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

Newfoundland & Labrador Centre for APPLIED HEALTH RESEARCH

Rapid EVIDENCE Reports

SPOR Evidence Alliance

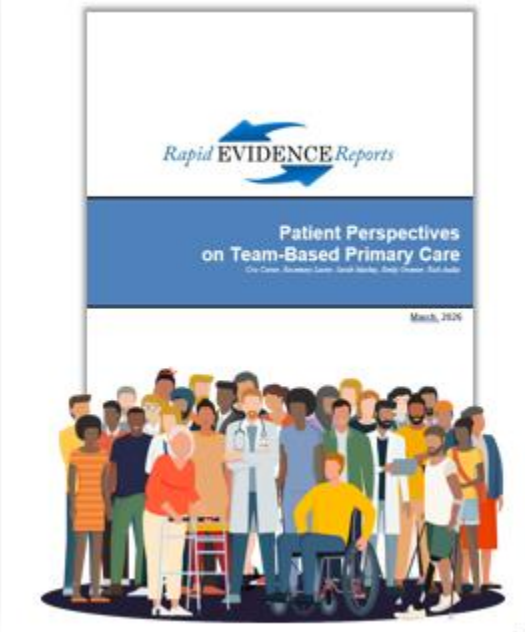
Alliance pour des données probantes de la SRAP

SPOR

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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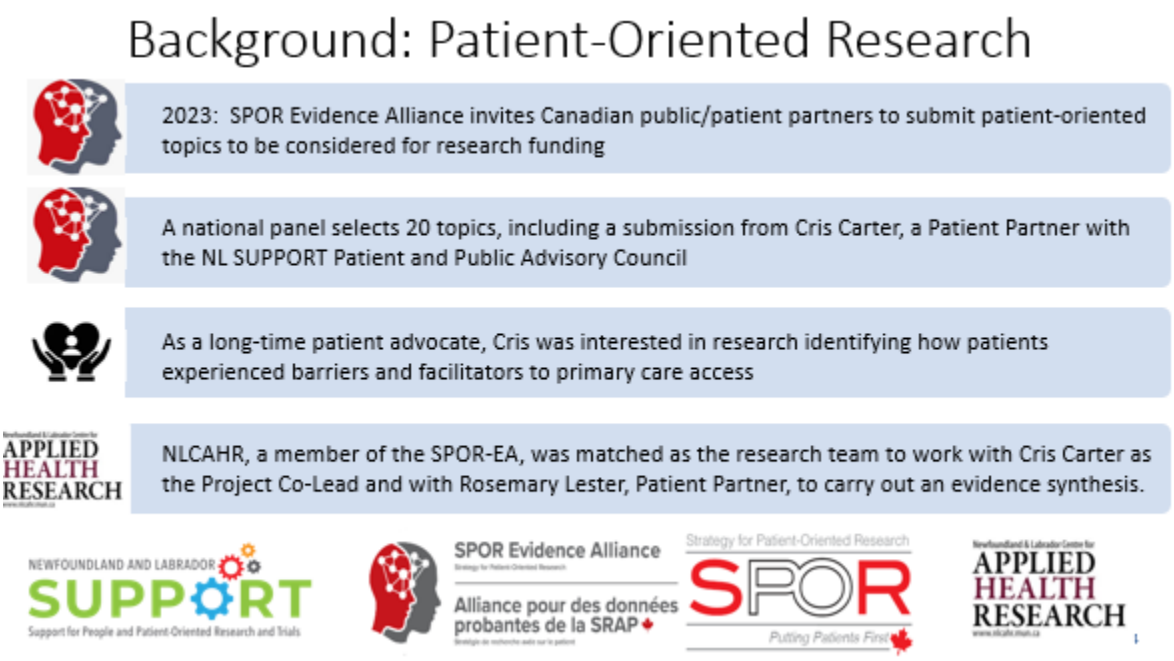
Slide 3: The Project Team (Cris)

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)



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

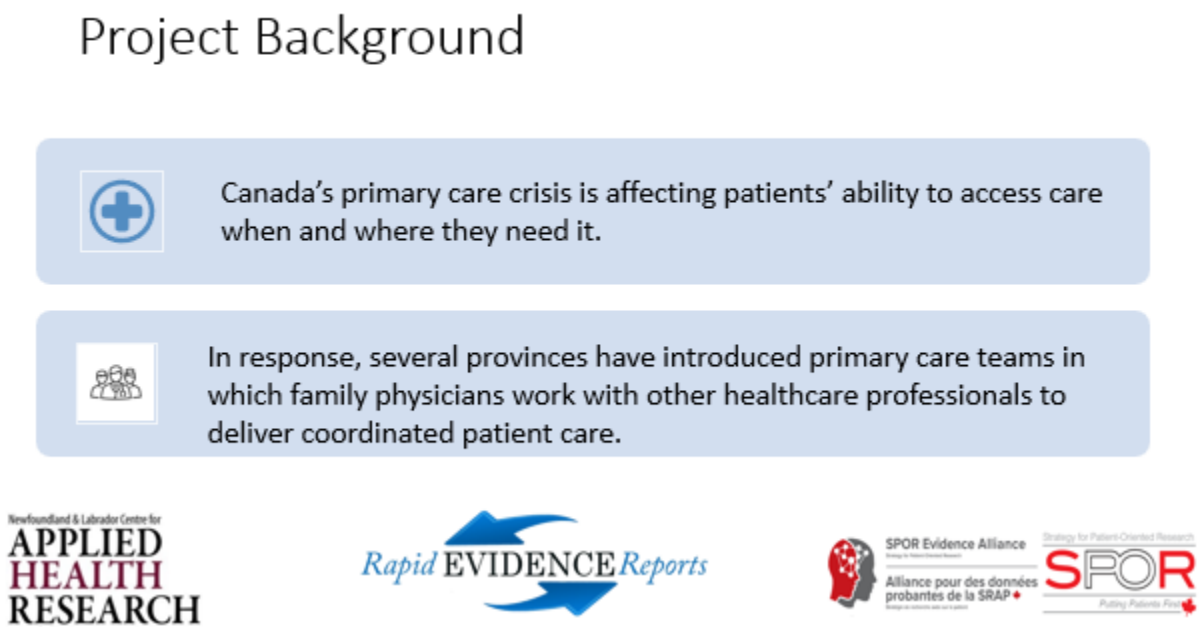
- Patient Partner on NL SUPPORT Patient and Public Advisory Council (PPAC).
- Former nurse with experience in both Canada and the UK
- Worked with SeniorsNL, serving as Executive Director from 1992 to 2008.
- Worked on: *"Through the Looking Glass: The impact of COVID-19 isolation on Long-Term Care facility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

Slide 6: About our Academic Partners (Cris)

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)

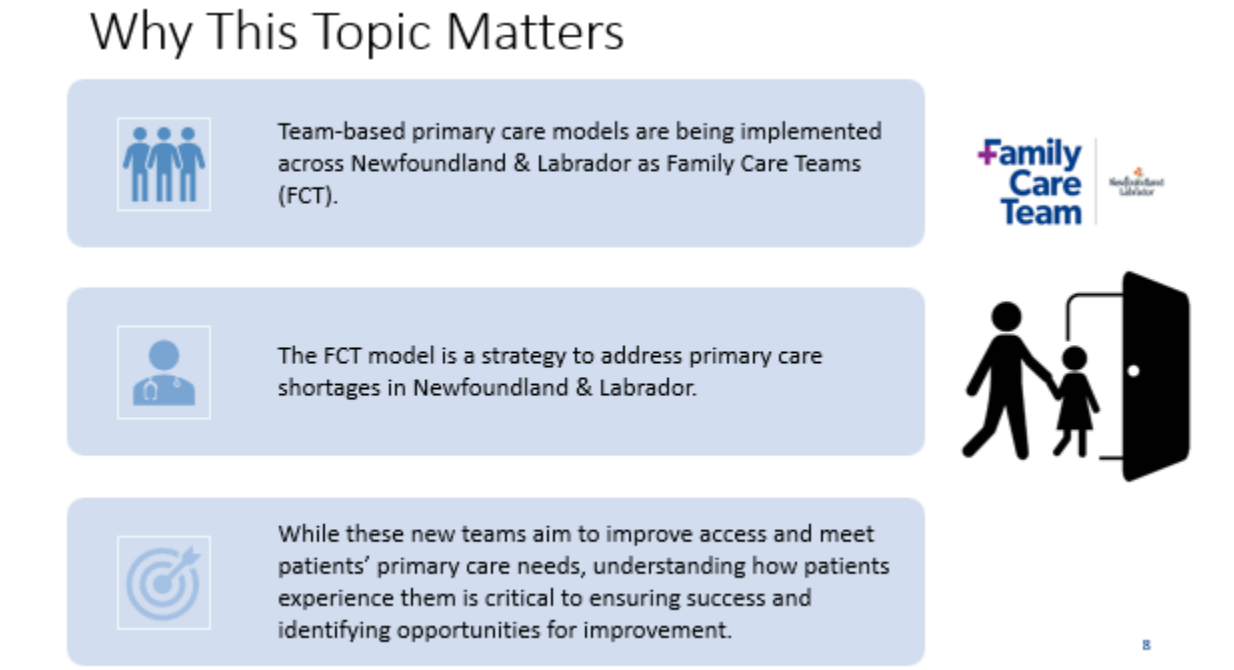


- Rosemary what you presented at the NLSUPPORT PPAC meeting for the background was great. Feel free to use that again!

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)

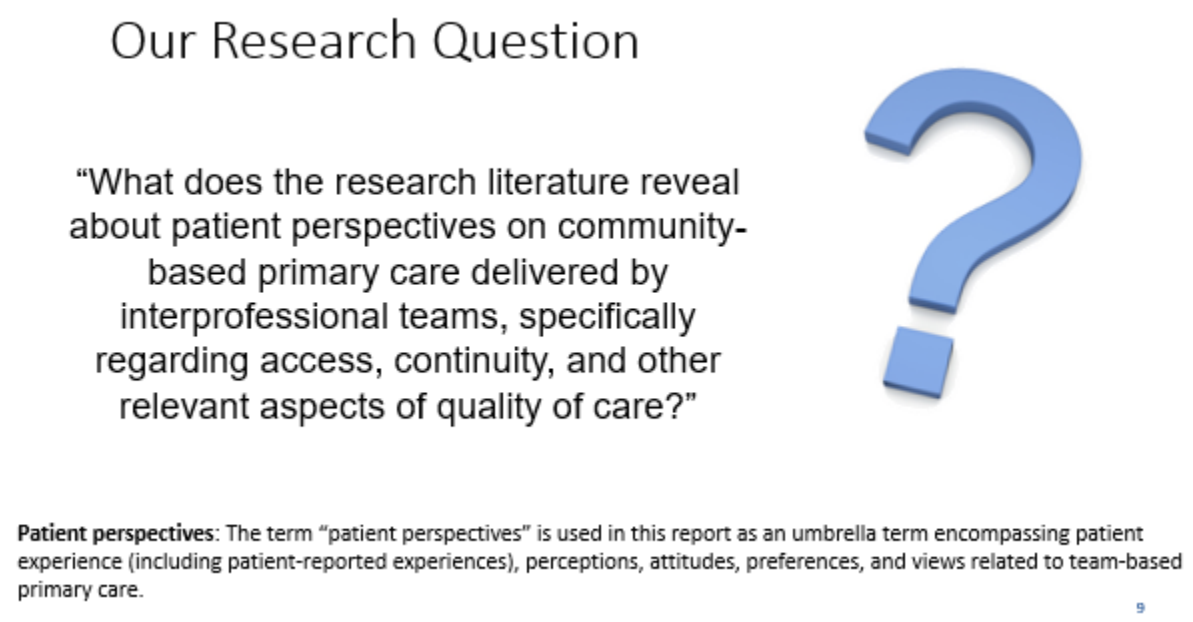


<u>Additional notes on Family Care Teams in NL:</u>

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)

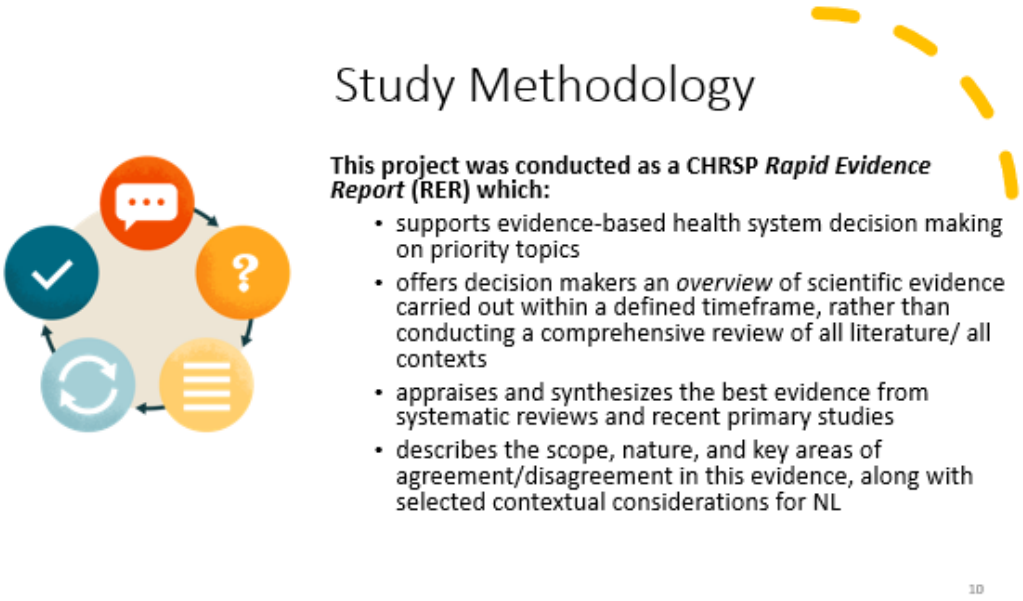


<u>Additional notes on research question (defining terms)</u>:

- **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).

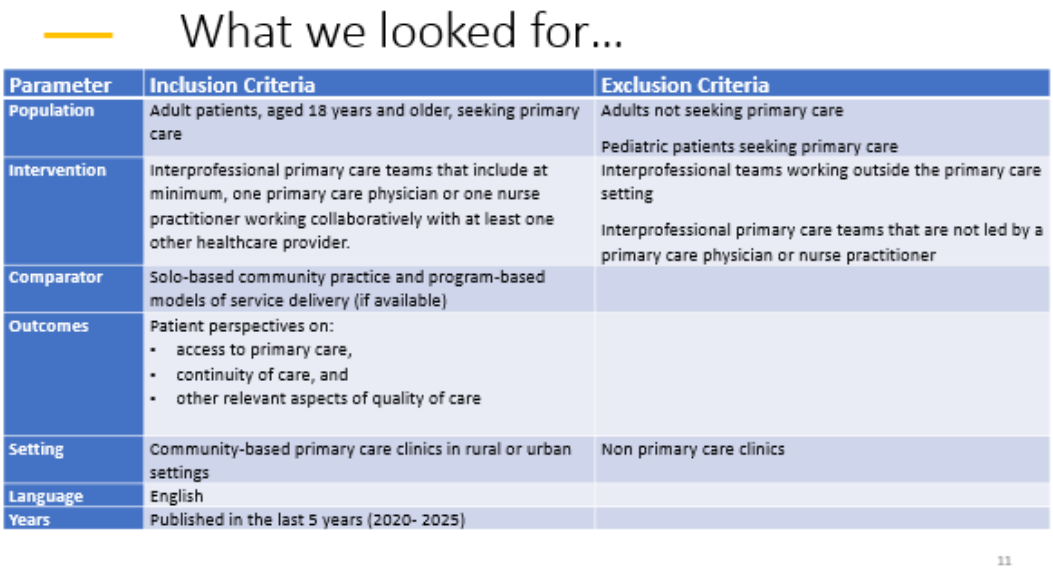
Slide 10: Study Methodology (Emily)



<u>Additional notes on study methodology:</u>

- 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: • 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)

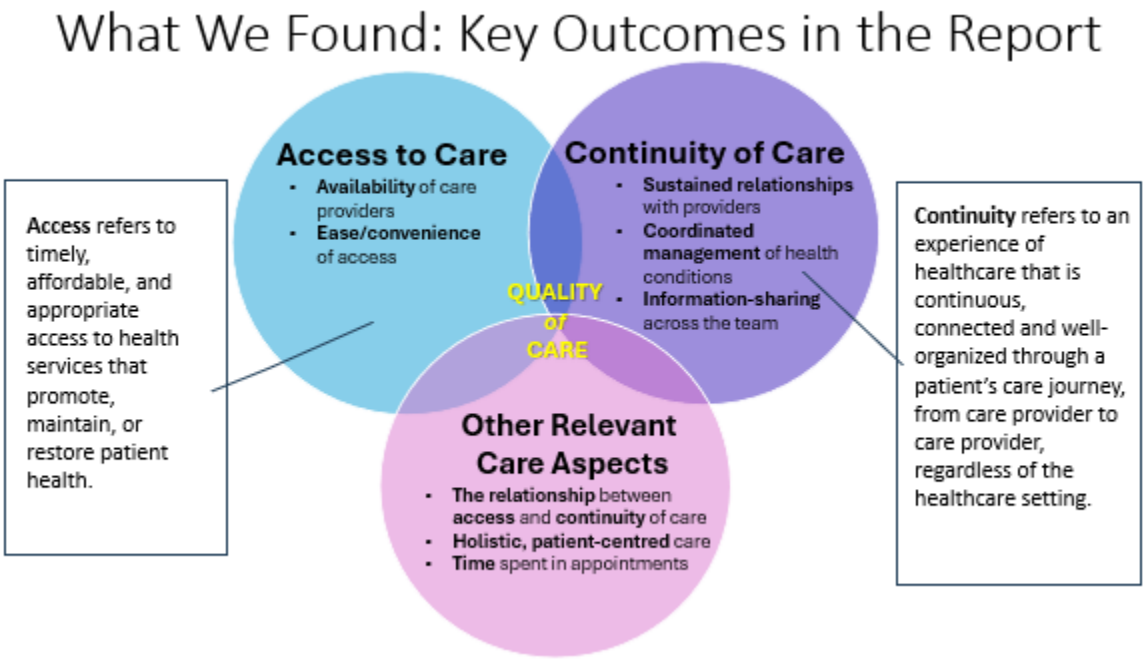
Characterizing the Literature

- **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)



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.

<u>Additional notes on how outcomes were characterized in the literature we reviewed:</u>

- 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.**

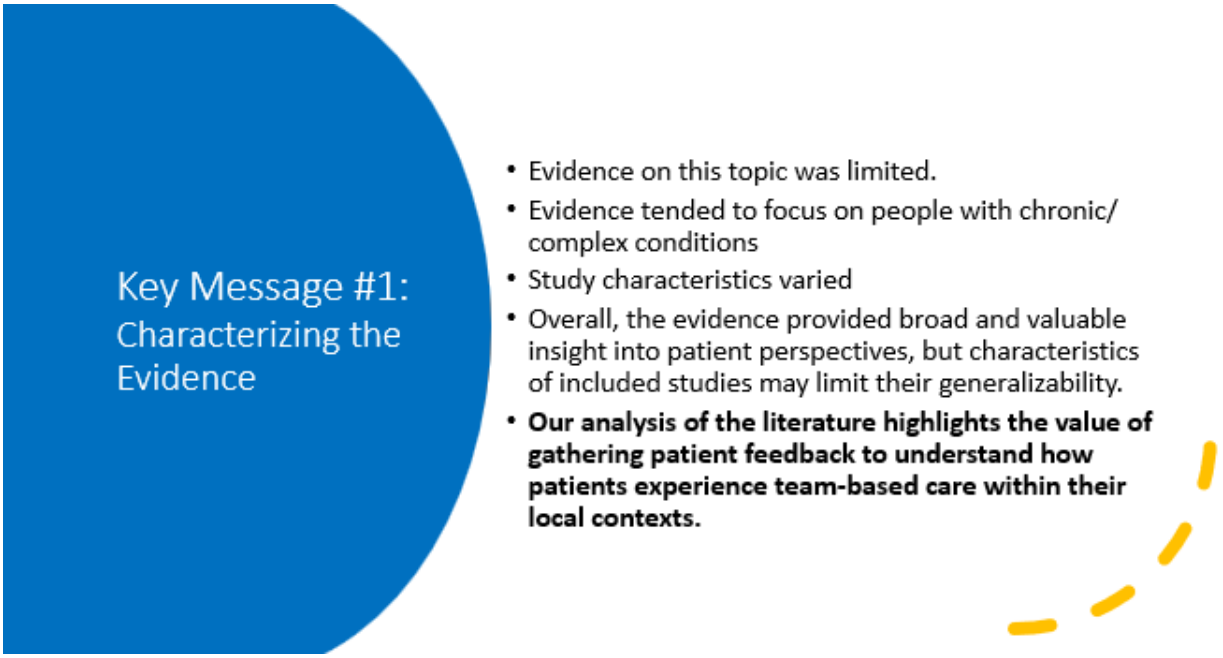
        - The remaining primary studies and the integrative review did not apply a formal framework but examined a range of access-related perspectives.
    - Most of the literature we reviewed examined access to care, including the integrative review and 12 recent primary studies

- **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)



Speaker's notes:

- Rochelle suggested reading the key messages verbatim see below

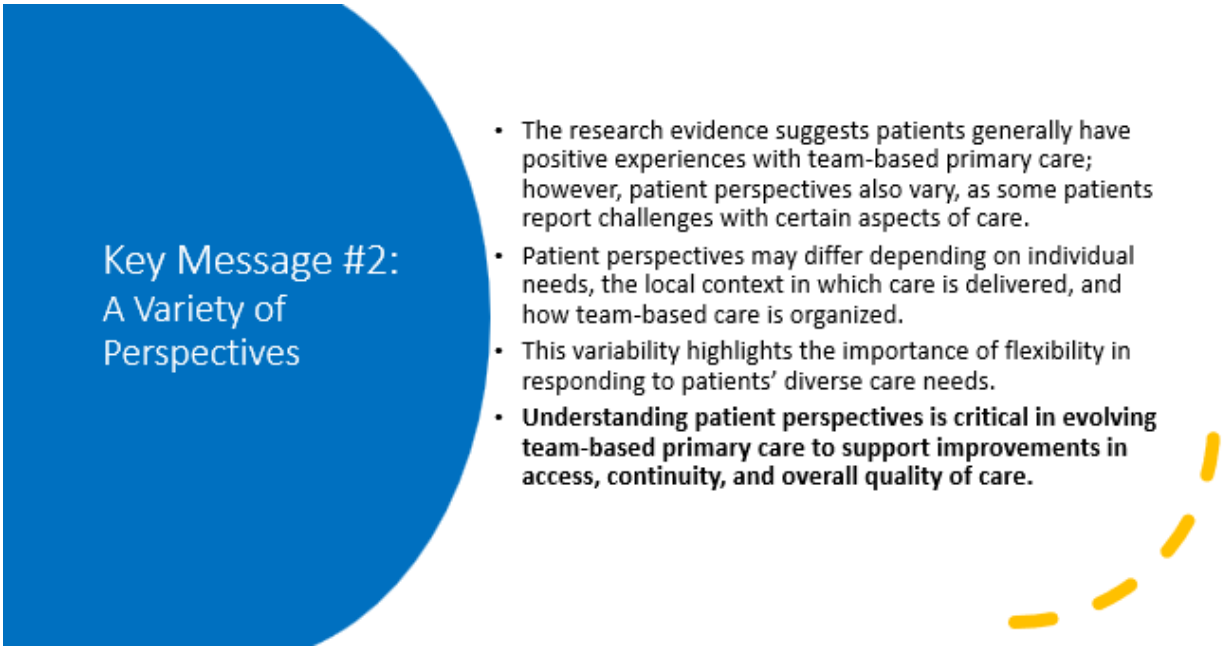
Full key message from the report: Characterizing the Evidence

- 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)



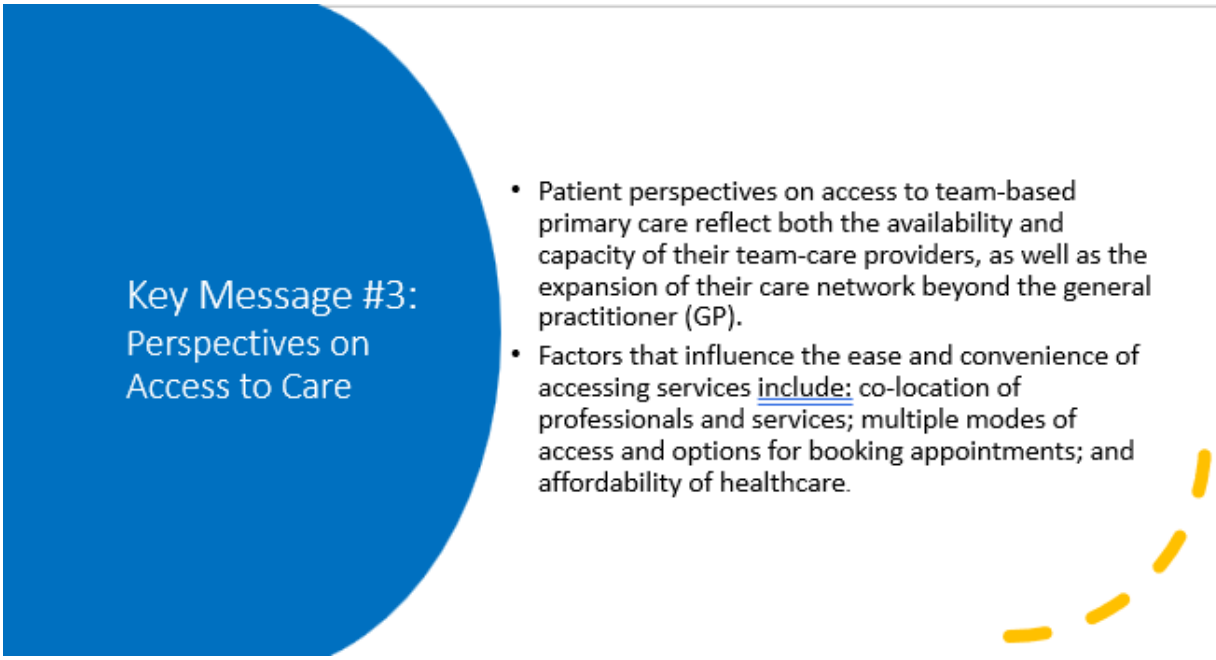
Speaker's notes:

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

<u>Additional notes on the key messages</u>

- 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)



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
Widening the care network beyond the GP	**Co-location of professionals and services** **Multiple modes of access and booking appointments (e.g., face-to face, telephone, video, email)** **Affordability of healthcare**	**Patient-level factors** •Individual patient characteristics influencing patient perspectives on access to care (e.g., health status, gender, education, social vulnerability, immigration status) **Contextual-level factors** •Local health system characteristics influencing patient perspectives on access to care (e.g., clinic size) **Organizational-level factors** •Clinic-level processes influencing patient perspectives on access to care (e.g., estimating supply/demand, referral algorithms, and consultation strategies)

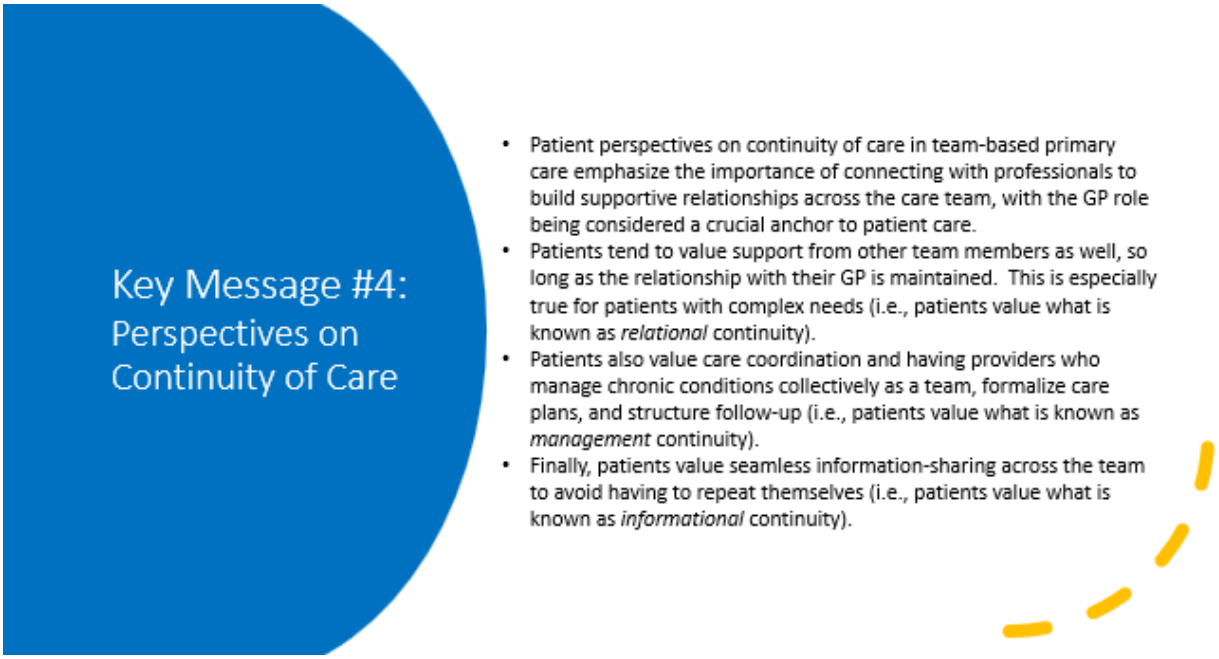
Potential speaker's notes for Access to Care Figure:

- 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)



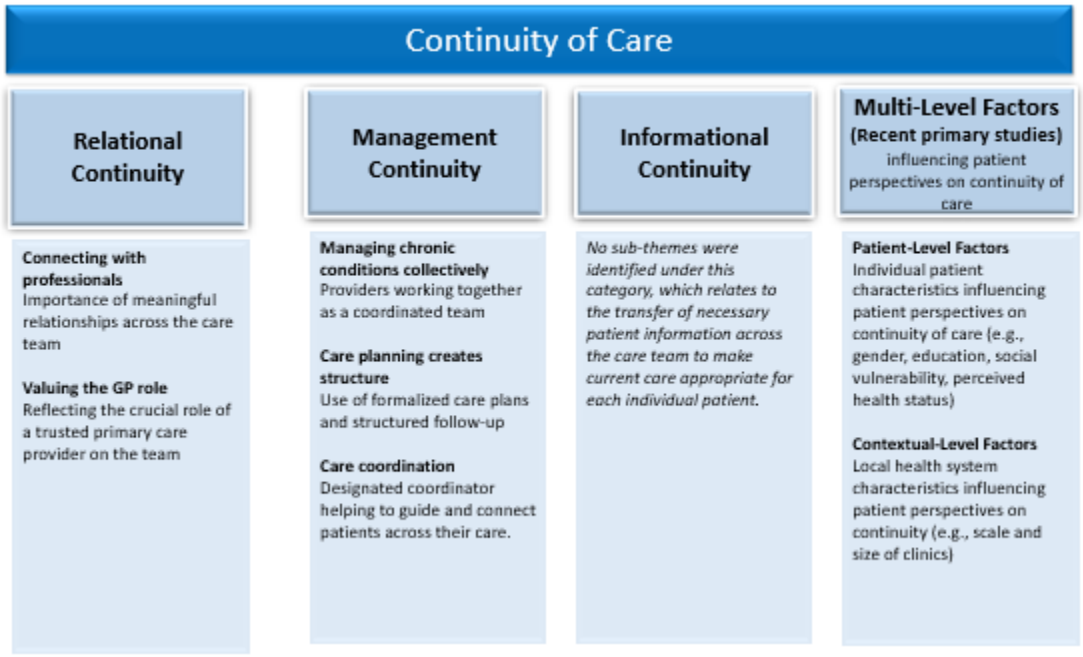
Speaker's notes:

- 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)



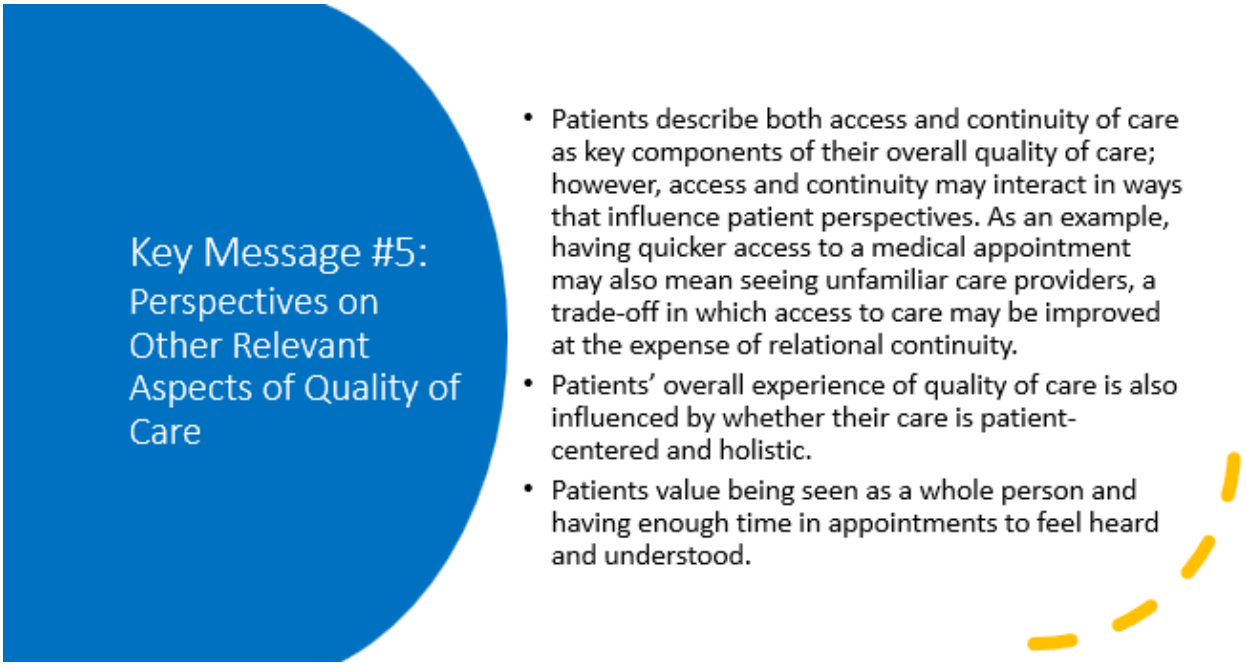
Potential Speaker's notes:

- 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)



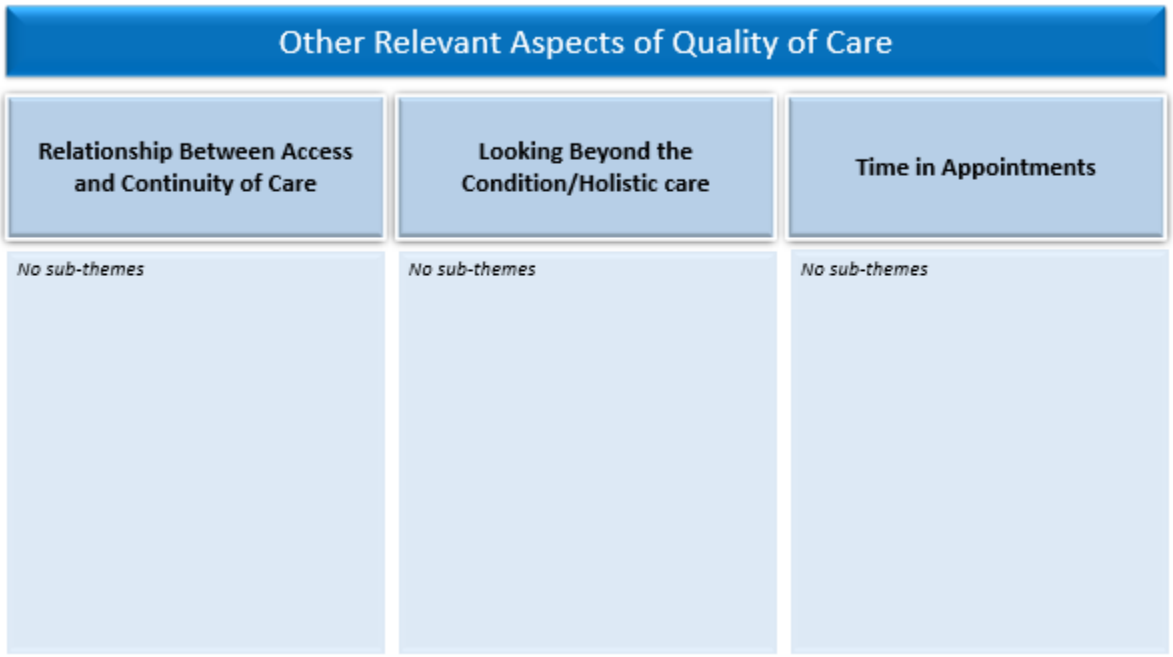
Speaker's notes:

- 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)



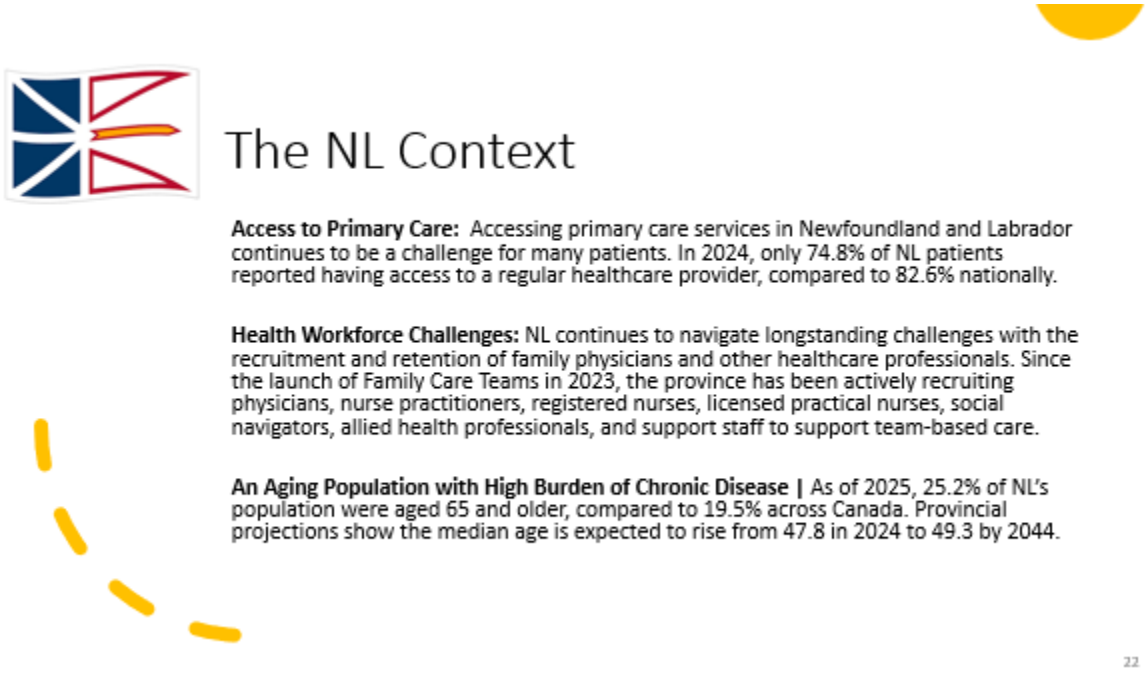
Potential speaker's notes:

- 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).

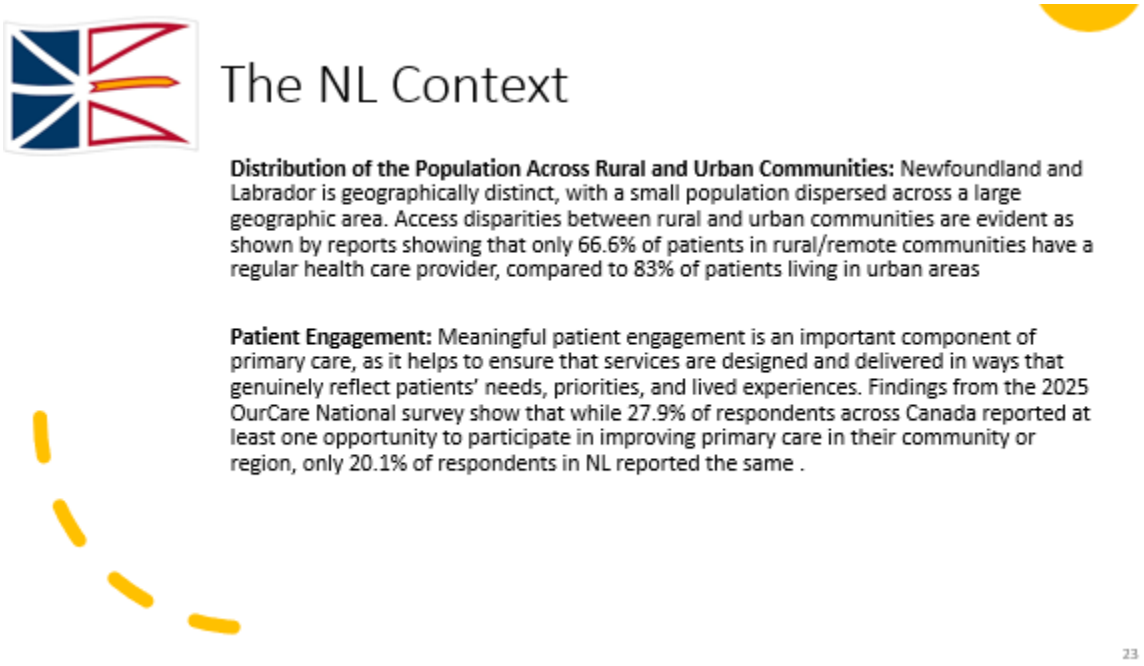
Slide 22: The NL Context (Emily)



<u>Additional notes on the NL Context</u>

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

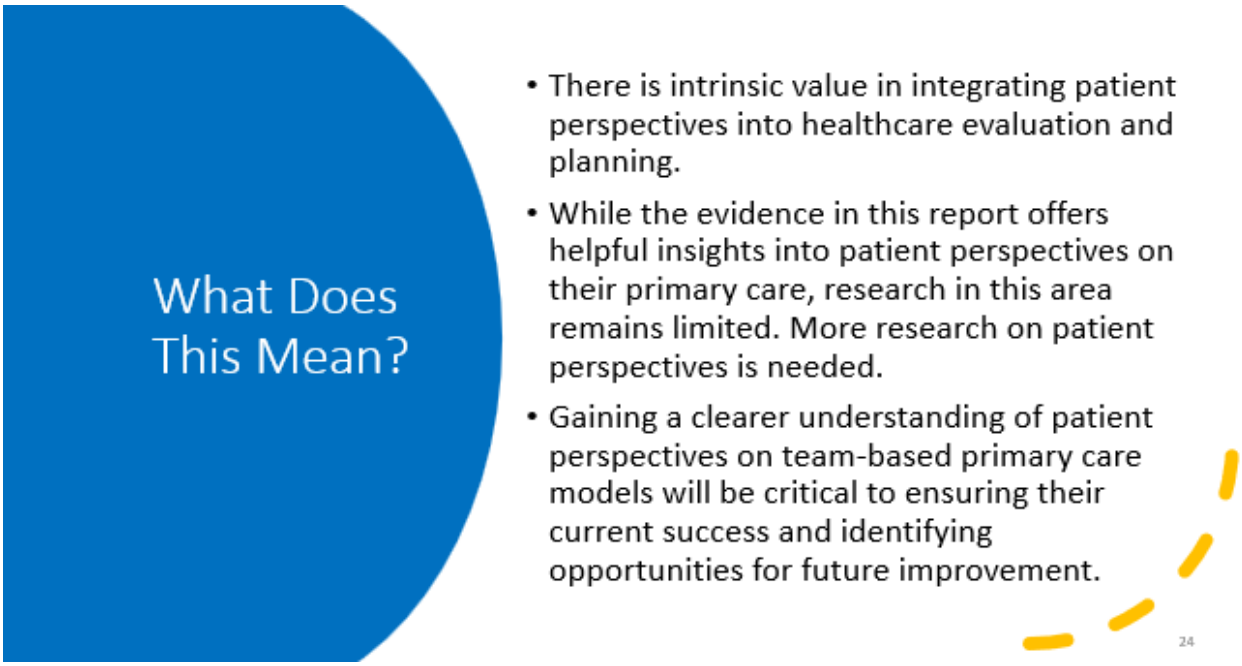
Slide 23: The NL Context (Sarah)



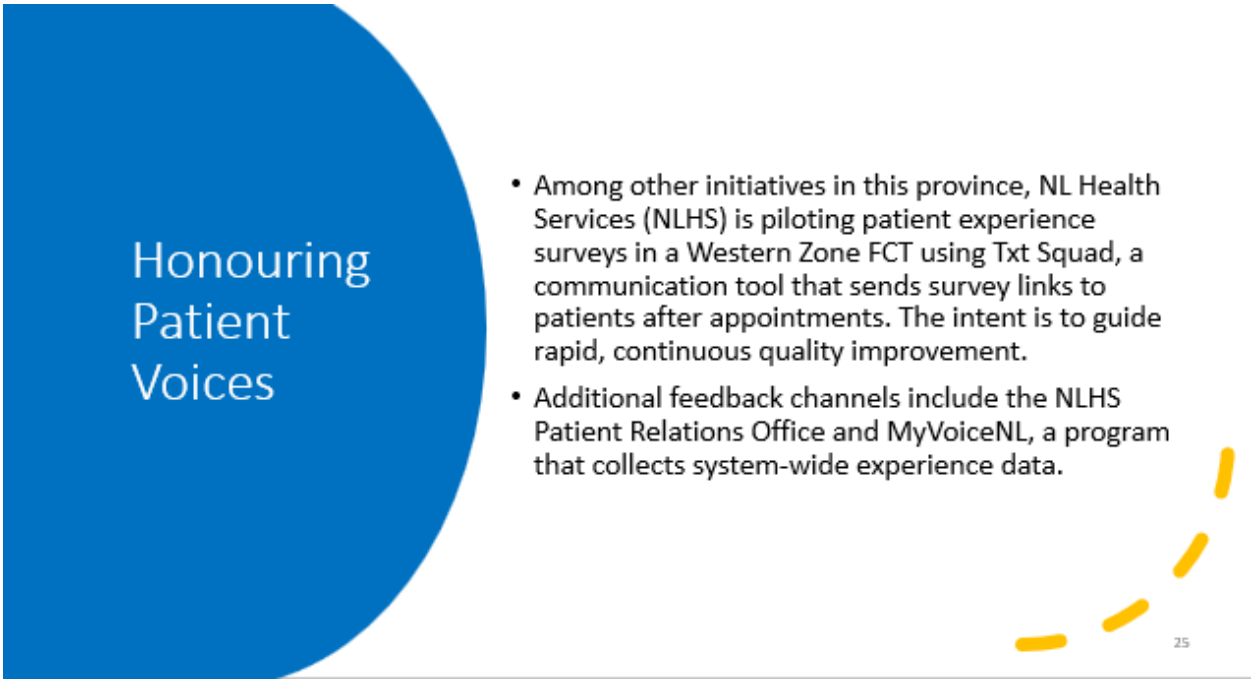
Additional notes on the NL Context

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

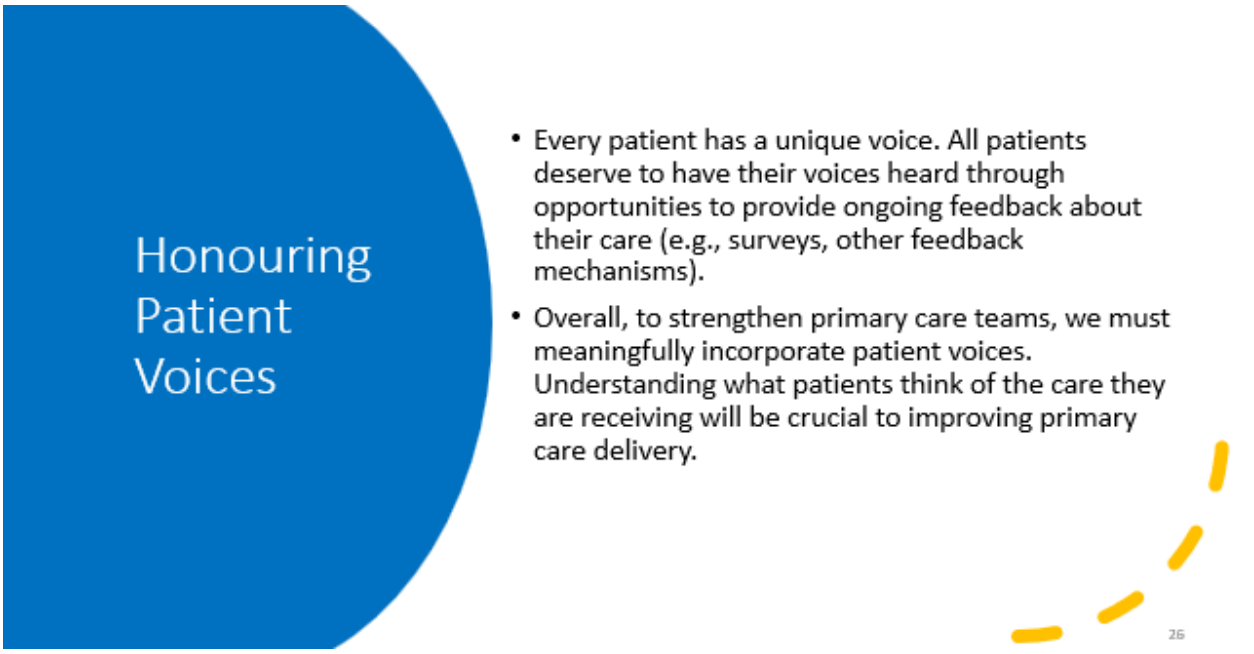
Slide 24: What Does This Mean? (Cris)



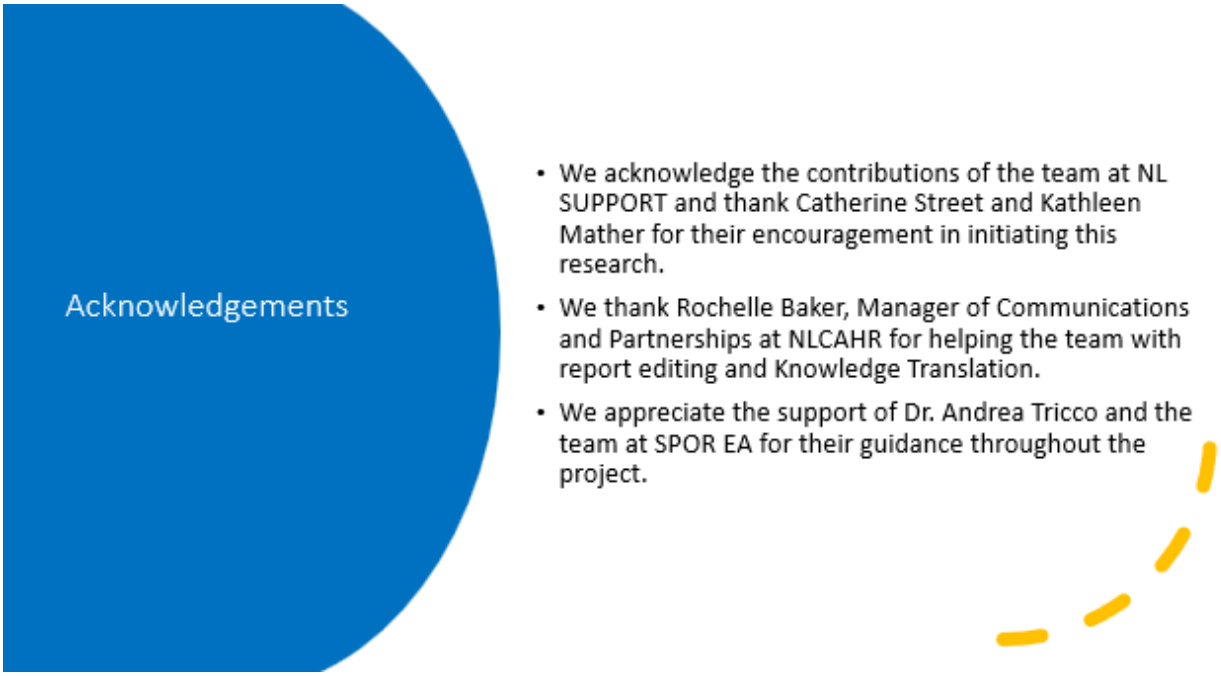
Slide 25: Honouring Patient Voices (Cris)



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



Slide 27: Acknowledgements (Cris)



Slide 28: Questions? (Moderated by Rochelle)

- Rochelle to moderate the Q&A discussion