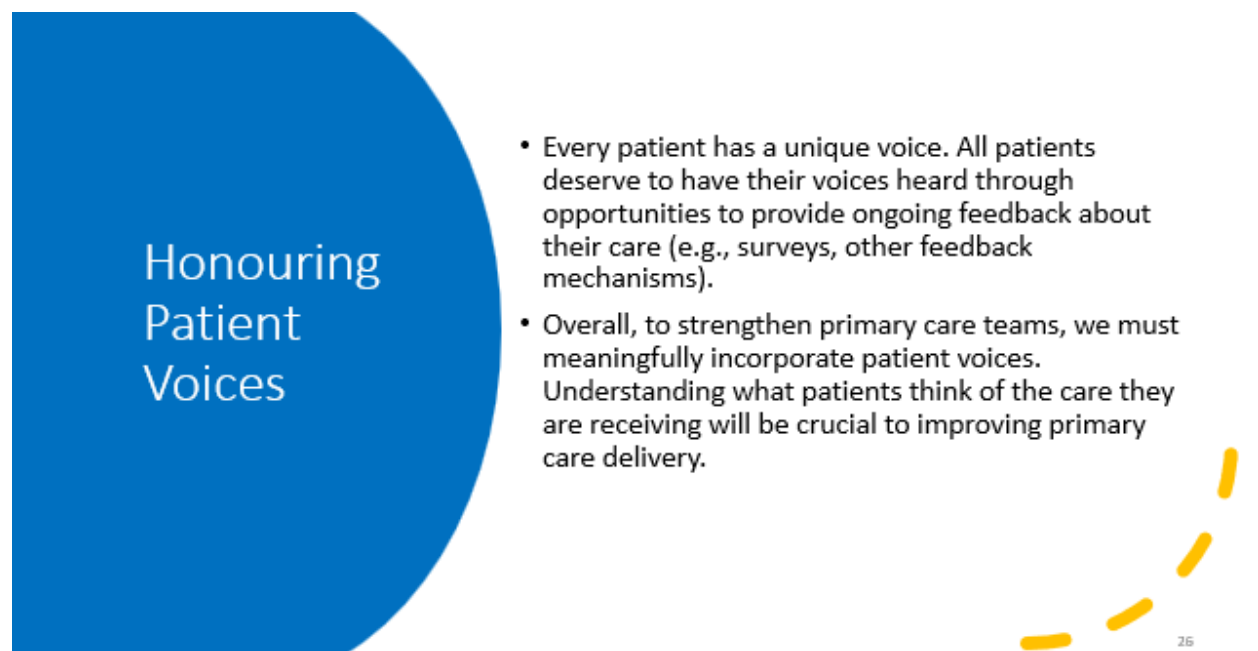


Honouring Patient Voices

- Among other initiatives in this province, NL Health Services (NLHS) is piloting patient experience surveys in a Western Zone FCT using Txt Squad, a communication tool that sends survey links to patients after appointments. The intent is to guide rapid, continuous quality improvement.
- Additional feedback channels include the NLHS Patient Relations Office and MyVoiceNL, a program that collects system-wide experience data.

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Slide 26: Honouring Patient Voices (Cris 1st bullet, Rosemary 2nd bullet)




Honouring Patient Voices


- Every patient has a unique voice. All patients deserve to have their voices heard through opportunities to provide ongoing feedback about their care (e.g., surveys, other feedback mechanisms).
- Overall, to strengthen primary care teams, we must meaningfully incorporate patient voices. Understanding what patients think of the care they are receiving will be crucial to improving primary care delivery.

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Slide 27: Acknowledgements (Cris)



- We acknowledge the contributions of the team at NL SUPPORT and thank Catherine Street and Kathleen Mather for their encouragement in initiating this research.
- We thank Rochelle Baker, Manager of Communications and Partnerships at NLCAHR for helping the team with report editing and Knowledge Translation.
- We appreciate the support of Dr. Andrea Tricco and the team at SPOR EA for their guidance throughout the project.



Slide 28: Questions? (Moderated by Rochelle)

QUESTIONS?



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- Rochelle to moderate the Q&A discussion