The interprofessional team-based primary care model currently being implemented in northern British Columbia represents a significant shift in primary care delivery. The purpose of this study is to examine how patients feel known in the context of an interprofessional primary care team that is not co-located, and to illuminate how practices of connection between patients, providers, and team members can influence how care is negotiated within the team. Through methods of observation and interviews, data were collected then analyzed interpretively.

The findings of this study highlight practices within patient-provider encounters that contribute to patients feeling known and maintain therapeutic relationship. The way in which primary care providers know patients influences decision-making about which patients need team-based care, and when. The relationship between primary care providers and team members is also influential in deciding who needs team-based care, yet existing relationships can be disrupted by the degree of uncertainty that occurs alongside major shifts in primary care delivery. Team-based primary care is negotiated through practices of connection and genuine conversation. These practices and conversations influence the timing of team involvement, the information that is shared, and the type of care that is provided.

Implications of these findings can support efforts to increase relationship-based care for patients and improve understanding about what patients value in receiving team-based care. Engaging in practices of connection and genuine conversation helps relieve uncertainty, whether at a team or patient level, and re-aligns the core attributes of primary care as central to delivering high quality team-based care.
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Introduction

Interprofessional team-based primary care models are increasingly being implemented in Canada, as well as in many other countries in the world. Team-based care represents transformation in primary care delivery, and a significant shift away from traditional solo provider primary care practice. These primary care reforms are an opportunity to sustain primary care systems and improve health outcomes for patients. However, as attention turns to the ways in which new models of primary care are performing, the processes by which teams develop and offer primary care services remain insufficiently understood. Within these models, patient experiences of team-based primary care are also under-represented in terms of how or whether patient experience or outcomes are improved.

This interpretive study is about how patients and providers negotiate team-based primary care. The purpose of this study is to examine how patients feel known in the context of an interprofessional primary care team, and to illuminate how patient-provider relationships can influence how care is negotiated within the team. The research questions of this study are:

1. How do patients feel known or not known by a team?
2. How are therapeutic relationships between patients and providers established, maintained, and nurtured over time?
3. How is primary care negotiated from an interprofessional team?

The participants in this study include patients, primary care providers, and interprofessional team members in an urban setting of northern British Columbia. The methodological approach to this research is through engagement with Gadamerian
hermeneutics. The power of hermeneutics is that it allows us to see what is questionable (Gadamer, 1976/1996). It is this task (Gadamer, 1960/2011) that is taken up within this research using methods of observation and semi-structured interviews.

Articulation of the processes and practices through which interprofessional teams function and provide care can offer insight and direction to those interested in delivery of high quality primary care. Attention to how patients feel known and engage in care-seeking practices can improve understanding of how to best offer team-based primary care services. Implementation of interprofessional teams brings change and uncertainty to the practices and relationships of patients and providers. This calls for an approach that seeks to uncover possibilities for new understandings of practice and ways of practicing in the context of team-based primary care.

As an approach, hermeneutics calls for understanding “…the whole in terms of the detail and the detail in terms of the whole” (Gadamer, 1960/2011, p. 291), and that “the movement of understanding is constantly from the whole to the part and back to the whole” (Gadamer, 1960/2011, p. 291). The “details” in play throughout this study are the practices of individuals, while the “whole” is team-based primary care. Examining practices of connection between patients, providers, and interprofessional team members can inform how team-based care is negotiated. The word “negotiate” is selected intentionally to reflect the movement of understanding between the detail and the whole as described by Gadamer.

Practices are defined in this study as “activities repeatedly performed over time” (Kesselring, Chesla, & Leonard, 2010, p. 4). Practices are influenced by the sociocultural and historical situation of individuals. A study of practices, then, requires attunement, or
careful attention to and persistent awareness of, personal, structural, and paradigmatic influences on the way in which practices are embodied and enacted.

The structure of this dissertation unfolds over eight chapters. The first chapter provides an overview of team-based care and background to the development of the Patient Medical Home model in Canada. Chapter Two reviews current literature to identify gaps in method and content in the area of team-based primary care. Chapter Three provides detailed methodology and methods for the study. The description of the analysis, a section on the role of the researcher, and ethical procedures are also in Chapter Three. Chapters Four through Seven are the findings of this study. Chapter Eight provides conclusions and implications based on the findings. The implications of this study serve to inform health care professionals, educators, and health care planners, and advance the research agenda for primary care in Canada.
Chapter One: Situating Team-Based Primary Care

Moving Towards Transformation

Team-based care is a relatively recent development in the Canadian primary care system (Shortt, 2004), with a vision that emphasizes the need for health care professionals from various disciplines to work to their full scope of practice, share expertise, and work together to improve service delivery and patient care outcomes (Kirby & LeBreton, 2002; Romanow, 2002). While most provincial governments have identified team-based care as a cornerstone of sustainable, high quality primary care (Government of Manitoba, 2012; Government of Ontario, 2010; Government of Saskatchewan, 2016), implementation of team-based care across the country has been variable, and evaluation of team outcomes and models in primary care remain mixed with positive and negative findings (Flieger, 2016; Glazier, Zagorski, & Rayner, 2012; Rodriguez, Rogers, Marshall, & Safran, 2007).

Re-forming primary care services and delivery requires major transformation in organization and structure of services and human resources. Efforts in this direction are primarily to improve health outcomes for patients (The Conference Board of Canada, 2014). However, the impetus for this shift was propelled in part from growing recognition that the traditional solo physician family practice model is no longer adequate to provide all manner of care for all patients (Sargeant, Loney, & Murphy, 2008), that family physicians require further support in caring for populations with growing needs and complexities (General Practice Services Committee [GPSC], 2015c), and that new models may help to ease physician burden (Pelak, Pettit, Terwiesch, Gutierrez, & Marcus, 2015).
While the call for transformation of primary care may initially appear somewhat physician-centric, it is important to identify that family physicians have long been considered to be the backbone of primary care (Martin et al., 2004). However, as concerns about the sustainability and quality of the primary care system persist (Health Council of Canada, 2012), other changes to facilitate realigning of services are required. One example is the legislative and regulatory changes made in Canada to facilitate optimization of role and scope of practice for different health care professionals.

In some provinces, such as British Columbia, activities that were previously restricted to physicians have been opened to other professionals through re-structuring of legislation to a competency-based framework. Prior to 2005, only physicians had prescribing authority, which was granted to them based on professional title. Today, nurse practitioners and pharmacists are able to prescribe medication autonomously, and registered nurses can diagnose some conditions and dispense medication with a “certified practice” designation from the regulatory college (College of Registered Nurses of British Columbia, 2016). These legislative changes have introduced nurse practitioners as primary care providers alongside family physicians, and also have increased the function, role overlap, and interdependence of health care professionals who are increasingly expected to collaborate (Macnaughton, Chreim, & Bourgeault, 2013) in order to provide effective team-based care.

With commitment to primary care reforms at the forefront of policy and practice discussions, decisions are required about implementation of new primary care models. Organizational and structural changes require significant financial and professional investment on many levels. Further understanding of how primary care transformation
might achieve the Triple Aim (Berwick, Nolan, & Whittington, 2008) while preserving the core values of primary care (McWhinney, 1998; Starfield, 1998) is necessary in moving forward to transform delivery of high quality primary care in Canada.

**Modeling Primary Care**

Acknowledgment that new models of team-based primary care are essential to sustainable primary care service delivery is now pervasive in countries such as the United Kingdom (The King’s Fund, 2015), Australia (Australian Commission on Safety and Quality in Health Care, 2010), and the United States (Agency for Healthcare Research and Quality [AHRQ], n.d). In order to better understand the origins and influences on the model of team-based care currently unfolding in northern British Columbia (BC), which is the location for this research, a brief overview of the development of primary care models in the Canadian context is given here.

In the United States, a model that has been widely adopted, implemented, and evaluated is the Patient Centered Medical Home (PCMH). The PCMH is a blending of the patient medical home, a term coined in 1967 in response to a call to house a child’s medical records in a central location (American Academy of Pediatrics, 2016), and Wegner’s Chronic Care Model (Flieger, 2016). The PCMH renews the focus on primary care (Sweeney, Bazemore, Phillips, Etz, & Stange, 2012). The PCMH is seen as a model to implement the core tenets of primary care (Westfall et al., 2014), and a vehicle to achieve the Triple Aim of improving health and patient experience while reducing per capita cost (Fontaine, Flottemesch, Solberg, & Asche, 2011).

In Canada, the College of Family Physicians of Canada (CFPC) released its vision for the Patient Medical Home (PMH) in 2011. Although the CFPC (2011) acknowledges
many shared elements with other models, such as the PCMH, the PMH is distinctly Canadian due to incorporating values of fairness, equity, and access for all to health care (p. 5). The PMH is defined as the place where patients feel most at home to discuss “personal and family health and medical concerns” (p. 8), and is built on ten pillars. The pillars include patient-centred, personal family physician, team-based care, timely access, comprehensive care, continuity, electronic records and health information, education and training, system and supports, and evaluation (CFPC).

The CFPC alternately describes the PMH as a vision, a concept, and a frame of reference, in addition to referring to it as a model. This language may be an attempt to reinforce the CFPC message that the PMH is not an attempt to “re-engineer” (p. 19) primary care. Rather, there is encouragement towards contextualization of initiatives so that the objectives of the PMH may be achieved without suggesting a heavy-handed course correction that might detract from innovation and success in creating a patient-centred health care system.

In all provinces and territories, primary care reform initiatives were underway years before the CFPC (2011) published their vision for PMH. The Primary Health Care Transition Fund (PHCTF) provided $800-million to provinces and territories, and also for regional and national initiatives, to invest in primary care renewal beginning in September, 2000 (Health Canada, 2007). Thus, by 2011 when the CFPC published the PMH model, many objectives outlined for the PMH model were already being met through initiatives such as Family Health Teams in Ontario, Family Medicine Groups in Quebec, and Primary Care Networks in Alberta (CFPC). The PMH concept can serve to strengthen such initiatives (CFPC).
British Columbia did not use the province-specific PHCTF monies of $74-million to invest significantly in projects committed to implementing team-based care. Rather, projects in BC focused on Quality Improvement Days to engage physicians, patient mapping, creation of chronic disease management guidelines, and financial incentives to physicians to improve chronic disease management (Health Canada, 2007). Initiatives to support patient self-management were also supported through the PHCTF (Health Canada). One critique of the BC government’s use of the PHCTF from pharmacists and nurses was that the focus was too much on physicians (Health Canada).

Critique of the government of BC for failing to embrace interprofessional team-based primary care continues, a decade after the PHCTF concluded. Lavergne and McGrail (2016) calculated the costs of the financial incentives provided to physicians for providing extra services such as complex care and mental health counselling. The costs for this program overall were more than $150 million, with no associated changes in number of primary care visits or hospitalization rates (Lavergne & McGrail), indicating poor cost effectiveness.

Shifts towards team-based care in BC are now being implemented. In 2014, the provincial government identified interprofessional teams as a priority for primary and community care (Ministry of Health, 2014), and by 2015 gave explicit support to establish “team-based family practices” (Ministry of Health, 2015, p. 10). The General Practice Services Committee (GPSC), which is a partnership between the provincial government and Doctors of BC (legally the BC Medical Association) adopted the CFPC (2011) pillars of the PMH to support goals of patient-centred comprehensive care (GPSC,
The most recent model of the BC PMH vision is below (reprinted with permission) as Figure 1:

The GPSC (2015b) further differentiates a Primary Care Home (PCH) from a PMH. The PCH is defined as a team-based approach where the PMH is “linked with health authority and community agency primary care services which form the foundation of a coordinated system of primary and community care in the community” (GPSC para 4). The differentiation between PMH and PCH is not transparent, but seems to indicate that if the “team” aspect of team-based care is not within the PMH but rather is represented by health care professionals who are health authority employees, then the correct term is PCH. Within this definition, the GPSC refers to the PMH only as a “full service family practice” (para 4), and not as an interprofessional team.
In Northern Health, where this research took place, commitment to interprofessional primary care teams is ahead of provincial initiatives, as outlined by the objectives of the study *Partnering for Change: Understanding the Contribution of Social Entrepreneurship to Primary Health Care Transformation* (MacLeod et al., 2011). As interprofessional team development and implementation progresses within Northern Health, language and definitions used to describe team-based primary care have changed to reflect current and common understandings of this phenomenon. As such, Northern Health also uses the term PCH to describe interprofessional team-based primary care. The definition is:

A person-centred medical care setting, such as a family doctor’s office, where people establish a long-term relationship with a personal physician or nurse practitioner who provides and directs their medical care. Interprofessional teams are available to the person and family if the person and their primary care provider, including the primary care nurse decide together that the person might benefit from team involvement (Northern Health, n.d.b).

This definition of PCH is different from the one offered by the GPSC, and there are some other inconsistencies and phrasing that are of interest to note in light of the research questions for this study. First, Northern Health places the PCH description under the heading of Primary Health Care on their webpage. Yet, the PCH is described as a medical care setting, with the social aspects of health care not explicitly included. Second, it is clear that not every patient is expected to interact with the interprofessional team, and there may be a temporal element as well as a gate-keeping element to determine who receives team-based care as well as when they might receive it. Both these elements highlight the importance of improved understanding of how team-based care is negotiated within a PCH, and how a feeling of being known may influence provider and team member understandings of who needs team-based care, and when.
This overview to the development of team-based primary care models serves to highlight some of the influences and drivers of current thinking and investment in primary care reforms in BC. The complexity and high stakes for success of implementation of interprofessional primary care teams emphasizes the importance of understanding who needs team-based primary care, and when, in order to receive high quality primary care. The next chapter will turn to examine some of the gaps in current understandings of team-based primary care, to further illustrate how the focus and approach to this research can contribute to knowledge of interprofessional primary care teams in Canada.
Chapter Two: Uncovering Gaps in Understanding

Transforming primary care requires major changes to the organization and delivery of primary care services. Some of these changes have been closely examined in terms of the structure, process, and outcomes of PCMH/PMH models in Canada, the United States, and other countries. This Chapter will consider current understandings of team-based primary care, highlighting areas of attunement in this research, while at the same time drawing attention to aspects of team-based primary care that may require further differentiation and articulation.

Working in Teams

With team-based care trending towards the norm in Canada (Martin, 2012), the concept of interprofessional collaboration has received much attention. Services have been realigned with hopes of bridging disciplinary silos\(^1\) (Sahota, 2009) and flattening hierarchies (Nutting, Crabtree, & McDaniel, 2012). Yet structures can be shifted more quickly than relationships (Flieger, 2016), and health care professionals can be significantly affected with implementation of new models of care delivery (Armstrong, 2013).

Changes that a shift to team-based care brings to a primary care environment can be overwhelming and challenging (Allan et al., 2014; Rodriguez et al., 2014). The cohesion and effectiveness of a team may be negatively affected when there are competing priorities (Allan et al., 2014), when teams are not co-located (Allan et al.), when implementation of change is prescriptive (Doctors of BC 2015; Van Roy, Vanheule, & Deveugele, 2013) and when professionals are uncertain or uninterested in

---

\(^1\) A “silo” is a term used to describe isolation in health care, usually indicating groups or departments who do not frequently share information or resources.
one another’s roles (Edwards et al., 2015). In the BC context, where team-based primary care is in early stages of implementation, attunement to challenges such as the ones listed above may contribute to understanding how such issues develop or resolve. The influence of co-location is of particular interest in this research, as most teams in urban areas of Northern Health are not co-located.

Information technology is also an important factor when considering the negotiation of team-based primary care in terms of understanding how information is shared and transferred over time. The teams that are not co-located in Northern Health do not fully share an electronic medical record (EMR). Rather, physicians in fee-for-service practices use one version of an EMR, and the interprofessional team members use a different version. The way in which team members use the EMR, particularly in how it influences factors such as communication and coordination, has been articulated in this research. Issues with information technology can be exacerbated when there are limitations of interoperability or inconsistency of use between team members (Banfield et al., 2013; Denomme, Terry, Brown, Thind, & Stewart, 2011; Krist et al., 2014; McMurray et al., 2013).

Current understandings of team-based primary care also reflect what facilitates effectiveness and collaboration within teams. Some authors report facilitators that are simply the polar opposites of attributes that detract from team-based care. Thus when team members know one another’s roles and scope of practice (Brown et al., 2015; Gaboury, 2009; Rodriguez et al., 2014), are co-located or have physical proximity to one another (Brown et al., 2009; Chang et al., 2014; Cromp et al., 2015), it has been found that collaboration can be strengthened.
Other factors, such as opportunity for team-building activities (Brown et al., 2010), a shared vision (Brown et al., 2015; Smith-Carrier & Neysmith, 2014), and leadership (Allan et al., 2014; Cromp et al., 2015, Flieger, 2016; Rodriguez et al., 2014; Smith-Carrier et al., 2016), are indicators of high-functioning teams. Examining the process of how and whether these facilitators are present in this research will contribute to knowledge about team-based primary care implementation in northern BC.

Communication between team members is another attribute of interprofessional collaboration that resonates throughout the primary care literature as central to effective team-based care (Banfield et al., 2013; Brown et al., 2009; Chang et al., 2014; Cromp et al., 2015; Gaboury, 2009; Morgan, Pullon, & McKinlay, 2015). Notably absent from current literature, however, and particularly with regard to interprofessional teams who are not co-located, is any guidance about how interprofessional team members become or stay involved in patient care. The timing, process, and factors influencing decision-making about which patients need a team is unknown. Further, the length of time or composition of interprofessional team members required for a patient’s optimal care is variable, and how this is negotiated within the team is also unknown. These gaps in understanding are indicative of a knowledge base not yet caught up with the shift in evolving systems of primary care delivery that involve teams.

Questions about how and when patients receive team-based care uncovers further questions about how patients feel known within a team. Almost no literature exists that includes discussion of patients as team members, while studies that have been published are within the acute care context (for example Lavoie-Tremblay et al., 2014). Aside from these scant findings, patients seem to be included mainly through efforts to involve
patients in management-level decision-making that is sometimes termed as “user-involvement processes” (Martin & Finn, 2011, p. 1053) in health care.

Understanding how patients are engaged with different health care professionals over time and who patients consider part of their team is not found in current literature. While it is recognized that it is possible to have multiple healing relationships (Scott et al., 2008) between patients and health care professionals, and that patients want to feel known (Ceraghi-Sohi et al., 2008; Schers, Van den Hoogen, Bor, Grol, & van den Bosch, 2005; Turner et al., 2007), how this unfolds within a primary care team, and how feeling known contributes to negotiating care towards improved outcomes in primary care, is missing from the ongoing discourse of team-based primary care.

The PCMH/PMH models of primary care hinge on team-based care (Cromp et al., 2015), yet team-based care is only one pillar of the PMH vision for high quality primary care (CFPC, 2011). It is necessary to consider some of the other pillars, with particular attention to how team-based primary care might influence some of the other attributes that are recognized as core values of primary care.

**Examining Core Attributes**

With the twinned motivations of evidence and policy guiding BC towards implementing the PMH, it is timely to inquire and examine how the widely recognized core attributes of primary care (Ferrante, Balasubramanian, Hudson, & Crabtree, 2010; Haggerty et al., 2007; Leatherman & Sutherland, 2010; Picker Institute Europe, 2016; Romanow, 2002; Starfield, 1998) are conceptualized. There is some variation in terminology when talking about aspects of primary care, which can threaten to obscure common understanding of key concepts.
Words like “values” (McWhinney, 1998; Starfield, 1998), “principles” (Picker Institute Europe, 2016), “attributes” (Haggerty et al., 2007) or “factors” (Christakis et al., 2004), are variously used to describe essential elements of high quality primary care. For clarity of purpose, the word attribute is selected for this study. The core values of primary care include key attributes but also intangibles for which evidence of effectiveness is not always possible or desirable; McWhinney (1998) gives the example of compassion. Thus, a focus on attributes extracts, to some degree, the highly debatable aspects of what might be inherently “good” about primary care.

Attributes of primary care have key characteristics through which they can be defined, and this process was carefully completed by primary care researchers in Canada (Haggerty et al., 2007). These attributes were then rated by recognized primary healthcare experts as to the importance of the attributes within different models of primary care (Levesque et al., 2011). Thus, there is a point of reference to understanding how primary care attributes are prioritized or emphasized in the Canadian context. Noticing which attributes are prioritized by health care planners and clinicians can also indicate what is valued about primary care in contemporary settings.

In this chapter, the attributes of patient-centredness, accessibility, comprehensiveness, coordination, and continuity are given priority for two reasons. First, these are attributes for which key characteristics can be enacted through practices of patients, primary care providers, and interprofessional team members. Second, these are attributes represented by pillars within the CFPC (2011) PMH model and adapted by the GPSC (2016) model.
While consideration of the role of personal family physician (or primary care provider) will be offered in the context of team-based primary care, the primary care provider role is not considered in isolation. Similarly, the CFPC (2011) pillars relating to information, system supports and evaluation are embedded within this research but are not a dedicated focus. Instead, attention is turned more fulsomely to the attributes that can be interpreted through practices to better understand how team-based primary care is negotiated in the context of therapeutic relationship and knowing or not knowing patients.

The GPSC PMH model (2016) provides descriptions for each attribute represented in the model, and the attributes are organized into three domains with titles of service, relational, and structural attributes or enablers\(^2\). The descriptions are based on the CFPC (2011) framework (GPSC, 2015b), thus not necessarily on definitions of attributes found within the academic literature. This section will provide an overview of these attributes, which informed the approach and data collected for this study.

**Patient-centredness**

At first glance, the attribute description of patient-centred, whole-person care is directed towards outcomes, and not process or method. The description states that care is easily navigated, centred on the needs of the patient, delivered in a culturally appropriate manner, with recognition of social determinants of health (GPSC, 2016). This idealized descriptor embeds a number of factors that require coordination between multiple levels of the health care system while assuming cultural competence and a broad understanding of health by providers. There is no indication of who determines the needs of the patient, or how providers might achieve patient-centred care. To improve understanding of how

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\(^2\) The list of descriptions is accessible only by clicking on the hyperlink “12 attributes of a patient medical home in BC” via the GPSC (2015) webpage at the following link: [http://www.gpsebc.ca/what-we-do/primary-care-bc/patient-medical-home](http://www.gpsebc.ca/what-we-do/primary-care-bc/patient-medical-home)
to provide patient-centred care in order to achieve the outcomes described for this attribute, the descriptor could be modified to include the four interactive components of the patient-centred clinical method (Stewart et al., 2014). These components, widely recognized in research and education fields, are exploring health, disease, and the illness experience; understanding the whole person; finding common ground; and enhancing the patient-clinician relationship (Stewart et al.).

**Accessibility**

The description of access by the GPSC (2016) appears to be a blend of the definitions offered by Haggerty et al. (2007) for first contact access and accessibility – accommodation. Yet the language is changed somewhat, from “[t]he ease with which a person can obtain needed care …” (Haggerty et al., p. 340), to “[p]atients are able to access …” and “patients know how to appropriately access …” (GPSC, 2016). The difference in this phrasing invites analysis and questioning.

The GPSC (2016) description seems to shift the onus of responsibility to the patient being the one requiring the knowledge and capacity to seek the care needed, rather than the PMH or health care system taking the responsibility to ensure patients do not encounter barriers when attempting to seek primary care. The GPSC description of access is further limited by focusing narrowly on availability of services (Aday & Andersen, 1974), while failing to recognize there are predisposing factors that contribute to patient decisions about accessing health services (Andersen, 1995), and that the structure of the PMH will influence care-seeking practices (Andersen, Vedsted, Olesen, Bro, & Søndergaard, 2011) and thus access (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008). The concept of “appropriate access” as described by the GPSC for this attribute is
unexamined within the model, and may inadvertently widen the significant and unequal
gap in care, particularly for marginalized populations (Adelson, 2005; Conradson &
Moon, 2009).

**Comprehensiveness**

The GPSC (2016) description for the attribute of comprehensiveness, following
the CFPC (2011) vision and objectives for this pillar, outlines how comprehensive care is
delivered across care settings, throughout the lifespan, and regardless of geographical
location. Comprehensive care is provided within the PMH, or via linkages to
“comprehensive services”. In this description, it appears that this model of PMH focuses
on the individual patient as the unit of analysis or interest. While the patient-centred
attribute description for the PMH does state that care is centred on the “needs of the
patient, family, and community” (GPSC), it is the patient as an individual that is the focus
in the remaining descriptions of the attributes. This raises questions about comprehensive
care, from a population health perspective. While the comprehensive care description
includes health promotion and prevention (GPSC), there is no explicit linkage between
the PMH and public health. Unless public health is conceptualized as a “specialized
service” (GPSC), which would be inconsistent with the way in which it is usually
discussed and operationalized within the Canadian context (Martin-Misener & Valaitis,
2009), the tenets of population health and linkages with public health appear to have been
overlooked in this model of the PMH. This lack of a population orientation (Haggerty et
al., 2007) may be cause for concern as the PMH is implemented.
Coordination

Coordination within and outside the PMH is linked with relational and informational continuity in the GPSC (2016) description of this attribute. In this way, it appears that agreement about defining coordination in contrast to continuity aligns with the findings of Saultz (2003). Saultz reviewed the Reid, Haggerty, & McKendry (2002) definitions of relational, informational, and management continuity with the conclusion that the definition of management continuity is a better fit within the concept of care coordination, as opposed to being a third type of continuity.

Coordination is dependent on continuity in the PMH (GPSC, 2016), and clear pathways are required particularly as patients transition “to and from specialized services” (GPSC). Attention is drawn again to the choice of language in this description, as coordination is focused only between the PMH and specialized services. Patients receive care and support from many community-based services that also influence health and primary care outcomes. Neglecting to consider how these services might be coordinated for patients and understood by team members within the PMH may be problematic in providing comprehensive, accessible, patient-centred, and team-based care.

A second important issue regarding the description of coordination within the PMH model (GPSC, 2016), is understanding how team members will establish and maintain personal relationships and informational continuity with one another, particularly for the PMH (or PCH) where team members are not co-located. The PMH is referred to as the “hub” for coordinating care, but this may be difficult if team members included as part of the PMH are not geographically proximal to one another. How
primary care providers and interprofessional team members know one another and share or transfer information related to knowing and caring for patients is of interest to this study.

Successful coordination of care relies on more than simply having information available (Banfield et al., 2013). Coordination is not at all observed by patients, but they will assume it is happening (Haggerty, Roberge, Freeman, & Beaulieu, 2013). Thus, within the PMH, it is worthwhile to pay attention to what information is disclosed by patients and what information is shared with patients.

Coordination is notoriously difficult to measure, and inconsistently defined within the literature (Banfield et al., 2013). Noticing and articulating what factors influence how information is incorporated into planning care for patients, as well as how information is shared or transferred between team members may be helpful to advance understanding of this attribute. In this study, attention to salient features and the process of how care is coordinated (or not) within and outside the PMH may offer new insights to improve coordination in primary care.

**Continuity**

The description of continuity for the conceptualization of the PMH in BC is:

Longitudinal relationships support patient care across the continuum of patient care, spanning all settings. The enduring relationship between the patient, family physician (or NP where appropriate) and PMH team is key, and needs to be supported by informational continuity (two way communication that informs appropriate and timely care) (GPSC, 2016).

The full description is included as this attribute is central to the framing of the research questions of this study, and is deserving of careful attention. Continuity of care is viewed as a principal attribute of primary care (Hill, Twiddy, Hewison, & House,
and is usually understood as intrinsically desirable (Tousignant et al., 2014). Thus, some of the language within the GPSC (2016) description seems somewhat limiting.

The first sentence in the description is that longitudinal relationships will support patients across all settings. The scope of this statement is unclear. It seems uncertain whether it is expected that the strength of the longitudinal relationship between patient and provider will be supportive regardless of setting, whether longitudinal relationships can be expected to develop in various settings, or whether an entirely different meaning is intended. Further, the focus on longitudinal continuity is representative of the temporal aspect of the relationship, while wording to highlight the healing aspects or expectation of quality in a longitudinal relationship is missing.

In choosing a word to describe the longitudinal relationship between patients and providers, the GPSC (2016) description includes “enduring”. The word endure can have both positive and negative connotations, but seems a unique choice given the array of research that focuses on describing the patient-provider relationship as healing (McWhinney, 1998; Scott et al., 2008; Tarrant, Windridge, Boulton, Baker, & Freeman, 2003), and further research that suggests that continuity is dependent on the strength of connection (Heaton, Corden, & Parker, 2012; Phillips-Salimi, Haase, & Kook, 2011; Ridd, Shaw, Lewis, & Salisbury, 2009) in order to be sustained (Reid & Wagner, 2008).

If words such as healing, sustained, or connected seem inadequate to describe the relationship between patients and providers, it is equally puzzling to consider why the GPSC (2016) description does not incorporate widely accepted definitions of types of continuity as developed by Haggerty et al. (2003). Relational continuity is straightforwardly reported as “an ongoing therapeutic relationship between a patient and
one or more providers” (Haggerty et al., p. 1220). This definition captures a degree of the temporal and quality dimensions, and it also keeps the patient central to the definition.

The definition of informational continuity may have been just as helpful; “the use of information on past events and personal circumstances to make current care appropriate for each individual” (Haggerty et al., p. 1220). This definition is broad yet indicates the type of information that may be considered. It refers to using information, rather than the much narrower term of “two way communication” (GPSC, 2016).

Specifying informational continuity within the GPSC (2016) description as two-way communication is a restricted interpretation. If it is meant that information is communicated between two providers, leaving the patient out completely, it lacks patient-centredness. It also lacks application for team-based care, particularly for written communication. When information is not recorded or transferred, it is a barrier to continuity and high quality care (Agarwal & Crooks, 2008; Schers, van den Hoogen, Grol, & van den Bosch, 2006). Team-based care may be less effective, and poor informational continuity can also impact relational continuity, comprehensiveness, and coordination.

Continuity is an attribute that is experienced by patients (Haggerty et al., 2013), and dissatisfaction will result if patients receive conflicting advice (MacPhail, Neuwirth, & Bellows, 2009), repeat their story multiple times (Jones et al., 2009), or have to “start all over” with someone new (Wong, Watson, Young, & Regan, 2008, p. 95). Patients are ever in a process of managing asymmetrical relationships with providers (Andersen et al., 2011), and are already required to navigate numerous obstacles as they attempt to penetrate the clinic system and communicate information (Newcomb, McGrath,
Covington, Lazarus, & Janson, 2010). Thus, efforts to decrease and avoid instances of poor continuity can help prevent some of the consequences of missed opportunities for coherent care such as mistrust, miscommunication, relational disengagement (Phillips-Salimi et al., 2011), and social distance (Tarlier, Browne, & Johnson, 2007).

Understanding how practices of knowing and connection within patient-provider relationships contribute to all types of continuity, and how these practices influence the negotiation of team-based primary care, is a primary focus of this research.

The purpose of drawing attention to some of the key attributes and descriptions of the PMH model in BC is related to the novelty of the model, as it became available only recently (GPSC, 2016). Given that the PMH in BC has not yet been implemented extensively, there is opportunity to examine the language, tenets, and domains of the model. The intent is not to critique but rather to examine and see what might require further articulation through an in depth consideration of how the PMH model may influence patient and provider relationships as well as the delivery of primary care.

The GPSC (2016) PMH model does not incorporate patient perspectives, or the perspectives of any interprofessional team members. It focuses mainly on primary care providers. While this is not ideal, it is sensible considering the nature and purpose of the GPSC. This model also represents the only conceptualization and visualization available that is specific to the BC context. While Northern Health created a model for implementation of interprofessional teams, it did not include definitions to the detail as in the PMH (GPSC, 2016) model. Because the GPSC model stems from thinking on behalf of the provincial government and physicians, it can be expected to be influential in decision-making about the structure and function of the PMH across the province.
Some idealized language is used within the descriptions for primary care attributes within the GPSC (2016) model, and there is also some ambiguity. One key concern is how access is defined, as well as a lack of a population orientation. Also, there is no attribute of equity included in the GPSC PMH model. Although equity is identified as a value in the CFPC (2011) vision, which is the foundation for the GPSC model, it is left undefined as an assumed good in the CFPC document.

A lack of explicitness about equity in a PMH model is troublesome. Recently in Quebec, it was found within the new models of primary care delivery, continuity worsened for patients with chronic disease (Pineault et al., 2016). The findings of this study report that over time, continuity and perceived outcomes of care improved more in the traditional practices, while in the new models, accessibility and responsiveness increased only for patients who did not have chronic disease (Pineault et al.). Thus, patients with greater burdens of illness did not benefit from new models of care (Pineault et al.). Without close attention to how access, continuity (particularly relational continuity), patient-centredness, and team-based care are described and operationalized, and without orientation to the health of the population or attending to inequities, BC risks implementing a model that will not improve health outcomes or patient experience.

As the model of the PMH is operationalized in BC, further attention will also be required towards understanding practice structures that contribute to high quality primary care delivery. The structural domain as it is currently outlined within the GPSC (2016) model is quite high level and does not dwell on important features of practice structures within the primary care office. Ideas about how team members might be offered to patients, the referral or consultation system between team members, feedback and
communication loops, or planning and coordinating care are all of interest in understanding how team-based care can be negotiated, yet there is little guidance both within the model or in the current literature about what works well, especially for teams that are not co-located. With transformation of primary care, the design can be critical in fostering and maintaining relationships that can improve primary care (Andersen et al., 2011; Haggerty et al., 2011; Haggerty, Roberge, Freeman, Beaulieu, & Breton, 2012; Ridd et al., 2009). The structural domain of primary care is as important as the performance domain (Hogg et al., 2008).

A last point to note here is that many of the GPSC (2016) descriptions of attributes are quite narrow, and exclude widely accepted definitions of attributes for primary care. Creating a unique set of descriptions for primary care attributes may contribute to problems in evaluation of outcomes of the PMH model. When definitions that are used to give meaning and provide understanding for diverse groups of people working within the same system vary widely across regions or countries, it is difficult to credibly compare and learn whether what is working in one context might be applicable to another context.

Assessing Gaps in Methods

Current methods of research in primary care overemphasize some approaches while overlooking others. This section highlights gaps in methods through examining studies that focus on continuity of care. The attribute of continuity is selected for examination in part because it is foundational to primary care, making evaluation of this attribute critical to understanding how high quality primary care is conceptualized and delivered. Second, the attribute of continuity is selected for examination of methods
because it may be the attribute most affected with implementation of the PMH and the accompanying shift towards team-based delivery of primary care.

To examine gaps in method, a straightforward approach was taken. First, with the understanding that continuity is experienced, the search for relevant literature centred on studies that endeavoured to understand how patients experience continuity as well as how providers might offer or foster continuity. Second, consideration of the methods used by authors in this topic area were reviewed to note what the common and uncommon approaches tend to be, including selection of participants, in order to identify gaps in the current knowledge base of how continuity is experienced. The following is a summary of the research reviewed organized by method.

The most common method to evaluate continuity is the patient survey or questionnaire (Baker et al., 2007; Campbell et al., 2010; Christakis et al., 2004; Dolovich et al., 2004; Gulliford, Cowie, & Morgan, 2011; Gulliford, Naithani, & Morgan, 2006; Hjortdahl & Laerum, 1992; Liss et al., 2011; Nutting, Goodwin, Flocke, Zyzanski, & Stange, 2003; Pineault et al., 2016; Rodriguez et al., 2007; Safran et al., 2006; Schers, van den Hoogen, Bor, Grol, & van den Bosch, 2004; Schers et al., 2002; Stokes et al., 2005; Tourigny et al., 2010). Numerous authors conducted semi-structured interviews with patients (Andersen et al., 2011; Broom, 2003; Cowie, Morgan, White, & Gulliford, 2009; Frederiksen, Kragstrup, & Dehlholm-Lambertsen, 2009; Jones et al., 2009; Miller et al., 2009; Naithani, Gulliford, & Morgan, 2006; Newcomb et al., 2010; Tarrant, Dixon-Woods, Colman, & Stokes, 2010; Tarrant et al., 2003; Thorne et al., 2005) or unstructured interviews (Rhodes, Sanders, & Campbell, 2014) to evaluate experience of continuity. Studies that used a mixed methods approach were somewhat common, and
most combined patient surveys with interviews or record audits, and are longitudinal or
cross-sectional studies (Boulton, Tarrant, Windridge, Baker, & Freeman, 2006; Green et
al., 2008; Katz, McCoy, & Sarrazin, 2013; Lee et al., 2006; Kristjansson et al., 2013;
Mainous, Goodwin, & Stange, 2004; Menec, Sirski, Attawar, & Katz, 2006; Panattoni,
Stone, Chung, & Tai-Seale, 2014; Tousignant et al., 2014; Williams, Dunning, & Manias,
2007). Focus groups with patients is also a method used by several authors (Alazri, Neal,
Heywood, & Leese, 2006; Locatelli, Hill, Talbot, Schectman, & LaVela, 2014; Matthias
et al., 2010; Noël, Frueh, Larme, & Pugh, 2005; Preston, Cheater, Baker, & Hearnshaw,
1999; Wong et al., 2008). Locatelli et al. and Preston et al. also conducted interviews.

Methods that are employed less frequently to study continuity include secondary
analyses such as systematic reviews (Agarwal & Crooks, 2008; Crooks & Agarwal, 2008;
Uijen et al., 2012), other literature reviews (Uijen, Schers, Schellevis, & van den Bosch,
2012; van Servellen, Fongwa, & Mockus D-Errico, 2006), and one qualitative
metasummary (Haggerty et al., 2013).

Three studies were found that employed discrete-choice experiments as method
(Cheraghi-Sohi et al., 2008; Gerard, Salisbury, Street, Pope, & Baxter, 2008; Turner et
al., 2007), while two studies included provider focus groups (Delva, Kerr, & Schultz,
2011; Sharman, McLaren, Cohen, & Ostry, 2010) (Sharman et al. also did provider
interviews). Less commonly used methods were interviews with providers and/or
decision-makers (Banfield et al., 2013), surveys of providers (Hjortdahl & Borchgrevnik,
1991; Schers et al., 2006), analysis of medical records or use of administrative data
(Parkerton, Smith, & Straley, 2004; van Walraven et al., 2008), and case study (MacPhail
et al., 2009).
Examining the methods of inquiry and measurement of a concept such as continuity uncovers current thinking about evidence-informed primary care. The methods that are commonly chosen highlight that the types of knowledge that have legitimacy and currency in health care commonly focus on a single aspect or perspective, which may be misleading regarding the simplicity with which a problem may be addressed or understood. There are three main issues when relying to a large extent on quantitative data, and in particular with survey data. First, it is known that surveys tend to oversample those with higher levels of education and literacy (Haggerty et al., 2011), thus obscuring the experiences of many patients who may not be encountering continuity in primary care.

The second issue with over-reliance on survey data is that results tend to be positively skewed (Haggerty et al., 2011; Willis, Evandrou, Pathak, & Khabhaita, 2016), even when negative experiences are described (Willis et al.). In particular, Willis et al. found that when negative experiences could be attributed to structural issues, such as workload, perceived shortcomings in care were excused by patients. This finding indicates that with patient surveys as a single method for a study, there is risk of covering up negative experiences. Choosing a patient survey as a single method for data collection also risks creating a disconnect between the experience of the patient and other perceived inter-related factors that may affect patient experience of care, such as structural issues, of which staff workload is one example.

Finally, evaluating the experience of continuity solely through patient survey answers obscures how patients weigh any number of factors that they may consider when deciding about their experience of continuity. Some of the factors, such as those from the
structural domain of care, may not be included on a survey. Ordinal scales provide little understanding of how or why participants select the answers they choose.

Patient surveys can be helpful in providing a large amount of aggregate data on which quantitative analyses can be performed. However, there is a risk in how these analyses may be used to inform practice or policy. Malone (2003) identifies how a paradox may occur when anonymous units of aggregated data, such as patient responses to surveys, are analyzed in order to suggest very particular interventions for patients who exist in complex circumstances.

While the patient survey is identified here as a commonly employed method that oversimplifies the complex experience of continuity, other methods reveal similar issues through study design. A key concern with most of the studies reviewed in this section is the dichotomizing of interrelated variables. Although continuity cannot be experienced without providers and patients interacting with one another, only six of the studies reviewed elicited perspectives or experiences of both patient and providers within a single study (Becker & Roblin, 2008; Kristjansson et al., 2013; Panattoni et al., 2014; Roberge, Beaulieu, Haddad, Lebeau, & Pineault, 2001; Scott et al., 2008; von Bultzingslowen, Eliasson, Sarvimaki, Mattsson, & Hjortdahl, 2006).

The concern with dichotomous thinking, which tends to “dull the analyst’s eye” (Rosaldo, 1983/1987, p. 295) is magnified in primary care research through the way in which primary care attributes are frequently treated as independent entities, or sometimes as a trade-off, for example to see if patients prefer accessibility or continuity (Locatelli et al., 2014). Primary care attributes cannot stand alone; rather there is a significant amount of overlap between continuity and other attributes (Banfield et al., 2013). For example,
the attributes of accessibility, continuity, and patient-centred care overlap (Brown, Ryan, & Thorpe, 2016), comprehensiveness is associated with equity and continuity (O’Malley & Rich, 2014), and continuity and coordination are often found to overlap (Uijen et al., 2012).

With a combination of attribute overlap and variability of definitions for each attribute, measurement quickly becomes unruly. For example, in a recent systematic review, Schulz, Pineda, Lonhart, Davies, & McDonald (2013) identified 96 measurement instruments for the attribute of coordination. While a lot of tools and measures are being produced through research efforts, there is risk of “methodological sterility” (Gadamer, 1976/1996, p. 117) in that the findings of these studies are unable to address key questions, such as how teams in primary care work (Bleakley, 2013).

The isolation of interrelated variables is an echo of the positivist paradigm. Current understandings of continuity and primary care exist within contemporary paradigms, where innovation will always land among existing paradigms, accompanied by social, historical, and cultural context (Kuhn, 1970). As such, although many health regions are attempting to transform primary care towards a team-based approach, measurement and evaluation as evidenced by the studies reviewed in this section, has been slower to shift away from measurement of traditional, solo-provider models of primary care. For example, it was not until 2014 that a measure was validated to assess continuity from more than one provider (Tousignant et al., 2014).

Researchers are now identifying significant issues with the proliferation of measures and metrics in primary care. These issues stem from both a lack of consistency and appropriateness, as well as the issue of allowing metrics (particularly performance
metrics) to “drive” care processes (Bower et al., 2011; Kansagara et al., 2014; Barrett, Ricco, Wallace, Kiefer, & Rakel, 2016; Eidus, Pace, & Staton, 2012; Ryan, Brown, Glazier, & Hutchison, 2016; Schulz et al., 2013). To redress some of these issues, there is increasing acceptance of the interrelatedness of variables influencing primary care, accompanied by calls to incorporate more patient-reported outcomes and patient-oriented experiences as measures of interest (BC Support Unit, 2016).

The gaps identified in this section are a reminder that with too much classification we distance ourselves from experience (McWhinney, 1996). None of the methods of the studies reviewed in this section included observation of practices of patients or providers in primary care, and authors did not examine experience as it was unfolding. Understanding team-based primary care is not achieved through study of a single attribute or variable. There is room for research drawing on a contextualized practice-based approach to potentially stimulate new knowledge about how patients and providers engage in situated, practical decision-making (Benner, Tanner, & Chesla, 2009) to negotiate team-based primary care.

**Assessing Gaps in Content**

The nature of the gaps in methods that have been identified uncover accompanying voids in content in terms of how knowing or not knowing patients and team members may contribute to understanding how team-based primary care can be negotiated. How primary care is negotiated within the PMH (or PCH) is largely unexamined in the BC context. Addressing this gap is necessary to fulfill calls that primary care be responsive to patient needs, preferences, and values by “… discern[ing]
what contextual factors are most relevant and ascertain[ing] how these factors interact” (Bayliss, Bonds, et al., 2014, p. 267).

Seeking to uncover how primary care is negotiated between patients and health care professionals is to be reminded that relationship is *a priori* to content in primary care (McWhinney, 1996). There is a need to examine more attentively the roles that relationships play in order for the PMH to be implemented successfully (Flieger, 2016), and sustained. While the relationship with the patient is considered central to primary care (Sweeney et al., 2012), a neglected facet may be “the extension of relationships with trusted colleagues to patients” (Stange, Burge, & Haggerty, 2014, p. 274). This aspect may have been neglected in the past because evaluation was based on traditional models of providing primary care.

With regards to tradition, Gadamer (1960/2011) urged reflection on the significance of the role of history and tradition in understanding. Primary care as practiced by family physicians comes with a long history of tradition understood by patients and providers that is disrupted with a shift towards interprofessional teams. Gadamer (1960/2011) explained how it is out of the past from which our present is shaped that we project a past horizon into our future. Things matter to us when they are accounted for in our projections, and so understanding how accepting patients are of team members, and how patients feel known by providers and team members is shaped by experience, and these experiences will inform present and future expectations of care.

We never become free of all tradition (Gadamer1960/2011). We have reasons to preserve traditions, though frequently those reasons may be unexamined (Gadamer). One example of an unexamined tradition may be hierarchy in health care settings. In this
study, attention was given to practices and structures that perpetuate or disrupt tradition from the provider and the patient perspective, to the extent that they facilitate or impede practices of connection or negotiation of care with a team. Thus, this research considered issues such as when and why primary care providers involved team members, communication between team members in terms of timing and content, and whether practices reflect efforts that contribute to or detract from providing team-based care.

Within the PCH model (which, in BC, identifies interprofessional team members as employees of the health authority or a community agency, and thus not exactly the same model as a PMH), the relationships between team members with one another may be just as important as the relationships between patients and team members (Flieger, 2016), particularly when a team is not co-located. Attunement to these relationships and how patients and providers feel known helps to reveal how primary care is negotiated within a team.

Acknowledgment of the primacy of longitudinal relationships in primary care (McWhinney, 1996; Stange et al., 2014) leads to a focus in this research on practices of connection in therapeutic relationships. Clinical practice itself is a negotiation of "applying general knowledge for the concrete case" (Gadamer, 1996, p. 16), and the sense of being known is central to human connection (Thorne, 2005). Thus, the interpretation of practices of connection in order to better understand the negotiation of primary care is a worthwhile approach that can help bring forth new possibilities for understanding team-based primary care.

Attunement to connection in therapeutic relationships, (as opposed to longitudinal or enduring relationships (GPSC, 2016)) brings forth opportunities to investigate what it
means to feel known. It is recognized that “when the chips are down … patients long to be known as a person” (Stange et al., 2014, p. 275). What has not been widely studied, however, are questions of how patients feel known, how interprofessional team members might get to know patients outside the traditional patient-provider dyad, and how this influences negotiation of primary care.

Dominant paradigms in health care may be one consideration as to why primary care research overlooks issues related to how patients feel known. Paradigmatic thinking can constrain practices and limit the pathways of change (Rabinow & Sullivan, 1988). Two such paradigms are efficiency and evidence. Both of these concepts have validity and clearly belong in health care discourse. However, for this study, the purpose of calling attention to these paradigms is to examine whether there may be unintended consequences when practices appear to prioritize evidence and efficiency.

Failure to achieve efficiencies within the system may result in recommendations for more of a “top-down” approach to attempt to achieve the desired outcomes (Allin, Grignon, & Wang, 2016, p. 52), and this may be a concern at a stage of early implementation for the PMH model. In this study, practices were considered in terms of how they might be influenced by efficiency and evidence, where there might be too much focus on accommodating forms of organization (Gadamer, 1996) with intensifying adherence to things like protocols, standardized procedures, or checklists (Chan, Brykczynski, Malone, & Benner, 2010; Day, 2009). A focus on efficiency and evidence may overshadow other aspects of care that might otherwise both reveal and strengthen how patients feel known.
Illuminating how patients feel known can provide a significant contribution to apprehending how patient preferences, values, and goals are understood by and between health care professionals within the PCH model. Whether, and to what degree members of the PCH are able to incorporate this knowledge about patients may influence the care that is provided, as well as the care that is offered. Decisions are made about whether to involve team members in a patient’s care, as well as decisions about which patients need team-based care (Eidus et al., 2012), and when. How these decisions are made have been largely overlooked in the primary care literature.

In part, processes of knowing and negotiating care may remain hidden due to the extent that providers draw on tacit knowledge to make these decisions. Peile (2014) asserts that learning relevant information about patient values is in the realm of professional judgment. Tacit knowledge is considered to be professionally relevant knowledge, yet is often ignored in medical decision-making (Epstein, 1999). This study seeks to address the research questions in part by attempting to articulate the tacit in negotiating team-based primary care.

Three facets of influence regarding how tacit knowledge shows up in the enactment and embodiment of practices of connection are accorded particular attention in this study. The first facet is language. The role of language in a hermeneutical sense is more than learning to convey empathy or checking that a patient understands how to take his medication. In primary care settings, and particularly within patient-provider encounters, there are constitutive rules regarding conversation and social practices. This means that the action in context would not be appropriate for any other context, and along with such actions are ranges of language that are inseparable from the action so that
particular practices are not without them (Taylor, 1971/1988). Examining how agendas were tended to during a visit and then asking the provider or team member about it after the visit was one approach that helped to draw out some of the interpretations of social practices that occur within patient-provider encounters and how they facilitated or impeded therapeutic dialogue, issues of connection, or therapeutic relationship.

Language is also helpful towards an understanding that practices may not always seem rational in observation. A situation may be replete with contradiction, but dialogue allows us to gather an adequate depiction so that while not necessarily rational, the practices are coherent within the particular situation (Taylor, 1971/1988, p. 43-44). However, caution must be employed in this exercise when relying on text created by one person about another. What one team member or primary care provider records with the intent to provide a coherent depiction of the important aspects of a patient encounter may be inadequate information for a different team member. In this way, gaps can appear between what is said and understood during an encounter and what is documented about the visit. How providers and team members recount and prioritize the issues of a patient encounter can result in certain practices of the encounter becoming invisible.

The second facet influencing practices that was considered in this research was that of identity. A primary care encounter unfolds with a conversation at its centre, as patient and provider seek common understanding to project towards particular goals. The provider seeks to understand the patient’s identity, to hear the narrative of their self-identity (Giddens, 1991) and interpret that narrative to not only diagnose an illness or disease but also to understand what the illness means for the patient at that particular time
in the experience of their life. This process contributes to how care is planned for patients, including making decisions about involving team members.

The third facet this research is attuned to in the study of practices of connection is Schutz’s Systems of Relevance (Wagner, 1970). Schutz asserts that in any situation, there are manifold degrees of understanding (Wagner). Thus, in varying situations, we have knowledge that has differing layers of clarity, coherence, and relevance (Wagner). Our knowledge at hand partially arises from the many roles we have, and it is because of such roles that knowledge can become inconsistent, or knowledge may be inconsistently applied in practice.

Summary

This chapter has attempted to highlight gaps in understanding about team-based primary care and how it is negotiated within the Canadian and BC context. As BC moves towards implementing the PMH and PCH models of team-based primary care, it is timely to inquire and analyze how the hallmarks of primary care might be incorporated within these new models. Team-based care, patient-centred care, accessibility, comprehensiveness, coordination, and continuity are foundational to a strong primary care system, and each of these attributes must be kept “in play” (Grondin, 2015) for appropriate research in primary care.

Through examination of how the core attributes of primary care might be assessed in the context of the PMH, there is recognition that paradigmatic influences may have contributed to some methods gaining acceptance and repeated use over other methods. In particular, efforts to integrate or recognize interdependence between key variables have been overlooked in favour of methods that isolate or dichotomize these variables.
In an attempt to reconcile and integrate some of the key attributes known to contribute to high quality team-based primary care, this research is a study of how team-based primary care is negotiated. The design and intent of this research is to prioritize relationship and how patients and providers feel known, who they consider to be on their team, and how that might change over time. Attention to these overlooked facets of primary care can help address some of the outstanding questions and uncertainties that accompany transformation of a primary care system towards team-based care, such as who needs a team, when do patients need a team, and how this can be negotiated. The research questions will be addressed interpretively, through a study of practices of connection. The next chapter outlines in detail the methodology and methods of this study.
Chapter Three: Methodology and Methods

This chapter reviews how a study of practices was undertaken through engaging with Gadamerian hermeneutics. The first section explores what is meant by “practices”, and frames the term within an interpretive stance. The section on methods describes how this research was carried out. Detail is provided to lend transparency and credibility to the approach, field work, and analysis. Last, a section on ethics is included to describe the role of the researcher and outline ethical procedures followed for the duration of this study.

Identifying Practices

A study of practices such as this research undertook is otherwise absent from primary care discourse. In the health care literature, there are some studies of practices that draw on organizational theory from the field of management and use an “intended eclecticism” in methodological approach (Nicolini, 2010, p. 1395). Like interpretivists, organizational theorists are interested in focusing on everyday activity (Feldman & Orlikowski, 2011), and understanding how practitioners “… recognize, produce, and formulate the scenes of everyday affairs” (Corradi et al., 2008, p. 3). However, from a methodological standpoint, it is an interpretivist definition of practice that informed this research. As such, practices are defined as “activities repeatedly performed over time” (Kesselring et al., 2010, p. 4). An interpretive approach helps to explicate what gets covered up when certain practices are emphasized, as well as the way in which understanding and enacting practices changes over time.

Studying practices can be difficult, particularly to explicate a practitioner’s decision-making, as practices are often taken for granted (Kesselring et al., 2010). The
purpose of research on practices is to help make them visible through articulation, and “… bring recognition to embedded aspects of practice” (Kesselring et al., p. 114). Uncovering practices can help to preserve them, while at the same time calling attention to the personal and situational aspects that may influence how practices are enacted (Kesselring et al.). In this study, practices of connection between primary care providers and patients, primary care providers and team members, team members among themselves, and between team members and patients were all observed in order to address the research questions of this study.

As practices are interconnected with context, studying practices can illustrate what happens when “…purposes trip over each other” (Geertz, 1973, p. 17). Purposes trip over each other through practices because an individual’s practices are themselves an interpretation of the broader social world (Dreyfus, 1991), and so the ideas and meanings of a practice are not just in the minds or actions of individuals (Taylor, 1992). In this research, practices that were perpetuated for reasons related to situational or structural aspects of team-based primary care delivery were considered in order to better understand how primary care is negotiated within a team that is not co-located.

Individuals inform their lives through their own interpretations. Errors in interpretation of meaning can therefore be sustained by certain practices that are a result of decisions made based on the initial errors of interpretation (Taylor, 1992). The paradoxical nature of practices is that they can be invisible (Solomon & Flores, 2001), yet they include choice and making decisions among possibilities (Gadamer, 1996). The way in which some practices remained unquestioned, or were otherwise taken for granted by participants was of interest in this research. Noticing practices that may
have been enacted related to errors in interpretation were also consequential to this research, and contributed to understanding how primary care providers, patients, and team members know one another, or feel known.

An interpretive study of practices has the ability to run alongside findings of empirical studies. An interpretive examination of a topic can help to assess and diagnose instead of measure and predict (Geertz, 1973). The purpose for a study of practices such as this one is that problems can be “dissolved by a description of everyday social practices” (Dreyfus, 1991, p. 7). Although interpretivists can only offer “an interpretation of the interpretation already in the practices” (Dreyfus, 1991, p. 22), that can be enough to see things differently, to question the way things are done and open the possibility of “bringing about a social changing of the mind” (Geertz, 1973, p. 319). In this way, the findings of this study draw attention to practices worthy of further attention and action in order to improve team-based care organization and delivery so that experience and outcomes can be improved for patients, primary care providers, and team members.

**Methodology: Engaging with Gadamerian Hermeneutics**

Historically, hermeneutics has application in theology, linguistics and jurisprudence, in order to help clarify the standard approaches and methods of such disciplines, and also as a process to assist disciplines to move beyond methodological limitations (Mueller-Vollmer, 1994). The task of interpreting and understanding something is in relation to the whole of which it is a part, and vice versa (Mueller-Vollmer, 1994). This is described as the hermeneutic circle, and movement between the whole and the part guides understanding, which is constantly occurring and being revised (Gadamer, 1960/2011). There is a temporal aspect to understanding as well, whereby
time is “… the supportive ground of the course of events in which the present is rooted” (p. 297). This study draws primarily on Gadamer’s philosophy of hermeneutics to address the research questions.

Gadamer (1960/2011) asserted that language is the medium of hermeneutic experience, and that our understanding is dialogic, whether with text or conversation. When the joint meaning of a common subject matter is disturbed, understanding becomes a special task (Gadamer, p. 180). Yet, interpretation is not just the subjective intention of an author or speaker; reconstructing what the author had in mind is a limited undertaking (Gadamer, p. 366). Rather, it is a hermeneutical necessity to achieve a “fusion of horizons” (p. 367) to ensure meaning is not reduced simply to what is stated (p. 464) or the intention of the speaker. The situations where joint meaning of a common subject matter may be disturbed within a primary care encounter, or between team members who are not co-located, are frequent in practice. Thus, attention to language and dialogue between primary care providers, patients, and team members was methodologically valuable in this study.

**Identifying a horizon**

The way in which we encounter something and it says something to us is through what Gadamer termed *prejudices* (Gadamer, 1976/1996). The word prejudice is used deliberately in attempting to re-unite the word with positive meaning. In Gadamer’s (1960/2011) writing, prejudices provide a framework for interpretation, are a necessary condition of understanding, and give a hermeneutical problem its real thrust (p. 272). In arriving to a situation, it already matters to us in some way (Magee, 1987).
Prejudices are pre-understandings that make up our viewpoint, which constitute how we are directed towards our experience (Gadamer, 1960/2011). Importantly, prejudices are not falsely set aside, or bracketed, in hermeneutic inquiry (Gadamer, p. 273). Rather, the purpose of acknowledging our prejudices is to create openness, as it is the ability of recognizing our own prejudices that allows us to constitute a horizon and set about the task of understanding (Gadamer).

The term horizon is an important word in hermeneutic study drawing on Gadamer’s work. An individual’s horizon is an essential part of a situation and “… is the range of vision that includes everything that can be seen from a particular vantage point. “To have a horizon” means not being limited to what is nearby but being able to see beyond it” (Gadamer, 1960/2011, p. 301). The choice of this word fits well with being able to describe expanding a horizon or discovering new horizons as we are situated and engaged in a temporal and constant process of understanding (Gadamer).

As our prejudices are based on our past experiences and historical consciousness, we cannot form a horizon of the present without the past (Gadamer, 1960/2011). As we project a historical horizon, it fuses with the present horizon, and is simultaneously superseded (Gadamer, p. 306). Thus, there is a “constant process of new projection [that] constitutes the movement of understanding and interpretation” (Gadamer, p. 269). It is important to note that Gadamer viewed understanding as interpretation, that interpretation is not occasional but instead is the explicit form of understanding (p. 306). It is this approach to considering that practices are informed by the past while projecting to the future that was helpful to be able to interpret and articulate the practices observed and discussed in this research.
The focus of this study is to understand practices of connection within primary care settings. When patients, team members, and primary care providers interact with one another, they are engaging with others who have different cultural, historical, and social influences and thus different prejudices and different horizons. In order to discover the standpoint of another, conversation is necessary (Gadamer, 1960/2011). This is not to say that agreement results from a conversation (Gadamer), nor is it failure to recognize there can be meaning in silence (Heidegger, 1962/2008). Rather, the art is in the question of “… how did he come to such an opinion” (Gadamer, p. 181). In a hermeneutical interpretation, language is primary, because “everything that is reflects itself in the mirror of language” (Gadamer, 1967/1994, p. 284). The ways in which participants in this study practiced and engaged in conversation to attend to agendas and exercise clinical judgment was important to this research. Attending to language and conversation between patients, providers, and team members facilitated understanding how patients feel known, how connections are maintained, and how patients and providers negotiate primary care.

Methods

This section describes the methods used to collect and analyze data in order to address the questions of this research. Detail is included to provide transparency to the research process. Data collection for this study took place between August, 2014 and February, 2015.

Research questions

The research questions for this study are:

1. How do patients feel known or not known by a team?
2. How are therapeutic relationships between patients and providers established, maintained, and nurtured over time?

3. How is primary care negotiated from an interprofessional team?

**Research site selection: PCH in Northern Health**

The Northern Health Authority is one of seven health authorities in British Columbia, and has been providing health services to northern British Columbians since 2001. In 2009, Northern Health’s strategic plan introduced a priority to establish Primary Care Homes (PCH), defined as a place where “…people establish a long-term relationship with a multidisciplinary team, and through this team, receive health care and are supported in managing their own health” (Northern Health, 2009). Although the current definition of PCH has changed, it is noteworthy that this language was introduced seven years before the GPSC (2016) published the PMH / PCH model based on the CFPC (2011) vision.

The focus by Northern Health on interprofessional primary care teams and PCH dovetailed with the formation of Divisions of Family Practice in BC, which are an initiative of the GPSC composed of “… affiliations of family physicians working together to achieve common health care goals … [providing] physicians with a stronger collective voice in their community while supporting them to improve their clinical practices, offer comprehensive patient services, and engage with their local health authority to enhance their ability to deliver care” (GPSC, 2015a). One Division of Family Practice is established in the urban centre where this study took place.

Prior to the vision for PCH in Northern Health, primary care services outside the primary care provider office such as mental health, public health, physiotherapy, or social
work were available but generally siloed, each with their own structures, communication, and documentation processes. If a patient required, for example, mental health counseling, he would be referred by his primary care provider, attend for the duration of the counseling, and then be discharged out of the service. If the patient required mental health counseling at a later time, he would be referred again to the service by his primary care provider.

Between 2009 and 2015, Northern Health managers and leaders actively engaged physician members of the Division of Family Practice in implementing interprofessional primary care teams in six prototype communities, including the community in which this study occurred. In May, 2014, the first interprofessional team members began work in the urban site of this study. By September 2014, two teams in this urban setting were operational, but stretched in terms of human resources to accommodate 11 primary care practices, some of which are group practices with large numbers of patients in their panel.

In the model conceptualized by Northern Health as a Primary Care Home within a System of Services (Northern Health, 2015), patients have the opportunity for more coherent and connected care whereby interprofessional team members are assigned to physician offices, all interprofessional team members use the same electronic medical record (EMR) (although it is important to note primary care providers use a different version of this EMR), and patients are no longer discharged between times of receiving service. Instead, the interprofessional team, similar to the primary care provider, is responsible for the primary care of the patient for the duration of time the patient is attached to that practice.
The data collected for this research took place when primary care teams were first being implemented. So new were the teams that data collection was delayed slightly to wait for a team to be operational. This influenced site selection.

From the researcher perspective, several criteria were considered important in site selection for this research considering the focus of this study. First, a team in which some of the team members had experience working together previously was helpful, as teams that have been working alongside one another for some time can be expected to practice differently from teams who have had less time to learn and practice together (Bunniss & Kelly, 2008). Second, a team where members had various years of experience in their role could help to elucidate differences in practices, as it is noted that providers who have more years of experience in their role will practice differently than providers with a shorter length of experience in a particular role (Benner et al., 2009). Third, a setting in which visitors such as students are a familiar presence in the clinic is beneficial, as patients are somewhat used to seeing unfamiliar people about, including in the exam room during the encounter. Providers may be more likely to assume a teaching role by explaining what they are thinking and doing as they proceed in their day, as found by MacLeod (1996).

Given the newness of PCH implementation, I sought advice and permission from a member of the Northern Health executive leadership team to approach particular sites. Three sites were approached with approval from Northern Health leadership and mid-level management, and two fee-for-service offices that were participating in the PCH implementation were approached. One urban fee-for-service office aligned with one interprofessional primary care team consented to participate in the study.
Attributes of participants

Participants in this study were assured of confidentiality when they consented to participate, and they were advised that their anonymity would be protected to the greatest extent possible considering some details may identify them to those working or living in geographical proximity to where this study took place. For the participants who are health care professionals, they may be identifiable by others who work with them or know of their work or practice. All participants have been assigned pseudonyms.

In the text, health care professionals are identified both by their pseudonym and, when relevant, their professional designation. Throughout the findings and discussion of this dissertation, the term primary care provider(s) is used to represent the four family physician participants and one nurse practitioner participant in this study. Similarly, the term interprofessional team or interprofessional team member is used to represent the clinician(s) employed by Northern Health who are not family physicians or nurse practitioners. For patient participants, any identifying details such as their specific diagnosis or details of their care have been changed or omitted if such details are not crucial to understanding the patient’s experience.

Interprofessional team members and primary care providers

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Practice Experience</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peggy, social worker (SW)</td>
<td>38 years</td>
<td>Female</td>
</tr>
<tr>
<td>Nora, registered nurse (RN)</td>
<td>14 years</td>
<td>Female</td>
</tr>
<tr>
<td>Ruby, registered nurse (Case Manager)</td>
<td>23 years</td>
<td>Female</td>
</tr>
<tr>
<td>Mel, occupational therapist (OT)</td>
<td>6 years</td>
<td>Female</td>
</tr>
<tr>
<td>Odette, mental health clinician (MH)</td>
<td>23 years</td>
<td>Female</td>
</tr>
</tbody>
</table>
Patients interviewed: Pseudonym and gender

<table>
<thead>
<tr>
<th>Name</th>
<th>Years</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quentin, mental health clinician (MH)</td>
<td>12 years</td>
<td>Male</td>
</tr>
<tr>
<td>Sonia (Lifeskills)</td>
<td>8 years</td>
<td>Female</td>
</tr>
<tr>
<td>Ursula, primary care assistant</td>
<td>14 years</td>
<td></td>
</tr>
<tr>
<td>Tessa, acting team lead</td>
<td>7 years</td>
<td>Female</td>
</tr>
<tr>
<td>Leah, family nurse practitioner (NP)</td>
<td>5 years in NP practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24 years in RN practice</td>
<td>Female</td>
</tr>
<tr>
<td>Henry, family physician (FP)</td>
<td>35 years</td>
<td>Male</td>
</tr>
<tr>
<td>Isaac, family physician (FP)</td>
<td>14 years</td>
<td>Male</td>
</tr>
<tr>
<td>Jack, family physician (FP)</td>
<td>20 years</td>
<td>Male</td>
</tr>
<tr>
<td>Kate, family physician (FP)</td>
<td>1 year</td>
<td>Female</td>
</tr>
</tbody>
</table>

The term “patient” is used throughout the paper for these participants, because they participate from their experience in this role, just as primary care provider and team member participants represent their roles, and not the many other roles they take on as individuals in society. Patient is also preferable to the transactional implication of the
term “client”, for the Latin root of patient is “pati” meaning “to suffer”. That patients seek care for relief of suffering is a reminder of the “being-for” (Heidegger, 1962) and “being-with” (Bauman, 2004) nature of team.

All the patient participants but one are empaneled with the fee-for-service practice that is one of the settings for this study. Initially, I hoped to interview patients who had been able to see members of the interprofessional team several times so that they would be able to comment on their experiences with the team. However, the patients requiring more time, visiting, and care by more than one member of the interprofessional team are the most complex patients. They are patients with severe and persistent mental illness or dementia, or have been recently discharged from an acute care setting and await placement in a long-term care setting. These patients were inappropriate to interview for ethical and medical reasons. This is somewhat telling about who needs a team, but it is also a limitation of this study.

**Unit of analysis**

The unit of analysis for this research are the practices themselves, as this is what is being interpreted for this study. The practices occur in the offices of primary care providers and team members, as well as patient homes. While it is the level of the team, as opposed to the singular office or organizational level that is the focus for this study, the practices of connection within the team are the entities contemplated for analysis and interpretation.

**Field work**

My presence in the field ranged from half to one and a half days each week of the data collection period, during which I observed 37 patient encounters, attended meetings
and patient rounds, and passively observed clinic “flow”. Sixteen provider and interprofessional team member interviews were conducted during the period of the study, and seven patient interviews were conducted, for a total of 23 interviews. Field notes and a personal journal were maintained throughout the period of data collection.

Observations of primary care providers

The months of August, September, and part of October 2014 were spent collecting data from the fee-for-service physician office. The fee-for-service office was visited first to allow a longer time for the interprofessional team members to be operational in their new offices and roles. The purpose of the observations was to observe practices in action (Kesselring et al., 2010).

To begin, I conducted exploratory observations of the medical office assistants (MOA) and reception area, to gain an understanding of how appointments were booked, how patient recalls were orchestrated, and how the clinic flow and office processes unfolded over the course of a day. I also spent time observing one MOA conduct her work, so that I could ask clarifying questions (Huby, Hart, McKeivitt, & Sobo, 2007) regarding what I was observing.

After approximately one and a half days of reception area observations, I began to observe patient-provider encounters between primary care providers and patients. I aimed to spend 1-2 half-day sessions with each provider. At the primary care providers’ request, I composed a short typewritten note to say I was a student researcher studying primary care teams, which the MOA gave to each patient the provider was seeing the day I was shadowing them. This allowed the patient to say yes or no to my observation of their encounter. If the patient said yes, I could enter the room ahead of the primary care
provider to complete the full informed consent with the patient and not extract face-to-face provider time from the patient.

For each patient-provider encounter observed in the primary care provider office, I attempted to remain a passive observer, although sometimes a patient would seek to include me in a joke, or fill in a detail of their history for my benefit. Once, the provider could not resist a teachable moment knowing I am also a nurse practitioner and encouraged me to palpate a joint.

During each patient-provider encounter, I sat off to the side as much as possible, and left the provider a choice of where to sit or stand. I maintained an expression of neutral interest, and did not attempt to make eye contact with the patient or the provider. I kept a field journal with me, but to varying degrees found it difficult to keep up with notes, as I did not wish to detract from the visit by writing in the notebook in a fairly confined space. I waited for natural transition times to make notes, for example as the patient moved to the exam table or if the provider was completing a requisition for the patient.

Throughout 28 patient-provider encounters observed in the fee-for-service office with five different providers, I paid attention in each to the spatial aspects of proximity and distance (Malone, 2003; Tarlier et al., 2007). I considered the dialogue, silences, and interruptions. I paid attention to how services or suggestions were offered to patients, how sensitive subjects were broached, and signals the provider gave to indicate the conclusion of the visit. I attempted to understand practices that appeared representative of issues of power or connection, how the context of patient circumstances was accounted
for or dis-counted during the visit. Finally, I considered how the encounter might have
influence on future practices of care-seeking and negotiating care.

Between patient encounters, there was sometimes opportunity to informally de-
brief about the visit. The provider might disclose patient background that informed his or
her decision-making for that visit, or discuss why s/he selected a particular service for a
referral over another. Other times, the provider exited the room to chart or dictate, or to
complete another task (for example to make a phone call) before seeing the next patient.

*Observations of interprofessional team members*

In late October 2014, the Acting Team Lead for the Northern Health
interprofessional team “assigned” to the physician practice that was participating in the
study introduced me to the interprofessional team. I spent October, November, part of
December, and January observing and interviewing the interprofessional team members.

To begin, I attended some meetings that included all or most members of the
team. Patient rounds were conducted first thing each morning, and so I observed this
meeting initially. Next, I conducted some exploratory observations in the office space of
the team.

The setting of the interprofessional team office was conducive to passive
observation. I spent a half-day with the primary care assistant observing and obtaining
clarification regarding scheduling of the interprofessional team, documentation processes,
how patients were contacted, and other duties of the primary care assistant.

Following these initial observations, I began to book half days with
interprofessional team members to observe patient-provider interactions. Some team
members were reticent to commit to a time for me to observe them. One mentioned that
because she was so new to the team, she wasn’t very heavily booked. Another struggled to find a suitable day because so many of her days included more than one meeting, so that her time to see patients was impacted. A third provider expressed discomfort with my attendance because she was meeting so many of her patients for the first time; she did not wish for the process of establishing rapport to be disrupted by the presence of a researcher. By the end of the observation period, I was able to observe a total of 9 patient-provider interactions with two mental health clinicians, one registered nurse, and one occupational therapist.

When arranging time to observe an interprofessional team member, I advised them I wished only to observe them in their everyday practice, so whether it was attending meetings or seeing patients or another activity, my objective was to passively observe them in their role. Some team members, however, expressed worry that this type of observation would not be an accurate depiction of their role. Particularly for providers who were accustomed to providing direct care to patients as the mainstay of their role, my observation of them sitting through meetings did not rest comfortably with them.

Of the patient-provider encounters I observed with IPT members, six occurred in the patient’s home, two occurred in assisted living / residential care-type settings, and one in a Northern Health office. For each visit, I followed the team member’s lead and attempted to remain as unobtrusive as possible. Patient consent was obtained either ahead of time by the team member telephoning the patient to ask if I might accompany the team member to the home, or other times consent was given on arrival at the meeting place of
patient and interprofessional team member. Through this process one person declined to be observed.

During patient visits, I sat off to the side or stood leaning against a wall, unless the patient asked me to come and be seated by the provider. In one home the patient insisted on making tea. When the team member accepted a cup and the patient urged me to do the same, I also accepted a cup of tea. I did not wish to appear rude or as though I was making a point of having professional boundaries more rigid than the team member by declining the tea.

As I spent time with different members of the interprofessional team, I did observe a number of meetings. I sat in on rounds each morning I was present. I sat in on process meetings, evaluation meetings, and caseload review meetings. I occasionally asked clarifying questions of the interprofessional team, more so than I did of the primary care providers, in order to understand what was going on. I recognized my horizon was oriented to the primary care provider perspective of primary care.

**Documentation**

Throughout the period of data collection, a field journal and personal journal were maintained. The field journal was utilized during observations and interviews to write down impressions of what I was seeing and hearing in order to inform later analysis. The personal journal was used to record end-of-day reflections, and to monitor my own changing prejudices or horizon as the research proceeded. Grey literature also helped to inform the primary data collection and analysis. News reports, knowledge of community resources and demographics, and attendance at, or minutes from, meetings connected to
primary care transformation and integration helped to contextualize the data in a socio-
historical and temporal manner.

**Interviewing**

The purpose of interviewing in interpretive studies is to provide a disclosive space
for narrative access to uncovering practices (Kesselring et al., 2010). The researcher
should strive to maintain openness and curiosity about the answers provided to the
interview questions, and interrupt as minimally as possible (Kesselring et al., 2010). The
interviewer should listen with a “sensibility for significance” (Kesselring et al., 2010, p.
18), in order to inquire further in a particular direction and revise previous conceptions of
understanding as the conversation progresses.

While I have experience as a diagnostic interviewer in my role as a nurse
practitioner, I discovered interviewing to uncover practices to be a new skill. In order to
practice the interview skills required to obtain the depth of information I was seeking to
answer the research questions, I conducted practice interviews with one provider and two
“patients”, as other researchers have done while in novice researcher roles (MacLeod,
1996; Simmons, 2007).

During the interviews for this study, I tried to keep in mind some guiding
questions that Kesselring et al. (2010) suggest in order to apprehend the practices
disclosed in the interview, as opposed to reflections about the practices or the causes or
results of the practices. The questions are: “What matters to the participant here; why is
the participant telling this story and why now; how does this narrative align with or
discriminate the concerns of this participant with other narratives in the whole text; how
does it fit with the whole of her expressions (both narrative and reflexive); how/who is
the participant in the story; how does the participant show up in the story; within what kind of world does this story make the best sense” (Kesselring et al., p. 19)? One other consideration I tried to keep in mind as individual interviews progressed was to notice what I was not hearing about.

Throughout data collection, I held the research questions at the forefront of my mind as a reminder to focus on uncovering and interpreting practices of connection and negotiation of care with an interprofessional team. This helped me to maintain the researcher stance throughout the interview process. To guide creation of the semi-structured interview questions I relied on suggestions or descriptions offered by other hermeneutic researchers (Crist & Tanner, 2003; MacLeod, 1996; Sorrel & Redmond, 1995), and the full interview guide for patients and providers is in Appendix A.

I interviewed each participant once. Primary care provider interviews were conducted in the fee-for-service office, and interprofessional team member interviews were conducted in Northern Health office space. These interviews were conducted at the conclusion of the observation period for each location. Patient interviews were conducted at two different times during the study, with two patients near the mid-point of the data collection period, and five patients near the end of the data collection time period.

Patient interviews were conducted in different locations based on patient preferences and availability. One interview took place at my office at the University of Northern British Columbia, one was conducted over the telephone, four were conducted in the lobby of a quiet public building, and one was conducted at an interviewee’s place of work in a private office. All interviews for this study (patients, providers, and non-clinician team members) were between 30 and 60 minutes in length, were recorded with
permission, and transcribed by a health care transcriptionist who signed a confidentiality agreement prior to completing the transcribing. The transcripts were then reviewed for accuracy, anonymized, and analyzed after data collection was concluded.

**Data management**

During the phases of data collection and analysis, field journals and the digital recorder were stored in a locked box in a private location when not in use. Consent forms and all other documentation that contains participant information are stored in a secured office at the University of Northern British Columbia. All forms of electronic data are stored on a computer that is password-protected. Hard copy data will be destroyed at the time of the completion of the dissertation. Digital data will be destroyed five years after completion of the dissertation.

**Analysis**

Analysis in a hermeneutic study is synonymous with interpretation (Moules, 2002). Interpreting originates in understanding and so the task begins with the research questions and is never completed (Mueller-Vollmer, 1994) with final interpretations being left to readers (Crist & Tanner, 2003).

Hermeneutic interpretation seeks to understand meaning in practices that may be invisible or taken-for-granted (McLeod, Tapp, Moules, & Campbell, 2010). The process of this seeking began with several reads through of the text (McLeod et al.; Thirsk & Moules, 2013) while considering what it is that addresses me (Thirsk & Moules). Initial readings were intended to invite general impressions, noticing of resonances, and familiarities and differences in the content of the text (Moules, 2002).
Following multiple readings of field notes and interview transcripts, interpretive memos are written of initial interpretations (McLeod et al., 2010; Thirsk & Moules, 2013), which is a process of attention to the particular (Moules, 2002). Each re-reading of the data was an effort to identify “echoes” of something that “… might expand possibilities of understanding” (Moules, p. 14).

Interpretive memos were expanded upon throughout the analysis. The analysis attempts to preserve the meaning of the whole, and so there is no extracting of themes or coding of data (McLeod et al., 2010). Rather, a hermeneutic interpretation allows the everyday to stand out and be uncovered (Moules, 2002). Hermeneutics considers what is said and also what is not said, and continuously questions things that are taken-for-granted (Moules).

Literature can be an aid in analysis when it is used to further grasp what participants have to say about a particular topic (Thirsk & Moules, 2013). In this regard, I restricted my review of the literature to updates about PCH implementation or other Northern Health reports. I avoided the research literature at this stage on my supervisor’s advice, in order to remain open to the possibilities of the data rather than to conform or be swayed by other authors.

Another aid in analysis is to subject initial interpretation to further dialogue. This was accomplished through meetings with my supervisor, who prompted me to articulate “what this research is about”. Discussion of interpretations can create further openness for understanding. To reach an adequate interpretation, it was important to put my own
interpretations at risk by admitting the limits of my understanding (Moules, 2002) and my ability to succinctly describe my findings.

Geertz (1973) discusses a paradoxical problem that I considered while planning and conducting the final interpretations of this study. Understanding can be obscured through both the inclination to attach transcendental properties to the understanding, or through the opposite difficulty, which is to confuse understanding with reductionism (Geertz). The paradox is that the more detail that is included, the more attached one becomes to the particularities, but the more detail is omitted the potential is to lose touch with the foundation the research questions are based upon (Geertz, p. 313). To help avoid this, I wrote and prominently displayed a piece of advice from my supervisor to remind me that I am seeking a reasonable interpretation that goes beyond my own (Martha MacLeod, personal communication, 2012).

Rigour

Evaluative criteria for qualitative research are controversial (Cohen & Crabtree, 2008). There is a wide range of interpretive studies employing various criteria in efforts to legitimize knowledge and interpretations. For the purpose of this research, I chose criteria outlined by Moules (2002), in a landmark article that is frequently cited by Canadian nurse researchers employing hermeneutics guided by the thinking of Gadamer.

Hermeneutic interpretations should have resonance. Readers should recognize that something in the interpretation “rings true” (Moules, 2002, p. 3), and takes the reader “…to a place that is recognizable” (p. 17). The validity and trustworthiness of interpretive research is what makes it believable (Moules, p. 17). It is for this reason that hermeneutic interpretations must be excellent descriptions.
Clear, coherent description of hermeneutic analysis also adds to the credibility and dependability of the interpretation. Koch (1994) suggests that credibility arises not from a reader necessarily agreeing with the interpretation but rather that the reader can understand how the author came to the final interpretation. It is careful documentation of the entire research process that helps demonstrate the dependability of the findings (Moules, 2002).

The “truthfulness” of hermeneutic interpretation is equated to “… a meaningful account that corresponds to experience”, so that truth is understood to be ever changing (Moules, 2002, p. 11). The truth of an interpretation is not whether or not the research can be replicated but rather that the understanding of the interpretation lingers (Moules). While hermeneutic interpretations are not generalizable, they can be transferable if readers recognize that findings are meaningful and applicable to fit into contexts outside the original circumstances of the study (Moules, p. 16). In this research, the adequacy of the analysis will be determined through assessment of whether or not the interpretations are revealing of “richly textured” understandings (Sandelowski, 1995, p. 182).

**Ethics**

**Role of the researcher**

An ethical approach begins with reflexivity regarding the role of the researcher. Prior to entering the field, I dedicated some time to consider my role as a researcher. Although my stance is not unique, there is little guidance in the literature for an experienced health care provider to take on a novice researcher role in a politically charged environment while continuing to work part-time in a primary care setting in the same health region.
Given my experiential knowledge of primary care, I recognized the area in which I needed to exercise the most caution was in displaying or accepting a level of familiarity with the environment. Ledger (2010) discussed how she found herself exchanging knowing looks with other providers, or joining in on a joke that only someone familiar with the setting would get. Simmons (2007) noted her participants assumed her knowledge on particular topics because of her professional role. These sorts of things did occasionally take place during data collection.

My strategy to address familiarity was to reflexively and persistently consider the boundaries of my role, as is necessary working in smaller communities (Baca, 2011; Moules, MacLeod, Thirsk, & Hanlon, 2010; Zibrik, MacLeod, & Zimmer, 2010). Applying knowledge of boundaries in this way was helpful, as I grew up and worked for several years in rural and remote communities. I could not entirely avoid situations of familiarity, in part because most health care providers wear so many “hats”, and also because I knew I had to maintain a working relationship as a NP with many of those I came into contact with after this study was completed. Furthermore, I realized I needed to protect many of these relationships if I hoped to be able to carry on a research programme in this area in the future. Through these experiences, I recognized how my own horizon and situation was changing as data collection progressed.

Throughout the course of this study I was regularly confronted by situations in which I had to consider how I knew information, and whether I could comment on a topic or not. This was one of the biggest challenges to me during the study and throughout the period of analysis. Analysis was also affected by my role because once data collection was completed, I did not truly exit the field. I continue to work as a nurse practitioner in
Northern Health and have not infrequent involvement with interprofessional teams and management-level discussion regarding future implementation of teams because of my roles as nurse practitioner and educator. While this level of engagement is potentially useful when considering knowledge mobilization and the application of my findings, it does affect the temporality of the analysis in that I continued to see things develop and unfold for interprofessional teams after data collection was completed.

Advice to clinician researchers from the literature includes an awareness that as an “insider” to the culture of health care I might not question things in the same way as someone with greater distance to the health care arena (Burnard, 2004). However, I think my knowledge of primary care was an asset to this study. Where I did notice my prejudices addressing me was with regard to the bureaucratic mechanisms of Northern Health. Between all of the rules and forms and certifications, not to mention meetings and spreadsheets and committees, I know that my expression was not always as neutral as it should have been as I observed, for example, an interprofessional team member duplicate charting or implement a process that was then reversed a few weeks later.

Researchers have also cautioned health care professionals taking on a research role in a health care setting in terms of patients wishing to interact with the researcher as a provider (Ledger, 2010). This was not a concern for me due to my experience as an educator in clinical settings. In my role as an educator, I cannot act as a clinician and so have been able to refer patients easily back to providers in their own setting, without engaging with the patient as a clinician. The setting of this research also served to alleviate this concern. The primary care provider participants frequently preceptor
students in their practice, and so patients were somewhat accustomed to having an observer in the clinic room during their visit.

For the duration of data collection, I tried to view my time in the study setting as work (Murphy, 2005). I regularly questioned my role and identity as a researcher. I made efforts to be careful to think before I spoke, and consider my position before I responded to questions or engaged in discussion. Maintaining a personal journal assisted me to be reflexive. Meetings with my supervisor were also helpful to debrief and discuss my role where it overlapped with other roles that I was attempting to maintain.

**Ethical procedures**

This research was undertaken towards partial fulfillment for requirements of a doctoral dissertation. Ethical approval (Appendix B) was obtained jointly from the Research Ethics Board of the University of Northern British Columbia (E2014.0512.031.00) and the Northern Health Authority Research Review Committee (RRC-2014-0011).
Chapter Four: Explicating Implementation of Interprofessional Teams

Chapter Four marks the beginning of the findings of this study. In this chapter, the focus is on understanding the changes associated with the process of implementation of a newly formed interprofessional team. The implementation of this team changed the everyday practices of team members, impacting confidence, morale, and relationships within the team. Many of the changes associated with the process of implementation of team-based care were unanticipated. This chapter examines key changes and experiences of interprofessional team members and primary care providers that influence how team-based primary care is negotiated and understood.

Locating Team

Data were collected for this study between two main locations, as well as patient homes. The first location is the fee-for-service office, where the primary care providers Henry (MD), Isaac (MD), Jack (MD), Kate (MD), and Leah (NP) keep offices and usually see patients. In this as in most fee-for-service primary care offices, co-location is not currently economically or, usually, spatially feasible, so the primary care provider “side” of the team is located in one office, and the interprofessional “side” of the team is in another office across town. The interprofessional team members include Mel (OT), Nora (RN), Odette (MH), Peggy (SW), Ruby (Case Manager), and Sonia (Lifeskills).

Although “side” is placed in quotations in the above paragraph, this physical gap between team members means the two sides infrequently see one another face to face, which contributes to a diminished ability to engage in conversation and informal dialogue. This, in turn, can affect how team members understand one another. Most clinician participants referred to the other part of the team as “on the other side” (Ruby),
or “on their side” (Mel), or “on the Northern Health side” (Jack). That both primary care providers and interprofessional team members thought of each other as being on different sides, and not necessarily on the same team, is a divergence from the conceptualization of the PCH and the expectations of Northern Health, and also from the ways many of these same individuals had collaborated and shared responsibility for care of patients in the past.

Four of the five primary care providers and four of the six interprofessional team members had worked collaboratively between 2008 and 2014 as part of a separate initiative. Mel, Nora, Peggy, and Ruby had all been part of a special services team to provide care and support to a specialized population who were patients of Henry, Isaac, Jack, and Leah. Yet as part of a newly formed interprofessional primary care team, almost all aspects of work for Mel, Nora, Peggy, and Ruby changed. Interprofessional team members were adjusting to a new office location, a broader range of patient ages and conditions for which to be responsible, a new referral and documentation process between team members, increased administrative burden, and new team members.

One of the main changes in role for interprofessional team members is a shift towards generalist practice instead of specialized practice. The intent from the organizational standpoint is that a generalist role would facilitate team members to employ a broad scope of practice. This in turn would allow the team to be more flexible and responsive to patient care needs.

Increased role overlap could mean that multiple team members would be able to perform different types of assessments or functions, such as assessing older adults for
long-term care placement, or cognitive behavioural therapy for patients with mild
depression or anxiety. This does sound promising and practical; however, it does not
consider the years some health care professionals have dedicated to gain expertise in a
particular area. The expectation to shift from a career of working, for example, in the area
of mental health, to now becoming competent in administering immunizations or visiting
new mothers was intimidating to interprofessional team members. Nora (RN) summarizes
some of her concerns:

[T]hat’s something that I struggle with too is what’s my role, am I a generalist, or
am I a specialist that goes into a certain area, and I think you’re losing a lot of really
valuable, well not necessarily losing it, but chopping it up and maybe one person
from the MS [Multiple Sclerosis] Clinic is on this team but not on the other four
teams. I think people have a lot of really good information and some people have
been working in one spot for 20+ years and they have a lot of valuable information
and that’s a huge loss if it’s not accessible to everyone so I don’t know. And I do
struggle with just what my role is supposed to be in that regard too. I don’t know
that I can do a patient as good a service as they would get just going to that [MS]
clinic.

It makes me nervous just being in this role and not really knowing what the
expectations are for what I can offer to our patients. [T]hey were talking about
sending pregnant people over here and wanting Public Health support and why
would you do that? You’re doing that [patient] such a disservice, even
contemplating bringing her over here right now. Go to Public Health, there’s good
people there that know what they’re talking about and at least she’ll get proper care.
(Nora)

Nora’s concerns, which are similar to those of other interprofessional team
members, are not indicative of a resistance to change or safe-guarding of specialized
knowledge. Rather, she focuses on understanding how patients are going to receive good
care. Interprofessional team members see the direct impact of changes in processes of
care on patients and may hold off changing practices until they feel confident that
patients will be adequately supported and cared for within new structures of service
delivery.
Changes to both structure and role interfered with and disrupted the previous relationship that was enjoyed between primary care providers and former special services team members, now interprofessional primary care team members. Time and attention that was previously focused on relationships with patients, primary care providers, and each other, was now re-directed out of necessity towards process changes at the organizational level of the health authority. The interprofessional team members lamented these changes both informally during conversation and observation periods, as well as during their interviews.

The team members who were previously part of the special services initiative described themselves as having been a cohesive group with a lot of autonomy. They regularly met with the primary care providers with whom they shared patients, to discuss plans of care or interventions, and they also saw patients with the primary care provider in joint appointments. As part of the newly formed interprofessional primary care team, these functions of team-based case management and joint visits with primary care providers did not take place.

Ruby reflects on how regular formal and informal contact with the primary care providers had been a benefit to the previously existing special services team:

It gave us an opportunity to get to know each other, know each other’s world, problem-solve together and develop relationships with our practices. I mean it’s taken a long time to develop the relationships we have with them and it’s been wonderful to be able to call and know the MOAs and know the doctors and trust each other and like each other. (Ruby)

Ruby’s reflection calls attention to aspects of team members knowing one another beyond roles or functions. She highlights the value of longitudinal relationships between team members. Trusting and liking a team member provides a degree of comfort as well
as increased willingness to reach out to a team member who is not co-located, in order to discuss a patient or ask a question.

Knowing “each other’s world” includes understanding what another team member may wish to know about a change in a patient’s status or care, it may include knowing whether a team member prefers being reached with a phone call or text message, or to consider when the best time might be to reach another team member. For example, if Ruby knows a primary care provider reserves one afternoon per week for home visits, she will not waste time trying to reach him through his office during that afternoon.

Understanding the practice world of another team member increases knowledge about how to effectively navigate team-based care for patients, providers, and team members.

Throughout the study, interprofessional team members were frequently observed in the Northern Health office discussing whether or not to involve or update a primary care provider about a patient’s condition, and whether to do it in writing or with a phone call, or whether it would “bother” the primary care provider. Often these discussions were informed by a team member who knew the primary care provider, and could tell the undecided team member what the primary care provider would likely prefer in that situation. This type of knowledge about provider and team member practices informed judgment and thus decision-making about patient care.

A number of primary care providers had differing preferences and expectations about how the interprofessional team members would be involved with “their” patients. “Everybody seems to want different amounts of information” (Nora, RN). Requests from primary care providers for information about patients ranged from wanting all documentation, to one-line notes, to updates only when something significant occurs with
the patient. The inconsistency of this feedback loop impacted both “sides” of the team. “It would be really nice to know when our [patients] are going to see the doctor. That way if there is something brewing, a lot of times we don’t know...” (Ruby, Case Manager).

When information is insufficient for a team member to be able to discern what the best course of action is for a patient, care can be affected. Effective feedback loops so that both “sides” of the team have enough information to provide timely, relevant care for the patient are desirable, however in the current system, pathways to communicate and document patient information are convoluted and time-consuming for the interprofessional team.

**Contending with Technology**

Dismantling service delivery silos in primary care in terms of allocation of human resources surpassed the pace of aligning technological solutions to streamline care. Interprofessional team members became mired in the reality of this. There are nine electronic systems the interprofessional team members variously have to use or monitor.

MOIS is the electronic medical record (EMR). It is the same EMR the primary care providers use, but it is a different version and so data cannot be pushed into or pulled out of the system easily, and this means an immense amount of duplication of data entry.

There is Synapse, which is the documentation system used by all mental health professionals, including community psychiatrists. Procura is used by home care, Powerchart and eHealth Viewer gives access to hospital and laboratory data, Pharmanet tracks most prescription medication that is dispensed to patients, and Pixelaire is for wound care. Panorama contains all immunization data, and Momentum is for RAI, which
is a comprehensive assessment tool for determining the long-term care needs of adult patients.

In addition to duplicating data entry between the primary care provider office and the interprofessional team office, data also frequently must be entered by interprofessional team members in more than one system. “There’s a lot of double documentation for the RAI and MOIS, like the medications. I have to care plan in RAI … I’ve only done it on the RAI, but I need to, obviously, do it on MOIS so how do I do it?” (Ruby, Case Manager). Due to different operating systems and formatting within the systems, there is no easy way to port data without the interprofessional team members spending long periods at their computers copying information first into one system, and then into the next, to try to ensure information shows up for all members of a team that are involved in a patient’s care. Yet even after documenting in MOIS, if interprofessional team members wish the information to be passed back to the primary care provider office, the information still needs to be collated, printed, and then faxed to the other office.

Adding to the difficulty of understanding and managing multiple electronic information systems, new interprofessional team members waited a long time to gain access the various systems. This hinders the ability of interprofessional team members to be fully operational.

I didn’t have the software that I needed on my computer until last week. So some of the stuff that I was supposed to be able to do, I was not able to do because I didn’t have the required equipment. And then MOIS, there were problems [because] when we started, some of the people were already well versed in MOIS so we would be doing things like looking how to do recalls and I was trying to find out how to even [look up a patient] on MOIS. (Odette)

Interprofessional team members received an orientation to use MOIS, and participants mention this was very well done. However, when they were unable to
immediately put these new skills into practice and form habits to use MOIS in a consistent way, their documentation practices were affected. Nora (RN) speaks about attempting to document in the required format learned during the MOIS orientation. “It’s hit and miss. It’s not part of my daily process” (Nora). Not being able to smoothly complete documentation as a task that can be taken-for-granted in the course of a health care professional’s role disrupts the workflow of the interprofessional team.

Throughout the period of data collection with the interprofessional team members, some team members were unable to sign on to the EMR at all and had to take notes by hand during patient rounds. Although Northern Health provides information technology support, it is via a call centre. Interprofessional team members had little recourse except to call, receive a ticket number, then wait for service. Some participants waited beyond two weeks to receive assistance for a technological issue that was essential to performing their role.

The administrative burden to locating, completing, and updating information required by various systems is significant to the workload of interprofessional team members. Ruby (Case Manager) remarked during one meeting that although the administration time of interprofessional team members was not tracked or measured, it was so substantial that some days she did not even feel as though she was caring for patients.

**Questioning Function**

The burden of this change in processes and structure with its subsequent impact on interprofessional team member availability and capacity to see patients was somewhat invisible to primary care providers, because it took place elsewhere. Primary care
providers did not as regularly come face-to-face with these changes as did the
interprofessional team members. Consequently, some primary care providers were
somewhat confounded by the impact the change in structure had on team member
function, such as the initial limited volume of patients the team was able to see:

    I know it’s just a start-up and they’re working through processes but five members
on a team, if they each got to spend two hours with a client, which is reasonable,
then you could say that’s a minimum of three clients each in a day. If you give them
an hour or two for driving around or whatever and they get to spend two hours, they
should be able to do paperwork inside the two hours. That’s three times five is a
minimum of 15 clients a day. So in the first month of operation, they managed 13
clients in a month. … right. So you know … there’s the culture that’s around, they
want to get all their processes right and all of that, that’s all well and fine but at the
end of the day, you know, what pressure is there to get the job done. To actually
get the job done. (Henry)

The lack of exchange of information and knowledge between primary care
providers and team members contributed to a disconnect between the “sides” of the team.
This lack of understanding about the changing practices of team members created some
hesitation in primary care providers, inhibiting referral of some patients to the
interprofessional team. Primary care providers could not assure patients of when they
would be seen, nor was there any certainty of what services would be provided:

    They haven’t been very clear in what they’re actually going to offer. It’s almost like
a carte blanche, well, whatever you need we will offer, but really what does that
mean? So to have a team that says ‘oh, we’ll do whatever it takes’, it doesn’t fly,
because you don’t know what the restrictions are. I think it would be nice if they
told us what the team cannot do, rather than say we can do whatever because if you
can’t deliver then I’ve wasted my time trying to access you for something that I
could’ve taken care of by myself. (Jack)

Jack’s comments illustrate how, in order to determine who needs a team,
gatekeepers (in this case primary care providers), require meaningful information in order
to understand what services and types of care the patient will receive if referred to the
interprofessional team. While Northern Health may have intended a message of
comprehensiveness in terms of care to be provided by interprofessional teams, primary care providers interpreted this message as lacking in clarity and definition. The lack of exchange in communication about role and function of team members at the outset of the primary care team implementation resulted in a degree of disengagement by primary care providers who were left wondering what the interprofessional teams could actually do.

**Taking Sides**

The primary care providers experienced ambiguity in understanding the services offered by the new interprofessional team. Isaac talks about presenting a “united front” in terms of providing patients with consistent advice and maintaining a plan of care regardless of who sees the patient. He remarks, “That works well in our office because we are constantly communicating. It doesn’t work well outside my office because I have no communication” (Isaac). In the primary care provider office, a “united front” is achieved not because of co-location, but rather because sharing physical space facilitates constant opportunities for face-to-face dialogue and information exchange that increases provider knowledge of colleagues and patients.

Jack explains a consequence of not being able to constantly and informally communicate with all team members:

Who’s going to be doing what in the role because often what happens when the roles are fuzzy and it’s not clear to the patients who they can contact about investigations or follow-up, it creates confusion. And if a patient feels frustrated, and feels that they are not being well cared for, even though it might be excellent care, the problem is no one’s been clear enough to tell him that. (Jack)

Nora also notes the difference in how team members know one another between belonging first to the special services team compared to the new primary care team:
It felt a lot more “teamy” before and I know they talk a lot about breaking down the silos and having a lot of exchange in our roles and overlap in our roles and I don’t see that like I did when we were the [special services team]. (Nora)

While a change in job or job description always brings a degree of uncertainty and there can be a sense of loss for the way things “used to be”, Nora’s statement alludes to a disconnect between the strategy of implementing interprofessional primary care teams and the reality for the clinicians who experienced “team” under the auspices of a narrow and then much broader initiative. The “they” that Nora alludes to in her statement are the team lead, care process coaches, and other middle managers, who were charged with implementing the Northern Health “side” of the newly formed interprofessional primary care teams. In structuring new teams, opportunities to include processes to allow for face-to-face dialogue and exchange of information between team members and primary care providers is diminished compared to interactions between the previous special services team and primary care providers.

Within the new structure of the primary care home, the interprofessional team members who were previous members of the special services team moved from a small, non-hierarchal membership with much informal dialogue and organic process to a large, shared office where they experienced close oversight from supervisors, increased administrative responsibilities such as learning a new charting system, attending daily case management rounds, and weekly or more frequent process meetings where progress and milestones were colour-coded onto a large spreadsheet with many tasks and deadlines that focused on team process.

Related to difficulties in understanding one another that were exacerbated through a lack of face-to-face dialogue, primary care providers perceived some of the newly
structured practices of interprofessional team members as adhering unfavourably to
“protocol”. Isaac gives an example of patients being taken off the interprofessional
team’s waiting list if the patient is not contacted after three attempts:

The problem is they’re very protocol driven. I get a letter from them saying, thank
you for referring this patient, we’ve been unable to contact them, we are returning
the referral. … Which kind of makes me wonder, that’s a protocol, whereas doctors
are more guideline driven because I can speak to being a physician. We’re taught
that these are the guidelines but you have the knowledge and experience to step out
of it, to question and to do what’s best for the patient. (Isaac)

Isaac’s reflection of his experience from a physician’s perspective indicates
clinical judgment to provide high quality primary care is required beyond patient-
provider clinical encounters. Even for something that may at first seem strictly
administrative, such as contacting a patient to book an appointment with an
interprofessional team member, requires knowledge of the patient, and a questioning
approach. Isaac points out that the issue of the patient being inaccessible may in fact be a
symptom, “… with the patient not being organized enough, and that could be a mark of
pathology in itself” (Isaac). In these instances, knowing whether patients cannot be
contacted because they are out of town for work, versus not answering their phone
because of mental illness and paranoia, is a salient detail that cannot be attended to via
protocols. This observation and questioning of what can be done through a standardized
process and what requires clinician judgment and knowledge raises questions as to how
structures and processes can be implemented and evaluated at an organizational level for
effective team-based care.

There are other worries fostered by lack of clinician-to-clinician dialogue and a
reliance on policies or protocols usurping clinical judgement:
The biggest concern I have as a physician is that the ball doesn’t get dropped. And when you don’t have clearly defined roles in a team and what that team’s going to deliver, that sets up alarm bells in my mind because the moment I know if I was going to refer to this team out there and the patients fall through the cracks, whose fault is it? (Jack)

Isaac’s and Jack’s comments reflect concern for their patients that is a result of not understanding the practices of interprofessional team members. Primary care providers may feel uncertain whether interprofessional team members possess comparable levels of discernment or an ability to recognize salience in a clinical situation. This uncertainty about how interprofessional team members use clinical judgment as opposed to adhering to organizational policies and protocols influences referral and communication practices, and thus the access patients may have and care they may receive from an interprofessional team.

In an attempt to partially remedy ambiguity of services provided by the interprofessional team, Northern Health developed a flyer to be distributed to physician offices. Some of the services to be offered by teams included “[chronic] disease management strategies”, “short term counseling”, and “coordination of community resources” (Northern Health, n.d.a). Also included in the flyer were strategies to deliver these services, such as “supporting self-management”, “follow up, monitoring and recalls”, “harm reduction strategies”, and “prevention and health teaching”, among others (Northern Health, a).

At first glance of this brochure, the services offered by Northern Health via the interprofessional team do not appear to extend beyond what already normally occurs between patients and primary care providers in a family practice office. Primary care providers were not convinced that asking the interprofessional team to perform some of
these primary care functions that already overlapped with their own day-to-day functions would be of benefit to patients. “As soon as patients leave what they identify as their primary care home, immediately their relationship hasn’t been established. So nothing can be leveraged from that, you still need to develop a relationship” (Isaac). Isaac recognizes the influence that longitudinal care and knowing the patient has on effective primary care delivery. The current process of referring a patient to a team member that neither the patient nor the primary care provider knows may be less preferable to the extent that a primary care provider forgoes a referral to the team for functions he can perform, in order to maintain consistency of care and provider for the patient.

In the interprofessional collaboration literature, one frequently endorsed benefit of teams is to ease some of the burden of complex patients from primary care providers (Bodenheimer & Smith, 2013), particularly in areas that pertain to health yet are outside the purview of traditional primary care and remain as gaps in the system, such as housing or finances (Virani, 2012). Primary care providers are engaged with this idea, and with the concept of team-based care; “team-based care is fantastic. If there is consensus about what the plan is” (Isaac); “I’m very much a team member” (Jack); “I think it makes all sorts of sense” (Henry). Yet the disconnect persists between the idea and the reality, and uncertainties remain about endorsing team-based care for their patients. “It’s not about just sending them off and saying you get fixed in whatever way, but it’s also about maintaining that relationship because things aren’t always that smooth for many [patients].” (Leah).

In other words, equivocal written communications are not enough to advance primary care provider engagement levels to a point of guaranteed or functional use of an
interprofessional team that is not co-located. Neither is a promise to shoulder some of the burden of caring for complex patients a reason to involve the interprofessional team if it risks damaging the therapeutic relationship with the patient, particularly for those patients who may have experienced disconnected care or been marginalized within the health care system previously. The concerns voiced above by primary care providers highlight that saying what an interprofessional team can do is not the same as knowing individuals who make up an interprofessional team and learning their strengths, knowledge base, preferences, and communication style through interpersonal contact and dialogue. The extent to which primary care providers and interprofessional team members are able to know and understand each other’s practice “world” can influence understanding who needs a team, who receives team-based primary care, and how it is enacted.

**Dis-location**

Although four of the primary care providers had experience working with four of the interprofessional team members in their previous role, this pre-existing relationship was almost undetectable at the time of data collection. Peggy reflects on the change in the relationship comparing her time as part of the special services team and her present role as an interprofessional team member:

I think we all took a lot of pride in the work that we did and the accomplishments and the subjective comments that we would get from family members and all the physicians, I mean they glowed, they just loved the work that we did, but if you ask them that today, I don’t think you’d get that. (Peggy)

This perceived change in relationship between primary care providers and interprofessional team members who had previously worked together was understood to be detrimental not just to members of the team, but also in forming new relationships with patients.
Physicians need to become versed in what we do, what does my team do, who is on the team, what are their names, what do I know about them, right. If [a patient went] to [their] physician’s office and have that trusting relationship and [the doctor] says it sounds like you need “this” and you know, “Mary” is going to come see you and this is what she does … if [the doctor] is not well versed in that, then they won’t know where to send that person. That information, if it’s not delivered properly, then people might not follow up. (Mel)

Importantly, both primary care providers and interprofessional team members acknowledge that relationships with patients have to be leveraged. Optimally, trust and understanding exists between team members, but trust must also be obvious to patients to maximize patient uptake and willingness to participate in team-based care. The disruption to the relationship dynamic that resulted from the members of the special services team assuming new roles as interprofessional team members also altered the mechanism by which team members, primary care providers, and patients all knew one another.

Formal and informal mechanisms such as joint case management meetings, joint patient visits, as well as informal consultations or face-to-face time between primary care providers and special services team members were lost to stringent new directions, new processes, and change. “You see us with our energy diminished and we’re pushed back, and people clam up and we don’t say very much. … [O]ur expertise that we come with is diminished and we don’t have the voice around that” (Peggy).

During a time of system-wide transformation at the health authority level, a top-down approach may be necessary to ensure deliverables are met and processes are sustainable. The implementation of this approach can have unintended consequences, such as the muting of input from front-line team members that Peggy describes. The long reach of such consequences can also impact patient care. Diminished confidence and a reduced sense of expertise while new processes and protocols are implemented can
contribute to the problem recognized by Isaac; rather than relying to a great extent on clinical expertise and judgment in day-to-day work, following protocols and policies allows health authority employees to cope with sea change.

The interprofessional team members were overwhelmed with change at the outset of implementation and had little time to maintain existing relationships, as they were intended to be responsive to nine different family practice offices, of which the five primary care provider participants in this study represent only one office. “[The] pace is a little bit crazy. … And it doesn’t feel good. You don’t leave work going wow, I did great today. No, no, no” (Ruby). The interprofessional team members describe a steep curve of learning a new role that coincides with substantial and cumulative increases in patient load, termed elsewhere as “change fatigue” (Allan et al., 2014). “I think the problem is there’s so much change all the time, and people can only be saturated with so much, especially when the workload is extreme” (Odette).

Odette’s perspective can be juxtaposed with that of Henry’s earlier comments, when he wondered what pressure the interprofessional team members had to see an adequate volume of patients. The two “sides” of the team were far apart at this point, neither really understanding the other’s experience or world of practice. For interprofessional team members, they felt disconnected from physicians who previously thought highly of their work but were now uncertain about what a new team structure might bring, and they felt equally disconnected from their employer and organization.

[M]orale right now is not really that great … we do spend a lot of time chatting about what’s going on and that can be time-consuming and it brings you down, you’re not as efficient …[N]ot having great communication, or just being told what to do, that’s caused a lot of grief and morale issues [because] they [managers] want our feedback but then at the same time, they just do what they want to do and
sometimes it’s against what we would’ve wanted, so it’s hard to change your ways, and especially if it’s not delivered in a great way. (Mel)

Interprofessional team members did not believe they had power to change very much about their work flow. Feedback loops, despite the presence of an on-site team lead and two care process coaches, were inadequate. The horizon for managers may have been focused on how the team was aligned with the organizational vision for the PCH, which may be different from the horizon of team members who focused on how patient care aligned with the function of the team in its current state.

Some of the juncture in power and leadership also may have resulted from a gap at the interface of managerial direction with clinicians who provide patient care. “I think leadership would be nice, it would be nice to have a team lead here who’s accessible, who you can come to with your clinical questions and feel like you can get an answer” (Nora). “Clinical direction is something that’s lacking” (Ruby). Lack of clinical leadership may have facilitated increased focus on change management versus patient care that, for some, worsened morale.

I struggle with decisions being made from up above as opposed to how they [Northern Health managers] talked about us doing PDSA’s [a continuous quality improvement cycle of Plan-Do-Study-Act] and then making decisions or working with that or revamping things. I don’t have a sense that we’re actually involved with the PDSA. We’re simply told what to do… It’s being, again brought down from above, and that doesn’t help with staff morale. (Peggy)

From Peggy’s comments, it appears that morale is impacted not just by the rate of change or being involved in a major undertaking of transforming the primary care system. Implementation of this interprofessional team felt top-down to team members, with little control over their day-to-day work, and little ability to draw on their own
judgment and knowledge to structure their days, the care they provided, or the relationships they wished to forge and maintain.

The early stages of implementation of team-based care are burdened with comparisons to the way things used to be, as well as sadness for changes in professional relationships. Yet a central, common goal maintains a strong thread of purpose for both interprofessional team members and primary care providers: high quality patient care. “I think the hope is: what are some of the lessons we can take from this and it would help patients ... I’m learning from it and we’re problem-solving together and the patient wins out in the end” (Ruby). “It becomes about what’s best for the patient and that is something that any doctor can always reconcile: what’s best for the patient” (Isaac). All interprofessional team members and primary care provider participants were genuinely committed to putting patients first, and it is this commitment that fostered much of the resolve among the participants of this study had to keep up with the changes in implementing team-based primary care.

**Summary**

The physical, political, and psychological milieu of interprofessional team implementation is one of change and uncertainty. As interprofessional team members time is taken up to change their role, physical location, documentation and communication practices to form as a new team, a rift becomes apparent whereby primary care providers and interprofessional team members recognize that a loss of connection and understanding one another has inadvertently taken place.

Between interprofessional team members and primary care providers, gaps in knowledge and information about one another accumulate as opportunities for face-to-
face conversation are depleted. As primary care providers and interprofessional team members stand on different “sides” of the same team, confusion is replaced with misunderstanding, and without physical proximity to one another, practices of othering can be observed. The lack of understanding each other’s world, however, is not a result of the infeasibility of co-location. Many of the individuals on the current team worked together on a previous non-co-located team, and report knowing and understanding one another well. The change is not in the composition of the team, or the role of the team, but rather the context in which team-based care is taking place and the lack of opportunity for connecting and conversing with one another.

New structures and processes, particularly for interprofessional team members, hinder the ability of all team members to know one another. The influence of structure and process in health care delivery cannot be overlooked, for as organizations shape processes, the processes shape practices of individuals. When health care organizations make decisions about priorities or how clinicians will spend their time, it alters how their everyday role is enacted. From the interprofessional team members’ perspective, this is not fully recognized by managers. The unanticipated consequences of new structures and processes seen in this study are how changing practices impacts relationships between team members, which influences delivery and quality of patient care.

Interprofessional team members and primary care providers recognize how gaps in information and knowledge about one another affect patient care. Knowing a team member or their preferences in terms of communication alters understanding of a

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3 This wording is based on a quote from Winston Churchill (1943) who said, “we shape our buildings, and afterwards our buildings shape us” (para 1).
patient’s situation, and this affects decision-making about patient care. Uncertainty as a result of not knowing a team member can delay care or result in mis-steps that may further strain relationships between team members. Finally, when interprofessional team members and primary care providers do not know one another well, it is difficult to genuinely offer team-based care to patients. Participants acknowledge that it is important for patients to feel known in order to leverage relationship and provide effective care. Some primary care providers who did not know interprofessional team members, or were unclear about the role of the interprofessional team, initially felt concerned and somewhat uncomfortable advising their patients to venture outside the family practice office for primary care services.

Team-based care and initiatives in interprofessional collaboration have shown up in numerous iterations over decades, arguably none of which have revolutionized primary care delivery with resulting improvements in patient outcomes. Ultimately, the successes and failures of these initiatives in fostering team-based care are borne by clinicians and patients. For these reasons, it is timely to pay closer attention to the patient-provider and provider-provider interface to better understand practices that lead to expanding the patient-provider dyad to include the interprofessional team. To more fully understand how team-based primary care unfolds in practice, the next chapter turns to examine the perspective of patients, and the practices that take place within patient-provider encounters that influence decisions to involve the interprofessional team.
Chapter Five: Exploring the Patient-Provider Dyad

While the context of providing primary care was transforming during the period of data collection for this study, the mechanism for patients to initially access primary care remained unchanged. The patient-provider dyad remains the cornerstone of primary care, and providers in this study continued to be gatekeepers for patients to initially access members of the interprofessional team. Chapter Four illustrated that the ways in which providers and interprofessional team members understand or know one another can influence how or when patients might be referred to the interprofessional team. In this chapter, attention is shifted to practices of connection and ways of knowing within the patient-provider relationship.

The patient-provider dyad has long been viewed as a foundational longitudinal relationship through which patients can feel known (McWhinney, 1998) and receive care and treatment to help maintain or restore their health. In spite of this, little is understood about who patients consider to be part of their “team” or how they feel known when thinking about their own health and care. This chapter will explore patient perspectives on how patients feel known and define “team”. These perspectives will help to inform how practices of connection are enacted within patient-provider encounters in ways that help patients to feel known. How providers know patients influences understanding of who needs a team, and when.

Patient Perspectives of Team and Health

While the primary care provider “side” and interprofessional team “side” represent one depiction of an interprofessional team, this is a somewhat health system-centric definition of team. Incorporation of the patient perspective is necessary if patient-
centred care is to be understood in the context of team-based care. Understanding how patients conceptualize who makes up their team is central to understanding how teams can provide patient-centred care.

Patients are people emplaced in their community, where they work, live, and play in their everyday environment. If health is conceptualized as an equilibrium, then it is “…experienced as weightlessness in which different forces balance each other out” (Gadamer, 1996). A person’s situation that prompts seeking primary care is one where health is no longer taken-for-granted, but instead moves to the foreground as they take on the role of patient. Articulation of how patients define and draw on team members or other resources to help restore health is lacking. This research attempts to partially address this question by inquiring how patients define teams, and how they feel known by team members over time.

**Defining team**

Patients include themselves as part of their health care team.

I look at this as I’m the middle of the wheel and that wheel will only move efficiently and appropriately if all of us are on board together, so there can’t be one spoke of the wheel that is a stronger influence than the other. (Charlotte)

Recognizing that patients may desire equal voice and power as a member of their health care team is a shift away from a hierarchal model of care. Charlotte visualizes all team members as equals. The image of a wheel is a familiar one, but reflects patient wishes for coherent, connected care.

Primary care providers are not necessarily the first or only person patients identify as helping to restore or maintain health. Other people and strategies are important as well. Charlotte names her fitness instructor and her dentist. Gary reads and listens to tapes.
Diane mentions her animals and her job, while Eleanor identifies individuals at a community-based support group. These supports and resources are outside the boundaries of the traditional health system, and help patients stay healthy without requiring contact with the formal health care system. When primary care providers and interprofessional team members understand the particular supports and strategies of their patients, there is opportunity to mobilize, enhance, or increase these supports or resources when the patient seeks primary care. This in turn may strengthen the patient’s ability to restore or maintain health with minimal or less health system intervention.

Patients also include more mainstay supports, such as friends, as members of their team. Diane says, “if I’m really in a bad way emotionally or really scared about something, they can hear it. They’re stable enough to handle it.” For Diane, a friend who can see her at her lowest and still listen is important. Charlotte further identifies this type of support by saying, “gosh, I think everyone needs a confidante.”

Another way friends offer support to patients is by allowing them to retain dignity and independence. Gary has a condition that affects his mobility:

I’ve got a friend that owns a farm next to me and I work with him off and on but he fully understands what I’ve got and he’s already told me, come on over, give me a hand, if you get tired, call it a day. They’re people I can go to without being doted upon … [but] another friend of mine, I was seeing him, so he’s moving stuff out of my way. It’s nice, but you know, it’s pride. (Gary)

Friends can help patients like Gary to retain parts of their identity that remains unaffected by illness. Friendships for patients are an informal support of high value when people have to take on the role of patient. The role a particular friend plays to support the patient, however, is individualized to the patient’s preferences and needs, which may change over time.
Family is also a significant support for patients.

You can phone them and say here’s the latest on my condition … and you get feedback from people who know you as a person and it’s not just as an objective question. There’s another layer there of, well I don’t know if Mom can take that. (Charlotte)

In Charlotte’s case, her family physician and surgeon recommended a second surgery for her condition. Rather than immediately agreeing to have the surgery, Charlotte consulted her closest family members to take their opinions into account in her decision. This action reveals how patients may involve supports who can be considered team members outside the health system and is a reminder that there may be discrepancies as to whose opinion may be considered “expert” by patients.

Patients rely on and use a number of strategies, factors, and supports to maintain health outside the formal primary care system. The extent to which patients can rely on these supports and resources impacts the timing and decision-making about seeking primary care. Even when patients can identify supports and resources that help to maintain or restore health, some can remain taken-for-granted. For example, when Diane identified members of her health care team, she omitted any type of health care professional. When asked if this was intentional, her response was, “Oh, that’s terrible. I guess maybe in some ways, they’re almost invisible, but not in a bad way … this is probably a Canadian thing too, that we’re so lucky that we have this” (Diane). By “this”, Diane is referring to Canada’s publicly funded health care system. Unless primary care providers demonstrate intent in getting to know patients, which in some cases may require asking direct questions about supports and resources, patients may not volunteer information about resources that contribute to health being experienced as a state of equilibrium.
Knowledge of the social world of a patient does have a place in a primary care patient-provider encounter. This information is usually collected under a heading of “social history” of the patient. Most aspects of information collected in a health history interview with patients have a biomedical or clinical focus, such as asking about symptoms of an illness, or what medications a patient is taking. The social history covers topics of upbringing and family circumstances, home life such as marital and income status, as well as hobbies, beliefs, and habits (Seidel et al., 2011). The social history is a window that offers a glimpse into the patient’s life as a person emplaced in community.

Social history is by definition historical as people are married, quit smoking, retire, and otherwise change aspects of their identity, existence, and consequently, their health status. Primary care providers and interprofessional team members who have an in-depth understanding of their patient’s social history can know the patient beyond the limits of an illness-focused lens. This can lead to improved understanding about how the balanced state of health has altered, and what supports and resources were employed until capacity is surpassed and tips the patient into the realm of seeking formal primary care services. If understanding a patient’s social circumstances can lead to better understanding of why patients decide to seek care, it may also contribute to patients feeling known, thus strengthening the therapeutic relationship. To uncover this possibility further, patients identify which health care providers know them best, and what it is about a connection with that provider that makes them feel known.

**Feeling known**

Of seven patient participants, six identified a physician (five family physicians and one internist) as the health care professional who knows them best. This selection by
patients likely reflects traditional models of health care delivery, namely solo family practice. Family physicians in fee-for-service practice remain the backbone of primary care delivery in Canada (CFPC, 2011). However, patients may perceive some changes in health care delivery; of the six participants who identified a physician as knowing them best, only three reported it was their current physician. The other three patient participants believed a previous physician knew them better.

The patient who did not think any health care provider knew him well states, “I only go for trauma. I think doctors are controlled by the pharmaceutical industry and a lot of what doctors learned is wrong” (Adam). Adam experienced a misdiagnosis of early dementia in his early 40s, which reinforced deep mistrust of the medical establishment. He currently relies primarily on alternative practitioners for diagnosis and treatment of ailments that are not physical injuries. He adds, “How well do you know the doctor other than they know your specific complaints?”

Adam sees no benefit in his primary care provider knowing anything beyond his biomedical status. Given that Adam plans to attend his primary care provider only for acute episodic concerns, this seems reasonable. However, Adam is a participant with whom I also observed a patient-provider interaction, on a day Adam attended for follow up of his most recent episodic issue. During this visit, I observed that his primary care provider did incorporate other knowledge about Adam into the visit. For example, inquiring about Adam’s mobility, the primary care provider asked about stairs and assistance from his wife, as well as returning to work. Adam and the primary care provider also had an amicable conversation about the hobby that led to Adam’s injury. The primary care provider was well aware of Adam’s views about Western medicine.
There is a mismatch between Adam not feeling known and what the primary care provider did actually know. This discrepancy is a reminder that high quality patient care can take place even when patients do not feel known, and that social history can be collected skillfully and informally by primary care providers. For patients like Adam, whose mistrust influences his beliefs and care-seeking practices, primary care providers can sustain a therapeutic relationship simply by keeping the door open and allowing patients to choose what type of care to access.

The remaining six patients who reported a physician knew them well all gave similar reasons as to why they felt known. Gary says, “I guess, actually he just seems concerned about me, whether it’s [my progressive health condition] or physical and we converse about the family and all this other stuff. So you know, he’s a personable person”. Gary’s physician expresses interest and asks about Gary’s life and personhood outside his role as patient.

Frank has had a few family physicians, as previous physicians have retired or moved. He says, “I’ve been lucky in all of the doctors … they’ve all been personable, knowledgeable, kind of straight shooters I think” (Frank). Like Gary, Frank chooses the word “personable” as a descriptor. He also uses the word “lucky”, reflecting an impression that not all patients are so fortunate to have primary care providers who are easy to relate to or are able to sustain a therapeutic relationship.

Charlotte describes her relationship with her family physician to explain why he knows her best:

Well, first of all, there’s nothing I can’t tell him. The second thing is the day he told me you’re the expert on your body and I’m the medical expert and between us it’s a partnership so I need you to tell me everything that you’re thinking and I trust that
you and I can do this together. And I’ve had really good luck with my doctors, yes, but he’s the first one that’s really said that. (Charlotte)

Charlotte, too, recognizes the role of “luck” in finding a primary care provider who intentionally takes time and effort to understand her and include her as a partner in her own care. It is important to Charlotte that her family physician explicitly invited her into partnership and encouraged her to not limit her contribution during visits to providing only her biomedical information.

The three remaining patient participants identified that a previous physician knew them better than any other health care professional.

[He] said ‘oh, my sister had rheumatic fever’ … it was almost a very personal feeling that we had with him for that many years. It was a very comfortable feeling, and he’d speak to us in public, not that we talked about anything. Rap on the [glass] walls of the airport and he’s waving … so it was very nice. (Eleanor)

For Eleanor, who also had rheumatic fever, a physician who disclosed some personal narrative helped her to feel understood. Further, he acknowledged her outside the clinical realm, in the world where she lives as a person, not a patient.

Brent explained how he felt known by his previous physician:

I don’t believe in a lot of chatter with the doctor, but I, you know, there’s more than just the physical side, there is an emotional part to it … I know [my previous physician] is a hiker, I was a hiker… We never spent much time about these things but we knew things about each other. (Brent)

For Brent, a shared interest helped him to feel known. Mutual understanding in a therapeutic relationship does not have to result from an over-sharing of information on behalf of the primary care provider or the patient, but patients may feel better understood when the patient believes their provider understands things that are important to maintaining their health. Conversely, knowing about a patient’s life and interests as a
person also helps providers to understand how people’s lives can be impacted by ill health.

Patients identified four components that prompted confirmation of feeling known by their primary care provider. Primary care providers can help patients feel known by being personable, treating patients as partners, disclosing personal narrative, and acknowledging the personhood of patients, accomplished in part by understanding patient interests and strategies that help maintain health. Feeling known by a health care professional does not necessitate delivery of high quality care, however, and there is a distinction to be made between patients feeling known and believing they are receiving good care.

I consider [my current physician] to be more an engineer than a healer, but he’s a very conscientious man. He watches the numbers. ... Once a year he gives me the thing, do you drink liquor, how much a day and all these kinds of things and that’s about it. (Brent)

Brent illuminates two important concepts in this excerpt. First, as patients age they may be more likely to require ongoing management of prevalent co-morbid chronic diseases, such as diabetes, arthritis, heart failure, and congestive obstructive pulmonary disease, than they are to require cure of an acute episodic illness. This gradual shift in focus and patient presentation has created parallel need for management guided by evidence. Care of patients with complex co-morbidities is a complicated undertaking and has prompted a burgeoning field of research. This is the second concept to which Brent refers when he mentions being asked about drinking. Annual screening for risk of alcohol dependence reflects adherence on behalf of Brent’s primary care provider to national guideline recommendations. Brent is a patient diagnosed with several co-morbid illnesses. He believes he is receiving good care, but by a provider who does not know
him very well. Perhaps there is less time to talk about hiking when trying to keep up with evidence-based practice.

It is possible that as guidelines are implemented with consistency in primary care, the therapeutic relationship is altered to some degree. This may be for better or worse in the field of family medicine, but it has important implications for interprofessional team-based primary care. Many interprofessional team members specifically address social aspects of health, such as helping with finances, housing, or support for children with special needs. If some components of a patient’s social history are not well understood or neglected by primary care providers, this will affect how primary care providers are able to assess which patients may require an interprofessional team. If some parts of the social history are not known, this also reduces the amount of pertinent information that gets passed on to interprofessional team members when they become involved in the patient’s care.

A secondary interpretation of Brent’s comments that his current physician seems more an engineer than a healer may be one that is indicative of nostalgia. Brent is in his mid-60s, and he asked during his interview if I had ever seen Dr. Welby, a television physician who has been stereotyped as the “myth” of family medicine (Guthrie & Wyke, 2000). Brent talks about Dr. Welby; “… he was one of those doctors that knew all the kids … everybody loved him because he was such a nice man. He probably wasn’t the most competent but …”. Brent goes on to compare this image with one of his current physician, who keeps track of everything on the computer and makes sure Brent is referred to appropriate specialists. It is for this reason, Brent says, that “I’m staying with [my current physician] … he is very exact”. Yet between referrals and technology and
keeping up with evidence, Brent believes there is a missing element. “Technology is more advanced today … but it also leaves some gaps. … I would feel better in the system and such that he and colleagues would sometimes talk. But I don’t think they do” (Brent).

Brent’s comments reflect a desire for connected, coherent care within the health care system, particularly in the area of communication between providers. That patients are cognizant of breakdowns or limitations of current provider-to-provider communication practices has implications for newly formed interprofessional teams that regard themselves to be on different “sides” of the team. Communication difficulties and disruptions between providers will be noticed by patients.

Brent also recognizes that the Dr. Welby stereotype may not be considered competent by today’s standards, and perhaps there is a perceived trade-off between competence or professionalism with feeling known by one’s physician. However, helping patients feel known is a competence in itself. Understanding what supports, resources, and strategies patients use to help keep themselves healthy, and how alteration in these supports and resources might influence care-seeking decisions, may be a necessary skill or competency for primary care providers to provide patient-centred team-based care.

Insights gained here into how patients define their own health care team, and how they feel known in the context of a therapeutic relationship can guide an examination of understanding what actually happens in primary care, and how patients and providers negotiate care with one another in the context of an interprofessional team. Remaining attuned to the value of understanding a patient’s social history and recognizing the person, not just the patient, can help to identify practices of knowing or connection in a therapeutic relationship.
Providing Primary Care

This section will explore key dimensions of knowing in patient-provider relationships observed during encounters at the family practice office shared by the primary care provider participants of this study. Due to the risk of confusion using the word “practice” or “practices”, in this section, the term “office” will refer to the location where family practice takes place, and “practice” or “practices” will be used when referring to the recurrent actions or language of providers in a hermeneutic sense. This exploration of practices through conversation and observation with participants serves to call attention to aspects of the structures and processes that foster connection, the deftness of skill required through application of clinical judgment, and the benefits that practices of connection can contribute to sustaining effective therapeutic relationships.

Connecting environment

Patients form impressions about primary care providers based on more than their direct experience with the primary care provider. The office environment, interactions with the medical office assistant (MOA), and office processes such as whether there is a long wait in the waiting room can also influence whether a patient feels welcome, or a “good fit” with the primary care provider. These components of patient experience merit further description and examination, because they are frequently overlooked.

The office is a clean, calm environment with a bright waiting area, a table with books and toys for children, and a central workstation for the MOAs. Satellite radio plays quietly in the background; there is art on the walls, the flooring is unmarked and smooth. Consultation rooms and offices are out of sight, extending down two well-lit hallways.
Each of the physicians maintains his or her own panel or roster of patients, while the nurse practitioner sees patients from the entire panel of the different physicians. Each physician works with his or her own MOA, and the MOAs are the first to connect with patients. When a patient approaches the desk or the phone rings, they step away from their other significant work of managing data such as chart transfers or data entry or generating recall lists. The MOA picks up the phone:

Hi, Roger! How’s your summer? Doing lots of bike riding? … That’s good, nice to hear that. So Monday if you want to come in … Okay. You know what I’d do with that? Take it to the Access Centre. (MOA)

During this phone call, which lasted less than a minute, the MOA is friendly and knows exactly who the patient is. She takes the time to exchange pleasantries, and asks him about a hobby she knows he enjoys. She books his appointment and when he has a question about his driver’s medical papers, she identifies the agency he should contact.

Conversations such as this between the MOAs and patients occur dozens of times each day, both in person and on the phone. Whether patients need an appointment, lose a form, or have a question about a prescription or results, the MOAs are smiling, patient, and resourceful. As the MOAs escort patients to consultation rooms for their appointments they are welcoming and offer reassurances, “It shouldn’t be too long.” This is not a false reassurance. Patients do not spend time languishing in the waiting room, but are seen close to their scheduled appointment time.

Henry (MD) says the average wait time for patients between arriving and being seen is about 12 minutes. This can be calculated using the electronic medical record (EMR). He attributes this to how well the MOAs know the patients.

I really think part of it is (the MOA) knowing the patients so well. She’s the one who’s booking them, and obviously it’s [also] me knowing the patients well. But I
notice a difference if anybody else is booking. [For example,] that person who’s only supposed to be coming in for 10 minutes because they’ve just got one thing, she knows the last four times it took 30 minutes and I just can’t get them out the door. So she won’t ask me ‘do you want me to make it 30 minutes,’ she’ll just make sure they have more time. (Henry)

Through a long period of working with Henry and knowing the patients, the MOA can quickly make decisions about booking patients. Rather than giving every patient the same block of time, the MOA synthesizes the information she has about the patient and determines the length of time they may need. This helps the office run on time, Henry can see more patients, and patients get enough time. The MOA and physician know one another so well that these practices can occur without discussion. Other providers in the office also have established structures that facilitate appropriate booking of patients that rely on knowledge of patients.

Isaac (MD) reserves six 30-minute appointments per week for complex patients who may require, for example, chronic non-cancer pain management. His MOA also knows Isaac’s expectations. For example, she will check to ensure all relevant investigations are available for review before calling the patient to return for follow-up. If a result is not available and the patient has an appointment, the MOA will call to re-book the patient rather than allowing them to attend the appointment only to be told they will have to re-book once the result is available. This also demonstrates respect for the patient’s time and signals to the patient that the provider is paying attention to what is happening with her care.

Jack (MD) has a relatively new MOA, who does not know the patients as Jack does. To counter this, Jack has a brief meeting with her each morning. Through these meetings, Jack orients her to the same expectations that the other MOAs take for granted through knowing the physician they work with.

“I tend to spend time with my MOA discussing the daybook, why people are coming in. How urgent is it? And sometimes, if patients will be coming in for lab
values or imaging results and it’s not available I’ll say to her why waste their time or my time, see if you can track it down. If you can’t, reschedule that appointment. And if you do have it, I want to review it before I see the patient. I’ll give you a classic example of today how that worked, I had a patient that I saw last week with abdominal pain and some bleeding vaginally so I sent her for an ultrasound and the ultrasound came back this morning. By the time I contacted the patient with the results of the ultrasound, I’d already spoken with a consultant and had an appointment set up for her to see them today.” (Jack)

These brief meetings between Jack and the MOA helps ensure the day unfolds smoothly for providers and patients. A telephone call to a patient with abnormal ultrasound results saves time, and with a plan already in place for follow up, the patient is also saved the anxiety of wondering what will happen next. These actions that providers perform recurrently “behind the scenes” culminate in patients experiencing care that is timely and attends to their needs.

For most patients attending this office, there is no frustration of having to talk with a harried MOA, no irritation of long waits before being seen, no anxiety about showing up for results that have not yet been processed, and no annoyance at having to repeat the entire process in another week once the results arrive. Such issues can be common in some primary care offices. Avoidance of all of these factors is accomplished through intentional, established structures of the office and, to a large degree, is taken for granted in the day-to-day work.

This is not to say that the office is a utopia or without snags. Printer problems, minor communication mix-ups, and other technology issues do surface. However, the structures of this office, from the calm atmosphere to the pleasant reception, to the timely visit that is conducted in an organized manner, all contribute to a facilitative environment where practices of connection can take place. Primary care providers can help “set the stage” for practices of connection through implementing structures and processes that
affirm that patients have lives outside the health care system, that their time is valuable, and that the patient experience should be smooth and coherent when attending the office.

**Attending patients**

In the office, each provider “runs” two consultation rooms at a time to conduct patient-provider encounters. Most of the rooms are almost identical, with a sink, counter, cupboards, chairs, and examination bed with a bar of assessment equipment hung on the wall above. Patients are roomed by the MOAs, who check vital signs and ensure necessary supplies or forms or equipment are present before the visit with the provider.

With each of the five providers in the office, I observed between four and six patient encounters. Through the process of obtaining consent with the patient when the MOA called the patient from the waiting room, I was able to observe the provider from the moment they entered the room with the patient. As the provider came into the room, patients might relax, or brighten, or sit up straighter when the handle of the door to the room turned. Some patients took photos out to show a provider, or offered garden produce to give away. The demeanor of patients as they waited for providers ranged from comfortable and relaxed to anticipatory and alert.

In making a decision to seek primary care, patients have experienced a disruption in their equilibrium so that they are no longer able to take health for granted (Gadamer, 1996). For some patients, such a disruption may be ongoing; they may seldom feel well. When individuals experience an alteration in their health status, they will draw on supports and resources as described in the previous section. In everyday life, routine and ritual are coping mechanisms (Giddens, 1991). If these actions of drawing on usual supports or strategies do not satisfactorily resolve health, primary care may be sought.
Primary care encounters thus disrupt everyday routines in life, and to some degree, are a source of anxiety. As such, the primary care provider is prompted to recognize that illness embodied in a patient is “not just a biomedical state of affairs, and not just a social state of affairs, [but] also a psychological-moral state of affairs” (Gadamer, 1996, p. 20). The task of the primary care provider is to engage in therapeutic dialogue, which is “a form of attentiveness, namely the ability to sense the demands of an individual person at a particular moment and to respond to those demands in an appropriate manner” (Gadamer, p. 138). In the following exemplar, Isaac engages in therapeutic dialogue with one of his patients.

Isaac is seeing a patient well known to him, and her concern today is “sleep”. He begins the visit by asking about her family. The nature of the conversation indicates she has a stressful relationship with one of her children, but she is feeling better now that he is no longer living with her. The patient remarks she has “time for me now”. Isaac picks up on this thread. He asks about her goals, and presses with gentle questioning for specifics. “What do you want to accomplish?” he asks. She is a patient with chronic non-cancer pain. She reflects, “I might live another year. I don’t want a [joint] replacement for this old body though, it’s not worth the government’s money!” Isaac responds genuinely, “I think you have lots of value”. As they talk it becomes apparent the patient is actually afraid to have surgery, and is likely a poor candidate for general anesthesia. Isaac offers and discusses many options. His language is encouraging and inclusive, saying, “Let’s have a conversation”, or “let’s keep that on the table”, or “let’s talk more about that.”

After a few minutes, Isaac raises the topic of sleep. The patient squares up in her seat to say, “I’ll tell you how I’m getting to sleep but you’re not gonna like it”. Isaac’s face remains open and he allows her time to tell him she’s been having a few drinks in the evening to help her fall asleep. He proceeds to screen her for problematic alcohol use by using the familiar CAGE tool. However, he asks the questions naturally and conversationally, by changing the wording just a tiny bit to match her context and circumstances. Isaac talks with the patient about addressing her pain in order to improve her sleep. He asks her to return for a longer visit next time and completes a requisition for an x-ray to investigate her joint pain. The visit appears to be drawing to a close when the patient asks, “Are you going to help me out with the Ativan or not?” Isaac says, “Ahhhh”, because she was not explicit in asking for medication for sleep. He reiterates some of his message about adequately treating pain to improve her sleep. The patient informs him, “Well it’s Ativan or booze”.

Isaac and the patient negotiate the management plan. The patient will receive a
short-term prescription for lorazepam (Ativan) but must return next week for follow up. By then the x-ray result will be back so that an approach to pain management can be decided upon, and the Ativan prescription will not be renewed. (Field Notes)

Isaac’s encounter with this patient reveal many practices of connection established through therapeutic dialogue. He begins the visit with a conversational tone, and is not problem-focused. He does not start out asking what sort of problems she is having with her sleep. Instead, he allows her to direct the conversation, but he focuses the discussion in a goal-directed manner by asking what she wants to accomplish now that she has some time for herself. When the patient expresses low self-worth, Isaac explicitly addresses it to disagree with her. He does not gloss over the statement or ignore it, and he doesn’t dismiss her concerns about surgery, which reveal her fear as the root of the issue.

When Isaac does re-direct the patient to the reason for her visit, it is not abrupt, nor is he dismissive of the other issues the patient has raised. When the patient tells Isaac how she has been falling asleep, his verbal cues match his facial expression in staying open and interested in the patient. His screening for alcohol use uses language that relates to the patient’s specific circumstances. Finally, as the plan is made, there is clear discussion about expectations and follow up.

After the visit, Isaac tells me some of the details of the patient’s significant psychiatric and trauma history. He knows her very well and it is evident that she feels safe with him. She provides him with all the information necessary to make decisions about her care, she is invited to participate in her plan of care, and the conversation is non-punitive, focusing on solutions and goals that meet the patient’s needs.

This exemplar illustrates many attributes of excellent primary care including a longitudinal relationship, patient-centredness, and comprehensiveness. This 10 to 15
minute visit covered topics of sleep, medication, alcohol use, pain, and family dynamics for a medically and socially complex patient. Isaac allowed the patient to shift the visit topics according to her priorities, and he describes this to me as choosing when to tweak or push patients to help them “drive” their own care. Gadamer (1996) explained this as knowing how to distinguish, and that this is the true art and meaning of diagnosis. The practices in this encounter show how skill in practices of connection, and knowledge of social history can foster therapeutic dialogue. This allows for effective care of complex patients with significant co-morbidities to take place in a routine primary care visit.

**Knowing patients**

Henry (MD) has been in this office the longest, and he has known many of his patients for more than ten years. When Henry enters the room to see a patient, it is obvious there is a long-standing relationship. The patient sits relaxed in her chair, her purse on the floor at her side. Henry smiles warmly and sits nearby while he asks what is new in her life. As they exchange brief pleasantries, Henry is able to hear an update about her home life, her family, and her activities.

It is this type of exchange that patient participants identify as a “personable” quality in their provider. The conversation takes place in a manner that would be expected of anyone who knows you well and is politely asking after your family and life. For Henry, however, this information provides additional insight, because this patient has a number of health issues: She has longstanding depression, insomnia, polymyalgia, gastroesophageal reflux disease, and frequent fungal skin infections. She is here today to discuss trying a special diet and also medication for sleep.
Henry’s initial conversation helps him re-affirm a trusting relationship. It also helps him to contextualize the patient’s health status into the wider lens of her life. He can now discuss her eating habits, diet, and sleep knowing about recent stressors in her family life, who is acting as a key informal support for her, and strategies she has been trying to keep herself well and to get enough rest. Through this initial, seemingly informal conversation, Henry has gained understanding of how the patient initially involved members of her “team” outside the formal health system, what supports and resources are currently available to her, and what the issue is that tipped the balance towards her decision of seeking primary care.

Through discussion, Henry uses recognizable motivational interviewing strategies to ask what the benefits might be if she were able to do more of the activities she enjoys compared to any risks she might identify to taking medication for sleep. In this way, Henry demonstrates understanding of the patient’s interests, another component that patients in this study identified as contributing to feeling known. He helps the patient further understand linkages between depression, sleep, and chronic pain. She changes her mind about wanting medication for sleep and is agreeable to try some of Henry’s suggestions about eating and activity, and also a trial increase in her antidepressant medication. In this approach, Henry treats the patient as a partner in her care by helping her to choose among possibilities for safe and effective treatment.

Henry knows this patient in a way that extends beyond her physical health issues, so he can help her challenge the narrative she presented of “only medication will help me get a good sleep” (Patient), and assist her to make different decisions about her plan of care that incorporate her current habits, values, and lifestyle without adding to her
medication burden. His recommendations “fit” into her life and do not disrupt her identity. This is accomplished within a 10 to 15-minute appointment, and Henry makes sure the patient knows when to return for follow up.

Following this encounter, Henry tells me some background information about the patient, what medications the patient had tried previously, her relationship with her spouse, what her previous employment was, and her state of health now compared to a couple of years ago. Almost all of the providers discussed cases with me in this way after visits concluded, and these updates serve to fill in gaps in the history not apprehended during a visit because all of this information remains tacit during the encounter. The primary care providers investigate symptoms and make recommendations based on *already knowing* the patient, and this tacit knowledge is accumulated through maintaining a longitudinal therapeutic relationship with the patient. What is unknown, however, is how this information is conveyed to other team members when necessary, especially those who are not co-located and so do not have the opportunity as I did for a quick post-encounter update in the office.

**Getting to know**

The two encounters described above were interactions where patient and provider knew one another well, over a period of years. Kate (MD), in contrast, is a novice primary care provider who joined the office during the period of data collection. With Kate I observed encounters to understand how or whether getting to know patients as a new provider showed up as different practices, and how therapeutic dialogue might be achieved when a patient is not known well by a primary care provider.
To begin, I was able to observe Kate as she was taking new patients for her own panel. This process involved a “meet and greet” visit so that she could collect health information about patients and arrange for chart transfers from patient’s previous providers. During each of these visits I observed, Kate offered information about what types of service she planned to offer, such as seeing patients if they are admitted to hospital, or delivering babies, and how she handles common requests such as telephoning a prescription renewal to the pharmacy. This recurrent offering of information to new patients by Kate during each “meet and greet” is a practice of connection because it clarifies expectations for the foundation of the therapeutic relationship.

After taking some health history from patients, arranging for charts to be transferred, and discussing services available by having Kate as a family physician, Kate tells her new patients where she grew up and attended school, a bit about her family, and her plan for staying in the community. The patient reaction to this disclosure of personal narrative from Kate is chiefly interest and accommodation. It is also one of the components identified earlier by patients as contributing to feeling known by providers. Patients leave these appointments with some understanding of what roles Kate assumes as their primary care provider, and there is reassurance that patients can get to know her better, because she communicates that she is not planning to leave the community within the next several years.

The practices of connection enacted through the “meet and greet” visits with Kate help to begin to establish the foundation for a therapeutic relationship between patient and provider. Patients also get to tell Kate about themselves; if they have any pressing or chronic health conditions, what their home and work environments are like, and about
their family. In this way, Kate is able to acknowledge the personhood of her patients, to understand who they are when they are not patients. Kate then documents this information, because this is new knowledge, and not a tacit accumulation of knowledge, which the more experienced primary care providers are able to rely on with patients they know well. Writing down the social history of patients, including their interests, activities, supports and resources for health, she has prompts for future visits to continue to develop therapeutic relationships with her patients. For example, when the man with the hip pain returns, she can check to see that he works twelve hour shifts on his feet. This helps her to contextualize and understand his meaning of the symptoms, as opposed to giving bland reassurances about hip pain being common for people with osteoarthritis in their late 50s.

There are other instances whereby providers who do not know patients well might shape their language and practices to promote connection, and facilitate therapeutic dialogue. As mentioned by patients, and illustrated by Henry in the earlier example, experienced providers frequently use a conversational interview style. These providers are not put off by patient forays into tangents about their personal lives, but rather probe further, and ask questions to link patient experiences to how health or their presenting concern for that visit is influenced by these experiences. These practices are indicative of genuine understanding. Genuine understanding occurs when attention is focused not on outward facts or actions indicating a lived experience, but rather what lies behind them (Wagner, 1970).

Kate, as a novice provider, did not have the same level of conversational tone with her patients compared to more experienced providers who knew their patients well.
Kate spent much more time explaining her rationale and findings to her new patients, and her interview style was slightly more rigid in that the textbook format of eliciting history is still discernible. In one patient encounter I observed with Kate, the male patient had left lower quadrant abdominal / groin pain. Kate spent time reviewing with the patient the differential diagnoses she was considering, that she was planning to order an ultrasound, and why the ultrasound could help to establish the diagnosis.

With these explanations, Kate is performing practices to treat the patient as a partner in his care, which can help patients to feel known. Kate includes the patient by articulating her decision-making and rationale, which allows the patient to understand and agree or disagree with the plan of care. The patient is not expected to unquestioningly follow Kate’s orders for him.

While a novice provider may have to explicate her intent and actions more thoroughly to engage patients and establish a therapeutic relationship, a different provider who knows their patient well can summarize the plan by saying, “Here’s the form for the ultrasound, come back in a couple of weeks.” A provider who knows his patients well can rely on an established therapeutic relationship and past practices of connection to convey a plan that is understood by the patient. Mutual understanding between patient and provider of this tacit information saves time in the encounter, which can also facilitate providers who know their patients well to be able to address multiple issues in an encounter.

Based on Kate’s practices, efforts to treat the patient as a partner in their own care, combined with a personable approach, may be the first steps in establishing a therapeutic relationship. If a provider can satisfactorily resolve the patient’s anxiety about
the health care encounter, in part by discerning the salient aspects of the patients’ narrative, this affects what the patient is willing to disclose, which in turn influences provider judgment and decision-making. When an attentive provider is seeking to understand the meaning of the patient’s situation as well as articulate their own intentions, the resulting therapeutic dialogue can foster plans of care that are fitting for individual patients who feel known by their provider.

**Articulating intentions**

The practices of an attentive provider seeking to make meaning of a patient’s situation through therapeutic dialogue are frequently tacit. This does not diminish the value of such intentions, and when asked, providers who are experienced in these ways of being with patients are able to clearly articulate their intentions. Leah (NP) describes an encounter during a busy day where she is asked to see a 23-month old patient she has not met before between other booked appointments. Leah enters the room without first reviewing the chart because she is running behind. She immediately picks up on some defensiveness from the mother, as well as a disconnect between the level of concern exhibited by the parents and the health status of the child, who was “toddling around, looking quite swell” (Leah). As Leah begins the history, she could not immediately uncover the source of defensiveness and concern she sensed in the room. Eventually, Leah asked the mother if the child had ever been hospitalized. Leah summarizes what the mother said:

> Atypical cystic fibrosis, hello. The bombshell drops, boom. And this well of information came flowing out which made me then understand the anxiety level of the parents. I said, Look I apologize, I don’t know everything about your child, I never met you before. That’s why I’m asking all these questions. And I will check your child over, no problem, but I do need this information first. Wow, she looks really well today. I do apologize for all these questions.” And then they said, “It’s
okay, we’d rather you ask more than less.” So … people have so many experiences with the health care system that their guard is up. (Leah)

This re-telling of a patient encounter speaks to several facets of therapeutic dialogue. First, the experience of the provider is revealed through her knowledge that something was “off” regarding the parent’s concern as soon as she stepped into the room. Leah recognized the anxiety evident in the parents and intentionally sought to uncover the source of that anxiety and discover the parents’ motivation for seeking care for their child. This is evident in her response to the distraught parents. She stopped the interview. She apologized for all the questions. She explained why it was important to ask the questions. She offered reassurance about the appearance of their child. With these intentional practices, she created a space for the parents to feel safe, which allowed the parents to feel more assured their concerns would be addressed in that visit.

As much as language is an important way to convey to patients that they can feel safe and understood, silence is also necessary. Recognizing when silence is called for, and being silent, is a practice that recognizes the personhood of the patient. Leah (NP) describes an encounter with an older woman who made a decision to disclose abuse, and begin to examine how it was affecting her health.

It was actually just sitting down, allowing her, going through the history … then just giving her time to share some of the abuse she’s gone through and just hearing that. And not that I know exactly what to do about that but I can hear it, I can validate her experience and then for this particular person, it was regular meetings for her to get that out. I mean she was looking for help in that she had symptoms, but she needed a safe place to get rid of this burden … I would say for older people or older women, if they look back on their life and there’s been trauma or abuse, there’s continual self-blame and guilt and shame. They may be presenting with anxiety, but if I have the time to work with them it can be very, very powerful. (Leah)
In this situation, Leah was cued that there was something more to the patient’s clinical presentation of anxiety. She intentionally returned to “going through the history” so that factors beyond clinical symptoms could be surfaced. Once Leah makes a conscious decision to explore a sensitive topic with the patient, she gives the patient the time to talk about her abuse. In this way, providers demonstrate an understanding of the moral responsibility that accompanies an intention to create a safe place for patients to be known. Leah understands that her role in maintaining therapeutic relationship includes being prepared to hear and address sensitive topics with patients. In this situation, Leah uses her judgment to seek genuine understanding by allowing the patient to present a previously unheard narrative of her identity. The intention of the provider is not to treat, but an intention to understand, so that healing and resolution of symptoms can begin to be formed.

**Knowing the specifics**

The dialogue between patients and providers who know one another well may not be as explanatory or detailed, as much of the understanding is tacit within the patient-provider dyad. However, practices of connection are still evident in provider language and conversation with patients. For example, patients with multiple co-morbid conditions may experience deteriorating health status when initial interventions no longer keep up with disease progression. The best plan of care becomes increasingly challenging for providers to manage and patients to implement, as medication burden and symptomatology increases. To prevent a patient’s function and quality of life from decreasing when medication is maximized, increased attention to other interventions focusing on behaviour change may be emphasized. This may be an especially important
time to have meaningful knowledge about a patient’s supports, resources, strategies, and personal interests to apply to the patient’s situation in efforts to restore or maintain health. For behaviour change to be effective, generic advice such as “eat less processed foods” may not be useful to the patient.

Providers who are able to plan care incorporating patient values and preferences do so using particular practices of conversation. Jack (MD) consistently employs these practices with patients, one example being to avoid topical questions when it comes to inquiring about a patient’s social history. With a diabetic patient, he does not ask what her diet is like. Instead, he asks about what cooking methods she prefers, which can help to determine if she fries a lot of foods or eats a lot of processed foods. He asks if she eats only when she is hungry, which helps to identify if she has any habits related to unhealthy snacking or overeating that might affect her blood sugars. He asks if she knows about different portion sizes for food groups, and has her demonstrate what a desirable portion size for protein or vegetable might look like. This helps Jack to quantify what she means when she says something like “I eat a lot of vegetables”. Specific questions such as these helps Jack go beyond the “outward facts” (Schutz, 1970) to distinguish what the patient means. Jack can help the patient to identify problem areas, such as snacking after supper, to help her improve her diet. He can also help her to identify ways she might make small changes, that are practical recommendations based on the patient’s own rituals and routines, and that the patient agrees to try. Jack’s plan includes a follow up appointment, so that the patient can return to report on progress and the plan can be modified as needed.
Jack asks for a similar level of detail about exercise for an overweight patient. Instead of asking the patient if he takes any exercise, he asks what types of activity the patient engages in, for how long, at what intensity, and whether he enjoys it. Instead of re-stating the evidence by telling the patient what he should be doing (get at least 150 minutes of moderate physical activity per week), Jack converses with the patient to figure out how his patient can meet the recommendations. With a personable approach, including the patient in decision-making, and knowing the patient’s interests, Jack provides evidence-informed patient-centred care. Based on Jack’s intention to understand the details of the patient’s situation beyond the biomedical detail that the patient is overweight, Jack’s clinical judgment can be applied to determine the best course of action. While in this case the decision is to support the patient to draw on his own resources, in a different situation, or perhaps in the future, it may be determined by Jack and the patient that the goals cannot be met by the patient using only his own resources and strategies. In such cases, when patient needs or goals exceed their existing supports and resources, this is a juncture of deciding whether or not to involve a member of the interprofessional team.

Summary

This chapter began by exploring who patients include on a team that helps them to maintain or restore health. The supports and resources patients identify such as friends, family, employment, pets, and other groups and individuals, exist largely outside the health care system. When patients become unwell, their resources and supports are drawn upon both prior to and in conjunction with seeking primary care via the formal health
system. How many available supports and resources a patient is able to access within their community may influence when or whether the patient seeks care at all.

In order to understand how patients draw on existing supports and resources in the community setting, as well as identify when resources and supports need to be bolstered in order to maintain or restore health, it is necessary for primary care providers to know their patients. Patients take for granted many aspects of how they maintain health in their everyday life. Primary care providers must therefore be intentional to inquire and uncover what sort of supports, resources, or strategies patients have at their disposal or not when planning care to improve the health of a patient. Attention to these aspects of a person’s life outside the biomedical and health system realm can help patients to feel known, and may result in more appropriate plans of care with which patients feel engaged. Further, understanding the supports and resources patients can draw on, or when they require additional support or resources, has implications for involvement of the interprofessional team.

Patients in this study distinguish four qualities enacted in practice by physicians that contribute to patients feeling known. When primary care providers treat patients as partners in their own care, have a personable demeanor during patient encounters, are willing to share some aspects of their own life, such as a hobby, and take genuine interest in the patient’s life beyond the patient’s health conditions, patients feel known. Patients do not always experience practices that embody these qualities, and one reason for this may be related to the prevalence of co-morbidity in patients.

Medical management of patients with multiple co-morbidities can be time consuming. Treating patients with multiple co-morbidities requires diligence in tending to
the many aspects of care for which evidence prompts primary care providers to adhere to in order to facilitate optimal patient outcomes. It may be possible to provide high quality medical care without knowing patients well, but some patients may not view this trade-off only as a benefit. Knowing patients in the context of their health and illness requires clinical judgment in distinguishing which aspects require tending to within patient encounters. This is a competency that facilitates care being experienced not just as high quality, but also as coherent, from the perspective of patients.

The second half of this chapter turned to uncover the practices of primary care providers that embody the qualities and ways of knowing that patients identify as helping them to maintain or restore health, and feel known by a health care provider. These practices of connection begin in the waiting room and with interactions with MOAs. Attention to structural aspects of providing care, such as appointment bookings, are intentional in this office, yet embedded in the everyday running of the office and help to set the stage for a therapeutic encounter between patients and primary care providers.

Patients seeking primary care do so when their usual routine and rituals of drawing on their personal resources, supports, and strategies no longer suffice to maintain or restore health. Patient-provider encounters in primary care are a disruption to the routine of the everyday lives of patients, and to some extent can be a source of anxiety. In part, therapeutic dialogue between the patient and the primary care provider helps to alleviate anxiety and facilitate practices of connection between the provider and the patient. Practices of connection using therapeutic dialogue facilitate the ability of a primary care provider to know patients well, and this can impact the coherence and comprehensiveness of care. In this study, primary care providers were observed to deliver
high quality patient-centred care to complex patients with significant co-morbidities within a primary care encounter in a fee-for-service setting.

Experienced primary care providers in this study helped patients to prioritize their health care needs and assist them to make linkages between their symptoms and health issues. Patient concerns were addressed and not glossed over or ignored. Patients participated in selecting safe and effective treatments, and plans of care incorporated knowledge of patient preferences and habits. These practices reflect how primary care providers draw on their clinical judgment to increase understanding of patients and their health issues beyond the limits of their biomedical symptoms.

The novice primary care provider in this study demonstrated practices of connection with patients she did not yet know well. This included offering patients some information about herself, such as where she grew up and her plans for staying in the community. Compared to providers who know their patients well, Kate spent more time clarifying expectations and articulating her judgment or rationale about next steps for the patient’s care. While being explicit about decision-making takes more time in an encounter, it can facilitate mutual understanding and help patients to participate more fully in their care. These practices may be key first steps in getting to know patients in a meaningful way.

Other practices of connection observed during patient-provider encounters include recognizing when an encounter is not going well. Stopping an interview and apologizing for a misunderstanding can help to prevent any further disruption to the patient-provider relationship and restore the possibility for patients to feel known. Allowing space, and even silence, for patients to voice concerns, and then acknowledging rather than
deflecting disclosure of sensitive issues is a practice of connection. Finally, providers who ask particular, specific questions about patient practices, habits, and preferences will better understand their patients in the context of their everyday lives outside the formal health system.

Primary care providers in this study offer a personable, patient-centred approach whereby the patient’s personhood is acknowledged, and the primary care provider understands details of the social history of the patient, such as what the patient’s interests and supports are. Through this approach, genuine understanding of the patient’s situation can be apprehended. The primary care provider may assist the patient with treatment or interventions to augment, mobilize, or increase the patient’s existing supports and resources that the patient identifies as helping them to restore or maintain health. These actions may assist the patient to return if not to equilibrium, at least to be better equipped to return to the social world in which one lives and works (Gadamer, 1996). Rather than focusing narrowly on the biomedical aspects and the paradigms of efficiency and evidence-based practice that can dominate primary care delivery, primary care providers in this study apply judgment to the particular case of the patient (Gadamer), resulting in care that goes beyond the terms of high quality or continuous; it is also coherent. Patients who are known by their primary care providers may be more likely to receive primary care that is coherent to them, and thus it may be easier to follow individualized plans of care to achieve improvements in health outcomes.

Within some patient-provider encounters, the primary care provider can distinguish that interventions, education, or advice offered by the primary care provider in combination with the patient’s resources, will be inadequate to restore health. This is
when the patient-provider dyad may be expanded to foster the patient’s access to team-based care. The next chapter explores how the application of judgment by primary care providers and interprofessional team members to the circumstances of patients can prompt initial and extended involvement of an interprofessional primary care team.
Chapter Six: Involving Team

Patients become formally connected to the interprofessional team beyond the patient-provider dyad through a standardized process. Not all patients in a primary care provider’s office will be involved at any given time with the interprofessional team. There is a gap in understanding and articulation about how, when, and for whom the interprofessional team becomes involved in providing longitudinal primary care for particular patients.

This chapter examines the process of involving the interprofessional team to help identify how primary care providers make decisions to expand the patient’s primary care team. Attention is given to how interprofessional team members become involved in patient care based on the information they receive from primary care providers about patients they may not know well, or at all. In this way, distinguishing some of the judgment required in deciding who needs a team can be uncovered.

Requesting Service

The current process to initially involve an interprofessional team member outside the primary care provider office is via completion of a unidirectional form called a Service Request. The Service Request is completed at the primary care provider office and then faxed to the interprofessional team office. Patients cannot currently self-refer to the interprofessional team. In the past patients could access Northern Health’s mental health or public health services without first seeing their primary care provider. This may change in the future but at present the primary care provider holds the decision-making power about who needs a team.
On the interprofessional team “side”, one person who sees every single Service Request is Ursula, the primary care assistant. Mid-way through data collection, I asked her if she was starting to see more consistency with the information provided on the Service Request forms being faxed from primary care provider offices from around the community. She raised her eyebrows as she showed me the Service Requests received that morning. “It’s a dog’s breakfast,” she informed me.

Some Service Requests have a full care plan attached including information about the patient’s health conditions, medications, goals related to health, and preferences for care. Others have the primary care provider’s documentation from that day’s visit attached, which might indicate, for example, that the patient has anxiety, and the request for service is about counselling for anxiety. Other Service Requests are one-liners, with “falls” (Mel, OT) as the only information provided.

All Service Requests are collected each weekday morning from the fax machine, so they may be reviewed during rounds, which take place at 0830. Rounds are conducted in a cramped meeting room and are attended by the interprofessional team, the primary care assistant, and a care process coach. On a whiteboard is written the format to be followed for rounds: Messages, Hospital Alerts, Review Last Day’s Appointments, Coordinate Today’s Appointments, and Other/Updates. Each topic is supposed to be reviewed in order every morning.

The primary care assistant hands out the messages, reviews the information downloaded regarding patients in hospital or recently discharged, and introduces the new Service Requests. These activities generate intense and disjointed conversation around the table. The conversation revolves around “who is that patient”. As the primary care
assistant shares information, team members examine the details and discuss who might know the patient. This becomes necessary when the interprofessional team receives only scant, often biomedically focused information on the Service Request. Based on the information provided on the Service Request, interprofessional team members have to triage Requests to make decisions about when to see patients, how long the appointment should be, and who is the most appropriate team member to see the patient. Compared to primary care providers, IPT members do not have the benefit of a MOA who knows the patient, nor fulsome documentation on a patient chart, nor easy access to the provider who knows the patient. Attempting to reconcile the lack of context with the information on the Service Request, comments such as, “He’s the one I went to the urologist appointment with”, “is that the lady whose daughters …”, or “I think he’s about to be evicted”, fill the room as team members try to situate the patient into the social realm so that the meaning and scope of the Service Request is better understood.

Odette (MH) gives an update of a patient’s status and sees blank looks from some team members trying to place who the patient is. Odette adds some of the social history from her own experience with the patient, saying that the patient’s daughter lives with a man who is using cocaine and is frequently violent, and the patient is very worried about the young child in the house. The daughter often calls the patient asking for help. Ruby’s eyes light with recognition, saying she remembers now, this was the patient who had just been to the emergency room for treatment of an anxiety attack. There is small flurry of activity as someone enters the patient information to retrieve the electronic report from the Emergency Room, so that more information might be learned about the patient and her current circumstances. (Field Notes)

The interprofessional team members use patient rounds to review Service Requests and update others about patients recently seen. Rather than focusing on the biomedical aspects of patients’ history, the discussion centers on social history. To cue team members to recall who her patient is, Odette (MH) offers reminders about the
patient’s relationships and stressors. This information is then pieced with the anxiety-related emergency room visit that until then Ruby (Case Manager) had considered as disparate information, and of which Odette was unaware. These pieces of information are then put together to form a more complete picture of the patient, who is not just someone with anxiety, but with particular issues impacting her anxiety that can be addressed with assistance from the interprofessional team.

In a disconnected manner, interprofessional team members use their clinical judgment to discern what might be salient details about the patient that foster improved understanding of the patients supports and resources that are exceeded, as well as the stressors that exacerbated the condition beyond what can be suitably or effectively addressed between only the patient and primary care provider. The interprofessional team members are seeking the same information that experienced primary care providers use to deliver high quality primary care. Yet in this example, the social history of the patient was not provided, and the interprofessional team had to piece together a more fulsome history beyond the clinical manifestations of the diagnosis provided on the Service Request. There appears to be a gap between the primary care provider deciding to involve the interprofessional team, and providing relevant information on the Service Request that might facilitate or increase meaningful understanding of the patient’s situation. To better understand this gap, as well as other aspects of team-based care that are not articulated clearly, it is worthwhile to examine from the interprofessional team members’ perspective the particular circumstances that prompt primary care providers to involve the interprofessional team.
At the time that data collection for this study ceased, interprofessional team members had been accepting Service Requests for eight to ten months; a large volume of Service Requests arrived to the interprofessional team office each day. The process of reviewing and assigning interprofessional team members to address patient needs identified in the Service Requests stretched the capacity of the interprofessional teams. Based on the volume of Service Requests I observed the interprofessional team review each morning, three distinct situations can be identified for which primary care providers requested interprofessional team involvement in patient care.

“Straightforward” service requests

“Straightforward” Service Requests are characterized by the request for a single, specific service. These requests are for services a primary care provider would not routinely perform, such as installing a raised toilet seat, or arranging Lifeline (a medical alert system triggered by patients in their home in case of falls or medical emergency). Alternately, the “Straightforward” request may ask a specific team member for a service the primary care provider could perform, but is anticipated to be time consuming, or an interprofessional team member has more expertise about the issue than the primary care provider. An example is a request addressed to the interprofessional team social worker to assist a patient to complete forms for subsidized housing. The term “straightforward” refers to the primary care provider’s perspective of the request.

When the interprofessional team receives and reviews a “Straightforward” Service Request, the information on the form is usually short and fairly directive. It is anticipated that an interprofessional team member will easily dispatch the service, and the patient is unlikely to require very much follow up. However, this is not always the experience of
the interprofessional team members. Sometimes, additional history would greatly assist
the interprofessional team member to provide meaningful care for the patient.

I attended a home visit with Mel (OT), to see her first patient of the day. The
Service Request was to “install Lifeline”. The first step of this process is to give the
patient information and a number to call to set up the service. Mel’s experience in visiting
this patient’s home helps to articulate why the seemingly “Straightforward” Service
Request can show up as complex and time-consuming in the world of practice, and how
missing information about the patient can significantly impact the therapeutic relationship
between a patient and interprofessional team member.

I wait for Mel (OT) to complete forms for Replay before leaving for a home visit. She packs her bag for the morning, as we will see two patients before returning to
the office. Mel’s work phone is dead because she has to keep it locked up over the
weekend and there is no way to charge the phone and also store it in a locked drawer
as per Northern Health policy. She programs the patient address into her personal
phone, and we walk to the car. It is snowing sideways and the parking lot is a sea
of slushy puddles. We drive and then park on the street and walk to a small rectangular apartment
block and press the buzzer to the patient’s apartment. The buzzer sticks and Mel
says this is a very common occurrence in winter in northern BC. On the seventh try
we hear it connect to an apartment above us. The patient comes down three flights of stairs to let us in. As we arrive back to the
top floor, she is out of breath, struggles with her front door lock and curses in
frustration. At last we are in the small, cluttered apartment and remove our boots.
The patient thinks we are both nurses, and pays no attention as Mel corrects her.

Mel is visiting this patient to offer Lifeline. The Service Request from the primary
care provider included the information that the patient had fallen recently at home
and was stuck between her furniture for four hours. Mel pokes her head into the
bathroom and asks the patient how she manages getting in and out of the tub. The
patient is not interested in a non-slip mat or a bath seat; she tells us she loves a soak
in the tub, even though it can take more than 30 minutes to get out once she’s in.
We move to the living room, and the seating choices are limited. The patient
indicates that Mel and I should be seated together. The patient sits perpendicular to
us in a recliner. We now have our backs to the door, and the route out of the
apartment is around the recliner where the patient is seated, past an over-sized oak
hutch filled with china, and then past the bathroom to the entryway.
Mmel begins to explain Lifeline. She offers a pamphlet to the patient and writes down
the name of the person who will help the patient install the service. The patient is
curious about cost. As Mel explains there is a small cost that is often waived or subsidized, the demeanor of the patient deteriorates. At the outset of the visit, the patient came across as mildly eccentric, with an unkempt appearance. However, her behaviour quickly escalates without apparent trigger except for the mention of money, and she exhibits anger and paranoia. She raises her voice in a tangential monologue and stands over us, angry and unresponsive to Mel’s attempts at re-direction.

By this time, Mel had managed only to hand out a pamphlet and provide one other number for the fire department to come for an emergency lift assist in case of fall. One teaching point is conveyed: Mel asked that the patient carry her cordless phone with her, so that if she falls she can call the fire department number that can be pre-programmed into the phone.

Mel has a Northern Health intake form with several different sections and numerous tick-boxes. For some time, I watch Mel’s pen hover uncertainly over the form as the patient rants above us. Finally, I see the pen droop and join the form in her lap. This task for the visit won’t get completed today.

After some time, the patient pauses, and Mel takes the initiative. She calmly thanks the patient and says we have to be going to see our next patient. There is now space to stand without being directly in the patient’s physical space.

The patient’s voice is calmer now, and she appears nonplussed about our intent to leave. Mel leaves the Lifeline pamphlet on a table but does not mention the service again. As we put our boots on while trying to back-pedal out the door the patient peers at Mel’s nametag. She mispronounces Mel’s name and asks if she got it right. Mel smiles brightly, says, “You can call me whatever you want,” and we close the door, walk quickly to the stairs and nearly run for the car.

In the car, we glance back to the door, half expecting to see the patient. Mel lets the car run and warm up for a minute or two – it is still snowing heavily, and we collect ourselves. Mel turns to me, dread on her face. “Oh no,” she says, “Where are my glasses because they are not on my face.” We stare at each other. She hops out to check her bag in the trunk and finds them. Relieved, we pull away from the curb, off to the next visit. (Field Notes)

Mel’s visit to this patient’s house to complete a Service Request appeared streamlined in intent, yet it took almost two hours to drop off a pamphlet and leave a phone number. By taking a closer look at what transpired, some of the everyday invisibility of the work of the interprofessional team can be made visible. The activities the interprofessional team members must complete in addition to providing direct patient care draws time, attention, and focus of interprofessional team members away from
increasing opportunities to develop more fulsome relationships with patients and primary care providers.

The first events that take up time are administrative and occur while Mel is still in the office. First, she completes forms for Replay, a remote safety system logging the interprofessional team member’s whereabouts that also prompts team members to contact the patient to tell them they must lock away pets, that there is no smoking, and ask about violence in the home. The arbitrariness of this system and risk to damaging rapport with patients before meeting them means not all interprofessional team members use this system in the same way. Primary care providers do not use it at all; its original use was for home care nurses.

Next, Mel must consider the places she has to visit before she returns to the office. She packs her bag with notes and resources, making a trip or two to the printer. She enters the patient’s address into her personal phone so she can receive directions while driving.

Mel exchanges her office footwear for winter boots and gets into the rest of her winter gear. Coping with weather variations is another factor interprofessional team members address regularly. Scraping windows, warming up the car, and maneuvering down streets that have not been cleared of snow are common winter tasks. Once arriving at the patient’s home, there is waiting for the patient to traverse three flights of stairs down and then back up to her apartment and some shuffling about to remove footwear and exchange greetings.

It is only at this point that the encounter between Mel (OT) and the patient actually begins. Although the Service Request was to assist with Lifeline, Mel knows the
patient fell and was trapped on the floor of her home. In her OT role, Mel begins to assess the patient’s home for fall risks, such as her bathroom. This may be a function unanticipated by the primary care provider making the Service Request. If the social worker had attended the patient’s home for this task, a slightly different assessment may have been completed, perhaps with a focus on finances or social isolation. This is important to highlight: Although the primary care provider is the gatekeeper regarding involvement of the interprofessional team, once the Service Request is received the interprofessional team members decide who is best suited to visit the patient. This is in part based on the information provided on the Service Request.

Mel did not have access to adequate information about the patient in order to prepare for her visit. This patient suffered severe effects of abuse and childhood trauma, appeared to have low literacy and financial insecurity. No mention of this history, or anything regarding risk of angry outbursts or psychiatric diagnosis was made on the Service Request.

Because of the unidirectional nature of the Service Request, the interprofessional team members cannot know how much information gathered during a home visit is known to the primary care provider, or whether the patient is well known to the primary care provider. Given the impact mental illness, low literacy, and insecure finances can have on a patient’s health, particularly for someone living alone, it is possible further interprofessional team involvement would be helpful for this patient. Yet the interprofessional team is not necessarily privy to the overall plan of care from the perspective of the primary care provider, or whether the patient may be accessing other supports or services.
Uncertainty based on lack of information can leave interprofessional team members in a quandary. Team members must decide whether to adhere to the straightforward request, install Lifeline, and move on; write a note to the primary care provider outlining their assessments resulting from the visit; or ask other interprofessional team members to visit the patient. The amount of information shared between primary care providers and the interprofessional team can impede team-based care even for “straightforward” requests.

A few weeks following the home visit with Mel, I happened to encounter the primary care provider who made the Service Request for the patient Mel and I visited. The primary care provider raised the subject of the visit with me, telling me she had heard about Mel’s experience was glad I’d attended the visit with Mel for safety reasons. I asked the primary care provider if she was aware of the patient’s angry outbursts. The primary care provider said, “Oh, yes. When she yells like that in here [a colleague] sort of stands by…”. I ask if she has been to the apartment. “No, but I should go. On the Service Request I said if Mel wanted me to go along I’d be happy to.”

The primary care provider was aware the patient could have an angry outburst at the time of writing the Service Request, but instead of including sensitive information about the patient on the Service Request, she offered to attend the visit. Over time, Mel and other interprofessional team members later learned to recognize this as a type of “code”; if a primary care provider offered to jointly visit a patient, interprofessional team members recognized it was “… that hidden [message], you should give me a call before you go see this person” (Mel).
The incongruity between information known by the primary care provider compared to information shared on the Service Request reveals there are degrees of disclosure health care professionals may be comfortable sharing with team members in writing. There are a number of factors to be considered in how primary care providers make decisions when determining what information to provide on the Service Request for the interprofessional team. The primary care provider may assume that for a “straightforward” request, most patient history will not be necessary or appropriate to fulfill the request. Primary care providers who are privy to sensitive family dynamics or social history learned over the time in a therapeutic relationship may feel hesitant about writing it on a form that is faxed to an office where it may be seen by several individuals who may not be involved directly in the patient’s care.

Alternately, the primary care provider may know the patient so well that certain aspects of the patient’s history are tacit, and not recorded in the chart. There may be a misconception of the roles of interprofessional team members, for example that a psychiatric diagnosis would not be useful knowledge to an occupational therapist. Primary care providers will also have pre-conceived and evolving ideas about what “team” means and whether interprofessional team members should be privy to all patient information. It can be difficult to convey tone or intent in writing, and there is risk of misinterpretation.

A lack of information on the Service Request might also simply reflect a busy day for the primary care provider. Information may be omitted as a time-saving strategy. Lastly, a technological issue may be the cause of missing information. Sometimes attachments may be missed or not all pages are transmitted.
These postulations of rationale for missing information illustrate how, without face-to-face dialogue between primary care providers and interprofessional team members the gap between the intent of the Service Request and the outcome can remain wide. Over time, misunderstandings or mismatching of information may impair relationships between primary care providers and interprofessional team members. Such mismatches may contribute to perceptions about lack of role clarity and responsibility for various aspects of patient care. This in turn reduces the effectiveness of team-based care, which can impact therapeutic relationships and subsequently how it is determined who needs a team.

“Foot in the Door” service requests

The second situation giving rise to Service Requests can be categorized by the term “Foot in the Door”. These Service Requests seem to represent a large proportion of the patients the interprofessional team sees. Nora (RN) describes this patient population as “teetering”. Patients are not well enough to maintain or manage their health with only the support of a primary care provider, but their health issues do not require acute care.

These patients often require a high degree of judgment and negotiation around composition of team. The image is one of an upside-down funnel, where the primary care provider writes one reason for the request on the form, but the interprofessional team members on the other “side” see many interventions required in order to provide care for the patient. The difference between a “foot in the door” request compared to a “straightforward” request is that primary care providers involve the interprofessional team knowing that team member involvement will likely be necessary beyond the reason written on the Service Request.
I filled in my first form for referral to this [interprofessional] team as of yesterday for an 85-year-old woman who lives alone and is having some bilateral edema and we’re going to try some compression stockings but she’s going to need some help with that. I’ve been told that everything is going to get seen and there’s going to be group rounds and things will be prioritized. What we’re looking for in our offices is responsiveness. Can this get done? How quickly can it get done? What’s the time frame type thing? For this particular person, I knew she would have to purchase the stockings, be sized and fitted for them, so I made some phone calls to find out the cost and was that even acceptable to her, ‘cause she’s possibly on a fixed income, so I did that legwork, found the number, let her know the cost and said are you agreeable to this? She said yes but I can’t go just yet, I have a visitor from out of town. Where real life collides with our ideas and suggestions [laughs]. I also sent her for blood work because she’s lost so much weight her dentures are flopping around in her mouth … I wonder if there’s a degree of malnutrition. I am thinking she may need way more support than just stockings. So stockings are just a tiny way of getting somebody in there. It’s way more complex than just one thing (Leah, NP).

Primary care providers anticipate team involvement, and there is a lot of tacit knowledge that Leah is able to articulate in conversation but is not usually included in writing on the Service Request. Thus, it is up to the interprofessional team members to make decisions about who and when to involve other team members. Primary care providers may call upon the interprofessional team as a generic entity via the Service Request, but it falls to the interprofessional team to decide beyond that point who makes up the team for individual patients.

This is one area where there is a risk of ineffective team-based care. Primary care providers may know their patients well, including social history and usual supports and resources of their patients, as well as patient preferences. Yet the interprofessional team may receive little or none of this information and be required to make decisions about patient care without further input from the primary care provider.

The patient may transition from feeling known by their primary care provider, to being subjected to multiple visits by interprofessional team members who need to gather
information, perform assessments, and make decisions about plans of care. While this model provides somewhat continuous care for patients, it may not be perceived as coherent.

Odette (MH) arranged to see a patient whose Service Request stated the patient required “bath support”. The information received via the Service Request indicated that the patient had diabetes and schizophrenia. Odette had met the patient previously for a concern relating to the patient’s schizophrenia diagnosis. Because Odette was the only one to have already met the patient, the interprofessional team agreed during rounds that she should conduct the initial visit with the intent to help the patient obtain bath support. Upon arrival to the patient’s home, the first impression was one of disorganization. The patient was unkempt, and directed much of the conversation to the fact that her new shoes did not fit well. The patient also requested advice about a rash on her chest. A support worker in the residence where the patient lived noticed our presence and spoke with Odette about the patient’s poor nutrition status and uncontrolled hyperglycemia. These matters took approximately 30 minutes. Odette needed to decide who the patient could see in follow up for some of these issues and conclude the visit in order to meet her next patient. We left without ever discussing whether or not she needed help getting in and out of the bath. (Field Notes)

Decisions about which interprofessional team members become involved in a patient’s care may become more complicated than anticipated. These complications can arise when the Service Request does not contain adequate patient history. Additionally, patient priorities may change between the time the Service Request is made and the time the interprofessional team member sees the patient.

During Odette’s (MH) visit, the patient required assessment of a skin condition, decision-making about monitoring and follow up for a chronic disease, and assessment of a chronic psychiatric condition. Odette also provided some solutions to the patient’s issue of her ill-fitting footwear, in part because this was possibly the patient’s most pressing concern during the visit. Although each of these assessments and decisions were made quickly by Odette, they were not arbitrary.
Involving interprofessional team members to address the health issues raised during Odette’s visit may risk a misunderstanding with the primary care provider, who only requested bath support for the patient. There is also risk of over-burdening interprofessional team members in terms of patient load, and of dis-engaging the patient from her care with too many people becoming involved at once. However, if all issues unrelated to what is indicated on a Service Request are returned to the primary care provider to address, the primary care provider may become disillusioned as to the benefits of team-based care and what services can be provided. “Foot in the Door” Service requests may in fact open the door to a number of unanticipated outcomes of team-based primary care.

When patients shift between receiving care within a patient-provider dyad to team-based care, attention to how information is communicated may be as important as what is communicated. Decisions about how to best communicate patient information is based on knowledge of the patient and of the other team members involved in the patient’s care. Dialogue via face-to-face discussion between interprofessional team members and primary care providers may be particularly useful to clarify and confirm unfolding plans of care being implemented by multiple team members. Conversation can facilitate shared knowledge and mutual understanding of patient needs, priorities, and preferences. This may help to avoid instances of patients receiving conflicting advice or duplication of services from multiple providers, which might disrupt therapeutic relationships with one or more members of the patient’s team.
“All Hands on Deck” service requests

The interprofessional team frequently uncovers multifactorial issues to be addressed after meeting with patients for the first time. The “All Hands on Deck” Service Request is one that differs from the “Straightforward” and “Foot in the Door” requests because the information provided by the primary care provider is sufficient for the interprofessional team members to recognize that multiple members of the interprofessional team are explicitly required to assist in a patient’s care. These requests may arise when a patient has had a health crisis and is just returning home or to the community, or an attempt is being made to prevent a hospitalization. Many of the patients named on these Service Requests belong to a “priority population” (Ministry of Health, 2014), such as frail elderly.

Throughout data collection, the interprofessional team regularly addresses issues of: guardianship, power of attorney, housing, disability, uncontrolled disease, decreasing competence, financial incapability, mental health, addiction, self-care, home support, family disruption, medication issues, mobility and independence issues, differing levels of service involvement, transportation issues, and safety issues. From the outset of the implementation of the interprofessional team, the level of patient complexity threatens to overwhelm the team capacity:

The supposed warm hand-off … I think could have been better. Some of the patients … have been very complex. Never the simple patient that has maybe recovered from their depression … and just needed a little bit of ongoing … instead it’s dementia, delusional, unstable housing, can’t manage their finances … like a multi-complex patient as the first or second patient. It would have been nicer to have some of the less complex people transferred over so you could get to know the team and figure out how they work, when instead, all of a sudden, poof, you’ve got the big one and then you’ve got to figure it out (Odette).
A “warm hand-off” occurs in some health care settings prior to a transition in a patient’s care, so that all members of the interprofessional team including the patient are on the same page about the plan of care and can share knowledge about the patient. In this way, interprofessional team members newly involved in the care of a patient can have questions answered, avoid missteps, and obtain enough information to be able to appropriately make decisions about the care of the patient. In these cases, patients are not usually present. This is because the patient is so unwell that multiple people representing a variety of services are already involved in providing care for the patient.

The type of information required to understand a patient’s situation, and how this information is learned raises a question about the timing of sending Service Requests to the interprofessional team. Meeting patients who have just experienced a health crisis, for example a stroke, or are “multi-complex”, as Odette points out, may hinder the team in getting to know the patient as a person. In such circumstances, the interprofessional team members will be increasingly reliant on information from the primary care provider, as the patient may be too ill or incapacitated to provide their own information about supports or preferences for care. Thus, if Service Requests do not include information reflecting the complexity of the patient, the interprofessional team may have incomplete or inadequate knowledge with which to make decisions. It can be easy to mis-step when expectations about patient needs are mismatched between primary care provider and interprofessional team members. If interprofessional team members meet patients for the first time when they are in crisis, the therapeutic relationship and thus effectiveness of team-based care may be delayed or disrupted.
Through the three different types of Service Requests reviewed, it is uncovered that the sharing of information that helps patients feel known can be hampered based on what information is shared, how it is shared, and the timing of the sharing, or in other words when the services of the interprofessional team are requested.

**Expanding Team**

Although primary care providers may send a Service Request with anticipation that more than one interprofessional team member will become involved with a patient, these anticipations based on knowledge of the patient and patient’s needs are not usually indicated on the Service Request. This information may be absent because primary care providers are uncertain how care might unfold for the patient, or they may wish to avoid being prescriptive about the priorities for patient care that can be better determined within the team. However, this unspoken process for involving more than one interprofessional team member means there is a gap in understanding about how the interprofessional team expands to include other interprofessional team members after the Service Request is received. This gap deserves further attention, to determine how interprofessional team members make decisions to expand the team.

During the morning meeting when Service Requests are reviewed, the entire interprofessional team is present. This offers an opportunity for each interprofessional team member to hear about the roles, services, ideas, and interventions that others have experience with or perform. The meeting room can be a synergistic environment and provide opportunity for interprofessional team members to learn about the expertise of others in a clinical context. Patient rounds as part of this morning meeting can be a way to expand the knowledge of the entire team.
Rounds every morning and discussing who we’ve seen … the fact that we get to bounce that off different people … and now we have mental health to bounce things off of. They come back with excellent suggestions and excellent resources and having Lifeskills – she is a fountain of knowledge and the things she can suggest [are] amazing. (Nora, RN)

Because rounds include all of the interprofessional team, everyone can have input and also learn about resources for patients they were previously unaware of. For example, the team discusses resources for children whose mother is receiving palliative care, whether there is a support group for transplant recipients, and what Home Support will and will not provide for patients. In this way, interprofessional team members increase their breadth of knowledge, which is beneficial when there are overlapping roles and functions of their work. Further, the interprofessional team is most likely to become involved in a patient’s care at a point when the patient’s own resources and supports are exceeded, and the primary care provider’s additional input has already been implemented. By the time patients reach the services of the interprofessional team, more specialized supports and resources may be required. There is no formal way to learn about resources available for patients, and so this dialogue in rounds, which can sound informal and scattered, is actually of substantial value to patients and team members.

This discussion in rounds also helps interprofessional team members to learn about each other and areas of expertise; “She understands when people have to have their power of attorney in effect and she knows how to present that in a way that is more palatable to the patient” (Odette, MH). Odette has learned this through working with Peggy (SW). Understanding what one another’s strengths are also helps to make decisions about involving other team members. Odette knows she could call on Peggy to help her explain power of attorney to a mutual patient.
Through the discussion of patients during rounds each morning, interprofessional team members can make decisions about whether or not a patient will require care from more than one team member. Sometimes one interprofessional team member will perform a function of another’s role, such as when Ruby (Case Manager) asked Mel (OT) if she would feel comfortable asking about a patient’s medication changes when Mel was on her way to visit the patient. Mel replied, “Sure,” and made notes to take back to Ruby after she’d talked with the licensed practical nurse at the assisted living facility in which the patient was receiving respite care.

Interprofessional team members decide who to involve based on their assessment not just of the patient, but of the patient in their home environment.

I saw that he had several mason jars filled with medications … like a jelly bean jar and [I say], “Oh, what’s this?”
“Well,” he says, “I go to [out of province city] and I’m away for long periods of time, so I kind of stockpile, I kind of keep some medications and then I have a bunch.” So [I] identified that nursing needed to go in. (Peggy, SW)

The image of jelly bean jars lined up filled with pills is something that may go unnoticed if the interprofessional team member had not seen this in the patient’s home. In an office setting, patients are rarely asked to bring their pills in, and instead a routine question might be, “How are you managing your medications at home?” This patient might have said he was managing quite well, as he obviously had a system. While patients present a narrative about their health and identity to health care professionals, this narrative may be challenged if there is a mismatch between the patient’s story and their environment. With opportunity to observe the patient’s medication “system”, Peggy can involve another team member to find out if this meant he was not taking his
medication as prescribed, whether he was unaware he could ask to have a prescription filled just before leaving town, or perhaps he was unable to afford all of his medications.

Interprofessional team members also made a point of inquiring into areas of patient function that “belonged” to another profession’s scope of practice, as a way of assessing need for the involvement of other team members.

We would always ask some questions about, “How are you getting up and down the stairs? Is that hard for you? Or is it hard for you to get off and on the toilet and if so, I’m going to get Mel to come in to see you.” (Peggy)

Observations made in the patient’s home by interprofessional team members who understand one another’s roles can provide or plan for care that transcends beyond what is salient only to their particular role or reason for that day’s visit. In team-based care, knowing the patient is important, and it is equally beneficial for team members to also know one another. Knowledge of patients and of each other influences judgment in determining who needs a team.

**Considering place**

Team-based care can be enhanced by considering place. During an update to the interprofessional team during patient rounds, Peggy discusses the plan of care for an elderly female patient who had fallen beside her bed in her apartment at night. The patient had Lifeline but knew if she pressed the button at the time of her fall, it would be the firemen who showed up to assist her. Telling Peggy (SW) she was too embarrassed to have the firemen see her in her underwear, she instead pulled her bedding over her on the floor and waited until morning when home care arrived. Instead of trying to reason with the patient to just call Lifeline, the interprofessional team members took the patient’s wishes and dignity into account. Mel (OT) arranged to see the patient to teach her fall
prevention and safe transfer techniques. Peggy (SW) arranged cleaning services for the patient, because “her sheets were black.” This response for this patient would not occur if not for an interprofessional team who could communicate easily with one another and see the patient in her home. Seeing patients in place provides different cues about health compared to seeing patients in a primary care provider’s office. Seeing a patient at home adds a facet to knowing the patient that is often not observed by primary care providers.

The opportunity interprofessional team members have to see patients at home is such that their knowledge of patients may develop differently than that of primary care providers. The interprofessional team members’ understanding of the meaning of a patient’s situation is augmented by the patient’s environment, and this may be lacking from the perspective of the primary care provider. This may lead to differences in terms of how interprofessional team members interpret what “counts” as health care.

The next day I went back to introduce Peggy [to the patient] because I was thinking he’s getting taken advantage of by this guy and sure enough I took in Peggy and [patient] said, “Oh yeah he’s buying it from me for $2000 but he’s selling it for $3500.” It was way out of my league, so that’s when I said, “You know what I need somebody to touch base with this guy and help him.” (Sonia, Lifeskills)

This patient’s landlord was taking advantage of him. When confronted with this knowledge while sitting in the patient’s apartment and seeing what the landlord planned to sell, the interprofessional team member felt compelled to act. Interprofessional team members recognize what is called for in a patient’s particular situation. The moral facet of health care addresses interprofessional team members differently compared to primary care providers, perhaps because patients are visited in their home environment. Seeing patients in place may contribute to different understandings between interprofessional
team members and primary care providers in defining health, or deciding on appropriate interventions.

It is one thing to see a patient in the office and think that the patient is shabbily dressed, or their hygiene is a bit poor, or they are chronically late to appointments. A primary care provider might unconsciously make allowances for these things, thinking for example, “well, they’re sick today, they didn’t feel like dressing up,” or, “they’re just a bit disorganized”. It is an entirely different experience to attend a patient’s home to see they are wearing the best clothes they have, there is no hot water because they have not paid their utility bills, and their basement keeps getting broken into because addicts are crawling through a window so they can sleep inside.

Compared to the primary care provider office, the patient’s home presents a very different social “front” (Goffman, 1959) to the team member. In essence, the patient’s home can be understood as a patient’s “backstage” area (Goffman, p. 112). While control of the setting for any type of encounter is considered an advantage (Goffman), the home environment may offer unanticipated insights towards knowing the patient.

Impressions that can be maintained by patients when in an office setting may be altered or discredited when the “backstage” of a patient’s life becomes visible to interprofessional team members. The home environment affects how patients are known. This knowledge gained by interprofessional team members may be shared with the team, it can inform clinical judgment, and thus impacts what types of services patients may receive and how patients feel known by a team. This in turn can reflect the degree to which patient outcomes are impacted, and whether patients experience their care as continuous, connected, and coherent.
Knowing a patient in place also adds a facet of morality that may be muted in the primary care provider office. When a patient tells a primary care provider “it’s hard to get up the stairs,” it is primary care providers like Jack, who ask such specific questions of his patients to help understand their meaning, who might ask how many stairs there are, or how long it takes to recover from breathlessness at the top. Yet even if these specifics are learned, it cannot replace the experience of following that patient up three flights of stairs to her apartment while she huffs and wheezes and halts, stooped over for breath while clutching the railing. Place influences health and understanding of health. Seeing patients in place makes it difficult to negate moral impulses (Bauman, 2004) as Sonia discovered in her distress when realizing a patient was being taken advantage of financially. If interprofessional team members and primary care providers perceive the overall concept of health differently, this may result in discrepancies of understanding patient priorities, and thus differing judgment and actions regarding plans of care.

Through seeing patients in place, interprofessional team members assess the home environment, relationships and supports, family dynamics, diet, literacy, financial stability, and more. Patients who require an interprofessional team need and receive something more than primary care; they receive primary health care. The question of who needs a team can now be addressed by thinking about who needs primary care versus who needs primary health care, and when.

Summary

In this chapter, it becomes clear that the primary care provider’s role in knowing patients and understanding a patient’s social history, including the resources and supports a patient is able to draw on to restore or maintain health, is important beyond the patient-
provider dyad. What type of information, how, and when this information is shared with members of the interprofessional team is central to understanding how the interprofessional team is able to be effective and meet the needs of the patient as well as other team members. At the time of data collection, the information passed between primary care providers and interprofessional team members was highly variable and impacted patient care.

Interprofessional team members draw on each other as information sources to supplement information received about a patient. Dialogue between interprofessional team members during a recurring morning meeting helps to contextualize the patient’s situation and augment the information received from the primary care provider. In particular, information that improves understanding of how or why the resources and supports available to the patient and primary care provider have been exceeded is readily taken up by the team. Understanding and incorporating this type of information improves the ability of the interprofessional team member to be able to draw on clinical judgment to make decisions about when the patient should be seen, and by whom.

There are three situations identified during this study that prompt primary care providers to involve the interprofessional team; the “Straightforward” requests, the “Foot in the Door” requests, and the “All Hands on Deck” requests refer to the initial reason the unidirectional request is initiated. The order of requests as they are listed here can be considered hierarchal in terms of how much interprofessional team involvement is anticipated by the primary care provider. In other words, a “Straightforward” type of request is anticipated to be just that, with perhaps one team member to perform one or two specific functions with the patient. The “All Hands on Deck” request reflects a
degree of social and medical complexity of the patient, and the primary care provider expects multiple interprofessional team members will be involved over a lengthy or intensive period of time with the patient.

With each type of service request, the amount of information provided by the primary care provider may be influenced by a number of factors that impact the quality, effectiveness, and coherence of team-based care experienced by the patient. With a “Straightforward” request, the primary care provider may not include substantive social history about the patient, because it may not seem relevant to the reason for the request of interprofessional team involvement. With the “Foot in the Door” request, the primary care provider may not be explicit about expectations for involvement of multiple interprofessional team members, or what the priorities for the patient’s care are. The “All Hands on Deck” request may arrive when the patient is in crisis or experiencing significant ill health, so that interprofessional team members are even more reliant on information the primary care provider sends, instead of having the opportunity to get to know the patient prior to a health crisis.

In each situation giving rise to a service request, lack of information provided by the primary care provider can lead to uncertainty, misunderstandings, duplication of assessments, a mis-match between provider, team, and patient priorities, and delays or disruptions in therapeutic relationships and effective team-based care. Interprofessional team members who are not privy to a patient’s social history, or other information not deemed pertinent to the reason for the service request, have less data to inform their own clinical judgment and thus decision-making. Once the interprofessional team becomes involved in a patient’s care, the risks of inadequate information sharing become bi-
directional, and are exacerbated by the lack of opportunities for interprofessional team members and primary care providers to have face-to-face conversations.

Although primary care providers retain their traditional gate-keeping function to decide when to involve members of the interprofessional team, the details of which team members will become involved initially and sequentially in patient care are determined within the interprofessional team, predominantly without advice or recommendations from the patient’s primary care provider. The second half of this chapter explored the reasoning behind how and for what reasons the interprofessional team may be expanded to include members not identified in the initial service request from the primary care provider.

Interprofessional team members may ask one another to become involved in a patient’s care based on the understanding of individual interprofessional team members’ strengths, interests, and areas of expertise. Interprofessional team members have formal and informal opportunities to have face-to-face conversations through which they can get to know each another. Through dialogue, interprofessional team members can learn and understand the breadth of one another’s knowledge, where their roles overlap with other team members, and skills of individual team members. They also learn what interprofessional team members feel confident and competent in, which informs decision-making about asking different interprofessional team members to become involved with a patient’s care.

The final consideration in terms of how interprofessional team members use their judgment to decide whether and when to involve other interprofessional team members in a patient’s care is about place. The majority of visits made by the interprofessional team...
to patients in this study took place in the patient’s home. Seeing patients as they live in their everyday surroundings is a way of knowing patients not often afforded to primary care providers who see patients only in an office setting. Interprofessional team members may develop different ways of knowing and understanding patients that are useful and important to share with primary care providers.

Understanding about a patient’s situation gained from being in a patient’s home informs the clinical judgment and thus the practices of interprofessional team members. Aspects of a patient’s health related to relationships, income, education level, hobbies or interests, and values, is of considerable focus in an interprofessional team member’s visit to a patient in their home. This may lead to interprofessional team members perceiving the concept and definition of health of patients differently compared to primary care providers. The role of place in this research is such that it shifts the focus beyond primary care delivered within the patient-provider dyad, and into the realm of primary health care delivered by an interprofessional team.
Chapter Seven: Negotiating Primary Health Care

When a patient becomes involved with the interprofessional team, two things have already taken place. First, the strategies the patient normally uses to draw on existing supports and resources to restore equilibrium, and thus health, have not been successful. This causes the balance to shift enough to prompt the patient to seek primary care. How and when this balance shifts depends not only on the severity of the problem, but also the type and availability of personal resources and supports an individual has access to and is able to draw on.

Second, the primary care provider has seen the patient and determined that the interventions, advice, and education that can be offered to the patient have been implemented to as great an extent as possible, but the patient’s health has not been restored. Further resources, supports, and knowledge are needed. The scale of health system involvement shifts again, with health in the balance, and the primary care provider requests service from the interprofessional team.

Although the longitudinal nature of the patient-provider dyad is intended to remain consistent over time, the involvement of the interprofessional team can be expected to vary in both frequency and composition of members. A fall for an older adult may result in a series of visits from a nurse and physiotherapist, but when health is restored these team members may not see the patient again for years, or perhaps never. For a young adult with depression, the only interprofessional team member to be involved will likely be the mental health clinician. These differences in the frequency and composition of the interprofessional team compared to the ongoing involvement of the primary care provider highlights how the relationship between the patient and the
interprofessional team may be different from that of the patient and primary care provider. This chapter will attend to the ways in which the interprofessional team maintains a therapeutic relationship with patients over time, and how the nature of these relationships can be expected to be different from those of patients and primary care providers. Understanding these differences can also be helpful to distinguish how patients and providers negotiate care over time within a team that extends beyond the patient-provider dyad.

**Staying Connected**

After interprofessional team members see a patient for the first time as per the Service Request process, interprofessional team members make independent decisions regarding the intensity and preferred method for planning and monitoring follow-up visits and ongoing involvement with individual patients and families. There may be plans to call or visit daily, to help prevent a patient’s deterioration or hospitalization. Some interprofessional team members create a recall list or other electronic reminder. “Recalls are key in that continuity” (Quentin); “… I usually just set a recall … because we need to follow up” (Mel). Recalls remind interprofessional team members to re-connect with patients to assess gradual changes in condition as with chronic disease or dementia, or people who are likely to need increasing supports over the long term.

Quentin (MH) also uses a recall system to monitor patient transitions to other parts of the health care system.

Even if I referred [the patient], I put them on recall for a time shortly after the first visit [with a specialty mental health service] so I can connect with her and ask if she did connect with the specialty and if not, I can ask her if there was a reason where I can kind of pick that piece back up and send her maybe to another option. (Quentin, MH)
Patients are sometimes unsure about what they should do if they are sent to another provider or service and for one reason or another it does not work out. This practice of creating a recall list and following up with a phone call may be reassuring to patients. It is a reminder that they are not forgotten, and can help patients feel known or cared about during a time that their health care needs are requiring increasing numbers of people and services.

Other interprofessional team members encourage patients and families to take responsibility for follow up.

[We] rely a lot on patients and families to engage with us. I tell them right off the bat when I meet them, “Now we have a lot of [patients] and we rely on you guys really heavily to get in touch with us if something comes up or just if you have any questions.” (Nora, RN)

This is a completely different practice, yet it can be equally helpful for patients. Nora makes it clear that patients and their families are partners in care, and that there is co-responsibility. This practice also conveys an “open door” approach, inviting patients and families to be in touch with the interprofessional team if there are any concerns.

Understanding about where the onus may lie for patients or providers to take responsibility for ongoing patient connections with the interprofessional team may differ, however both approaches described here have the common intent of ensuring the patient understands the interprofessional team is available to the patient and their family for health care needs or concerns.

When patients no longer need interprofessional team involvement in their care, they are not “discharged” from the team. However, during the early stages of implementation of team-based care, it was uncertain how patients might access the team after initially receiving service from team members. The process was not clear whether
patients would contact the team again or first seek advice from their primary care provider. To address this, interprofessional team members individually created systems of recalls and check-ins based on judgment of a patient’s agency in conjunction with a personal philosophy of what might work best for patients and their families. This helped patients to be as connected as they needed to be within the primary care system. At any given time, the patient’s team might have multiple interprofessional team members involved, or none.

Team capacity also affects the ability of interprofessional team members to participate in patient care. The volume of Service Requests to the interprofessional team was such that the function of the team had to be altered by Northern Health to attempt to retain capacity and thus engagement with primary care providers. The mental health clinicians were advised to reduce sessions of cognitive behavioural therapy for patients to three to five sessions only. After that, or if the mental health clinicians thought patients would require more than that after meeting patients, they were to refer patients on to specialized mental health services. The concern was that if patients required more than five sessions that this service alone would consume all of the mental health resource capacity within the interprofessional team:

> I have to now farm them out and I have to apologize to people, when I start I say, “I’m really sorry but I’m going to have to ask you 50,000 questions because I’m probably going to have to refer you on to another program.” So instead of them being open about what things are, they’re now filling in the blanks. (Odette, MH)

Interprofessional team members acting as a go-between for patients on their way to a specialized service felt this was a disservice to patients. Rather than getting to know the patient, they were only completing a task and moving the patient along in the system. In this example, organizational requirements impaired the ability of the interprofessional
team’s mental health clinicians to fully engage in therapeutic dialogue. This can impact the patient experience of team-based care. If patients report dissatisfaction or antipathy about their experience with the interprofessional team to their primary care provider, this may inhibit the willingness of the primary care provider to engage with or refer to the team. Restrictions on function due to over-capacity may lead to reduced utilization of the interprofessional team. In this way, an organization can solve their own problem through strict adherence to process, but in the end it may affect the success and effectiveness of team-based care.

When patients are shifted from the interprofessional team to a specialty service, it is unclear as to the future role of the team for the patient. “How do they know when to come back?” Odette (MH) asked in a meeting, and no one at the table had an answer. Presumably the patient would return to their primary care provider, with whom they likely have an established relationship, and the primary care provider could then involve the team again as necessary. Interestingly, no one at the table mentioned the primary care provider, or considered the role of the primary care provider in the usual care of the patient. The idea of repatriation to the primary care home, and whether this includes the interprofessional team, is complex and not fully understood.

The demands on interprofessional team members reduced capacity so that some members of the team had waitlists of more than a month before they could see a patient. This impacted not just initial responses to Service Requests, but also how team members were able to be involved in a timely manner in patient care. “People [are] saying they don’t have enough time to do a follow up phone call. If we can’t manage that one person, we shouldn’t be taking on a new person” (Nora, RN). “All the people we’ve been taking
care of and I just don’t feel like we have a handle on them” (Ruby, Case Manager). The question with high patient volume and need is no longer “who needs a team” but instead “who gets a team,” because patients need to be prioritized and waitlisted.

Issues of high demand for services also influence the judgment of interprofessional team members in terms of how they decide which functions they will perform in their role and to what extent they can enact their full scope of practice.

Before we changed [from the special services team], and before we opened the floodgates … my case management skills … I was starting to get really good … my skills were getting more broad and I was getting better with knowing medications and that sort of thing and asking those probing questions… doing as much as I could for that patient within my scope before having to branch out. Now with opening the floodgates I do feel like we’ve all kind of gone back to I need to do my OT stuff, you know. Then when I’m talking about [a patient], someone will say from the team, will say, “what pharmacist do they go to?” Well, I didn’t ask them because that was part of our old intake and I didn’t even think to ask them that because I was too worried about this, this and this, right. I just need to get their home safety [assessment] done now, so I can move on. (Mel, OT)

Mel goes on to explain how her competence is affected by decreasing capacity to keep up with the demand for service:

When you just know it and things roll off your tongue, that’s where you show you really know what you’re talking about, and you become efficient with your job … there’s just so much going on right now that it’s hard to be efficient and do everything that you were doing before. (Mel, OT)

Mel’s practice has shifted from a broad, generalist scope with ongoing development of expertise to practices that are encompassed as narrowly as possible in accordance with her role. This shift is described as a change in contextual competence (Hodges & Lingard, 2012). A health care professional can be experienced and competent in performing their role, but some of that competence dissipates when the context is altered (Hodges & Lingard). At a time of early implementation of team-based care, this has the opposite effect of what is hoped will be achieved through re-structuring primary
care delivery. That is, Northern Health hopes to transform primary care to increase
generalist practice and reduce narrowly defined specialized areas of practice.

Mel’s portrayal of her changing practices also highlights the interplay between
providing access to care and scope of practice. If there is an attempt to increase access by
increasing volume, the outcome may be that scope of practice is restricted, because health
care professionals must adopt restricted, narrow functions of their role and do just the
necessities in order to manage patient load and demand. However, by increasing volume
or access and narrowing enactment of scope of practice, there will be a point where
increasing volume is self-defeating, because now more team members are required to
address all patient care needs. This effect may also inadvertently cause a persistent shift
away from generalism and reinforce specialization, because health care professionals may
perform the narrowest aspects of their role in which they feel most competent and
efficient.

These issues of the ability of team members to form a responsive, effective
primary care team around patients raises the question of what best practices might be in
terms of planning for delivery of team-based primary health care. For example,
determining optimum panel size for an interprofessional team might be worthy of further
inquiry. In health care, best practices frequently revolve around standardizing care, but
considering the variability of involvement of an interprofessional team that is required in
order to be responsive to patient health care needs, it may be difficult to optimize health
human resource planning in this area. The tension between standardization and patient-
centred care deserves further attention and will likely require in depth understanding and
attention to the specifics of the context in which team-based primary care is being
delivered in order to effectively resolve or address this tension.

**Connecting with Patients**

Interprofessional team members experience relationship with patients differently
than primary care providers based on setting, organizational structures and processes,
frequency of visits, and duration or intensity of involvement in a patient’s care. Despite
these factors influencing how practices of connection are carried out, both primary care
providers and interprofessional team members seek to establish and maintain therapeutic
relationship with patients by seeking understanding of a patient’s situation beyond
clinical symptoms. To improve understanding of the advantages interprofessional team
members bring to team-based care, a return to the patient perspective of experience with
interprofessional team members will aid to determine how, when, and why team-based
primary care is of value.

**Valuing discontinuity**

I arranged with Quentin (MH) to meet at a downtown office space where he had
an appointment to meet Diane for the first time, who was referred to the interprofessional
team for anxiety. The primary care provider had attached the most recent progress note
for the patient with the Service Request, and the name of a medication that had been
initiated for the patient. Quentin did not start the visit as though he was picking up the
information from the Service Request and carrying on with it in a continuous manner.
Instead he introduced himself, discussed his role, and the boundaries of his
confidentiality. Next, rather than assume the diagnosis of anxiety to be correct, he used a
form to take her history and screen for other psychiatric illnesses.
This practice of “intake” with patients new to the interprofessional team was contentious for primary care providers and Northern Health management. Primary care providers believed that because they had already completed the assessment and made the decision to involve the interprofessional team that the interprofessional team members were duplicating work by re-assessing patients. From the Northern Health management perspective, a “meet and greet” visit with patients did not enact the “team” model of the primary care home that presupposed information, along with the patients, would be easily transferred from the primary care provider “side” to the interprofessional team “side”.

For the interprofessional team members who completed their own assessments with patients, two purposes were served. The first reason is to establish rapport. One team member was overheard to say during a meeting that, “Rapport and relationship need to come first,” and that the reason listed on the Service Request is “not my priority” (Interprofessional Team Member). Given the many difficulties encountered with regards to the content and process surrounding the embattled Service Request, it seems to have little function in practice for primary care providers or interprofessional team members. Regardless of what the Service Request says, interprofessional team members still need to fill gaps in their knowledge of the patient and establish relationship with the patient to the extent that patients wish to be engaged with the interprofessional team and decisions about their care.

The second reason an interprofessional team member might complete an initial assessment of the patient is to take responsibility for his own practice. Registered nurses in hospital settings have long lamented the practice of physicians who will walk to a patient’s side, ignore the nurse standing with the patient, disregard the written assessment
the nurse has completed, and say to the patient, “so what brings you in today?” However, there is a difference of time and location between this example and Quentin’s (MH) practice of completing his own assessment.

For the hospital example, the physician completes her own assessment despite the fact that a registered nurse has just completed the same assessment moments ago. In primary care, the patient may have last been assessed weeks ago, and the condition or the patient’s agenda may be different now. In the hospital setting, the nurse and the physician are face-to-face, able to have a conversation about the assessment of the patient. In primary care, the two professionals seeing the patient do not see each other, and Quentin cannot see any other information from the patient’s chart when he meets with her.

As Quentin follows his own practice of taking Diane’s history, she discloses that she has an eating disorder. When her anxiety worsens, the symptoms of her eating disorder return. She asks Quentin if there is help available.

In this case, the process of not making assumptions about the patient’s problem was not an onerous duplication of information. Instead, it led to identifying a problem and helping Diane receive the help she needed. This encounter demonstrates that being able to pick up where the last health care professional left off might be an assumed good, or perhaps that partial information exchange is worse than no information at all.

A few weeks after observing Quentin’s encounter with Diane, I interview her. She has now been referred to the Eating Disorders program and is very pleased to be receiving help in this way. She talks about how she came to be able to discuss her eating disorder with a health care provider.

I really wanted help. Having [Quentin] give me the information opened up the door because they made the connection within [the system] for my treatment. I don’t
know if I could’ve walked into that clinic [for eating disorders] and done it. The fact that someone else did it for me … was what I needed. I was quite shocked actually that when I asked for help that way that there was help available. (Diane, Patient)

It was revealed to be a combination of events that led to Diane being able to mention her eating disorder to a health care professional. She saw a locum physician who also happened to be a woman:

This was just a random synchronicity that [locum physician] is a young female … it was almost nicer for me that I didn’t know her because I could just tell her because I wasn’t embarrassed. If I had [seen my regular, male GP] … I truly, I don’t know if I would’ve had the guts really to go seek it out. I probably would have gone for therapy [counseling covered by private insurance] but really, that’s not actually the thing … I need help specially with that issue and the only way [was] someone else made the call for me. I’m a professional person, I’m married, … I really focus on being compassionate and effective and functional … it’s a really nice opportunity to have just a chance where there’s somebody that doesn’t know you, and you can be brave in that minute and say, “Yeah, I’m all those things but I’m also struggling with this.” Where they don’t know you, so this is your shot at being really truthful. I really try not to lie but there’s part of you – because it’s protective – and there’s shame – really you protect addictions quite highly because you think that they’re helping you and you want to hang on to them even when you know that they’re not useful for you so you can talk a good game, too. And people do that … so when you do go to someone else they either don’t believe your game or they don’t have to or you actually get a chance to be brave and say, “Yeah, I’m not going to game you.” (Diane)

Diane’s narrative about her experience and decision to disclose her eating disorder reveals that there is value to discontinuity of care. Seeing an unknown interprofessional team member offers patients a chance to divulge an aspect of their identity that they work hard to cover up in other areas of their lives. The benefit of allowing patients a chance to see a different team member shines light on a different aspect of thinking about who needs a team. Diane’s explanation is also an important reminder of the gatekeeper role primary care providers have within the interprofessional team. Patients who wish to withhold information from their primary care provider may be deterred from accessing
the interprofessional team if the patient is unable to convey a need to the primary care provider that would instigate a Service Request.

**Explaining the system**

Another type of connection that patients value outside the patient-primary care provider dyad is one where health system navigation is made clearer:

I have confidence in a person like [counsellor] because as far as I’m concerned, my own point of view, she is my only window/doorway to the system for my daughter because I’m not going around knocking on doors saying, “Will you treat my daughter, will you see my daughter, will you take her on as a patient?” (Frank, Patient)

Frank’s adult daughter is frequently unwell and often refuses help for her psychiatric illness and alcohol dependence. Frank has consent from his daughter to speak to her counsellor, who is able to suggest additional community resources and programs to Frank to discuss with his daughter, or seek support himself. The availability of the interprofessional team to a family member is a beneficial role. With knowledge of specialized resources and services as well as an insider’s understanding of the health care system, the counsellor increases capacity for Frank to understand his daughter’s situation and care. The counsellor, as a “window” to the health care system, helps to make navigation more clear rather than a foreboding and complicated series of barriers and frustration for Frank.

**Making suggestions**

A third type of connection that patients report as a valuable benefit to team-based care is the opportunity to meet and establish relationship with interprofessional team members while they are relatively well. Gary has a progressive chronic illness that is
currently stable. He met two interprofessional team members for a visit related to his mobility.

They came out a couple weeks ago. They offered their suggestions; they’ve got a couple grab bars. Again, great group of people. Their suggestions are suggestions, I take them for what they are. I’ve got the grab bars sitting there, one of these days I’ll get out a drill and put them on … It’s more of a suggestion … trying to be proactive so I don’t end up cracking my head on the tub … “Maybe it would be an idea for you to have a grab bar there.” And I think their method of suggestion works a whole lot better than saying, “Well, we’re going to come in and we’re going to do this and that.” (Gary, Patient)

Gary conveys the idea that the interprofessional team is intended to be a support, a resource. By being proactive, the interprofessional team can offer Gary suggestions that he can then weigh against his own priorities and preferences. The interprofessional team members were personable, and they treated Gary as a partner in his care. These components help establish therapeutic relationship by helping patients to feel known. Access to the interprofessional team expanded Gary’s own resources and supports.

When I ask interprofessional team members about their approach to becoming involved in a patient’s care, Peggy explains that she tells patients, “Everything we’re giving to you is just a suggestion, so you know the options are there and if we can support you in your home, we will do that.” It is an echo of Gary’s words. This approach was something some of the team members learned working on the previous special services team.

When we would first see people [with the special services team] we would ask them to fill in a self-assessment, so questions like, “Are you concerned about your memory, are you concerned about mobility? Are you concerned about falls or nutrition?” And so based on those … we made it clear that it was all about them and that we were only interested in supporting them to remain in the home of their choice as long as possible. And we would not be intrusive … we would be there as a resource. With our follow up visits, we would use those areas of their concern as a jump-start. It was always about them. It allowed us to then look a little bit beyond
because they would explain, “Oh, this is how I’m doing now with this area.” (Peggy, SW).

Interprofessional team members cultivated this approach while working with a specialized population, however the benefit may be applicable to all patient populations.

Mel talks about meeting people “… before things start to crumble.”

In establishing rapport with that person you also get a whole lot of ownership on [the patient’s] part. They call me, “I remember when you said this, I’m starting to see that now, I’m wondering if you could have a visit with me.” … Then they welcome you back. Instead of you saying, “You need this, because you have all these problems.” (Mel, OT)

Interprofessional team-based primary care is improved if the approach is proactive and not reactive. This has important implications for the timing of involvement of the interprofessional team. Ruby (Case Manager) reinforces this by noting it is important to meet patients “… when they’re not in a crisis”. Yet the current state of interprofessional team involvement was perceived as reactive. “We’re going into crisis” (Peggy, SW).

A proactive approach to interprofessional team-based care is patient-centred because the patient is not in crisis and better able to participate in their own care. The interprofessional team members and patient have a chance to get to know one another and establish a therapeutic relationship. Interprofessional team members help patients to understand the resources and supports they can provide for patients and convey the message of having an “open door” should the patient require their assistance. The chance for interprofessional team members to meet patients, perhaps particularly the “teetering” (Nora, RN) population, before a significant deterioration in the patient’s health, might be especially helpful to plan care.
Checking in

Proactive or early intervention team-based care is similar to other upstream solutions in health care in that it is difficult to measure a return on investment for prevented events. There is also a risk that care provided by “checking in” with patients or “making suggestions” can be viewed as an inefficient practice. Interprofessional team members understand there is value in these practices.

So the guy I saw with you, I know him quite well and that’s just from a lot of visits. He’s isolated and yeah, it’s just frequent visits, being able to have the time to chit chat. I never went in especially for anything, Home Care sees him every three weeks or so and … [changes] his catheter and that sort of thing, but [I] just look at his pills, do a set of vitals, which is not totally necessary but it’s a good excuse to get into people’s homes. “I just need to come and do a blood pressure.” It’s such an easy in. People love it. That is usually my excuse and then people will open up to you. Same as the gentleman I’ve been seeing this morning, I knew he didn’t look well and had I been someone he didn’t know that well, I don’t think he would’ve told me he has a raging scrotal infection … he never would have told anyone … the doctor had no idea, nobody knew anything about it. Until he showed me. I don’t think he would’ve shown me had he not known me so well. So that’s good payoff, just from visits. (Nora, RN)

Nora established a therapeutic relationship with this patient in part by seeing him regularly. She arranged to do this based on risk factors associated with his illness and isolation. He is a patient who is “teetering”.

Nora’s knowledge of the patient and her application of clinical judgment allow her to make pertinent assessments by seeing the patient in his home, talking briefly with him, and giving him an opportunity to raise concerns without having to decide if it is worth the effort to telephone someone or sort out transportation and assistance to see his primary care provider. In Nora’s example, there are several patient and health system benefits. First, there is a cost saving because the infection is identified in time to be treated at home and not the hospital. The patient experience is improved because he was
able to disclose a sensitive health issue to a professional he knew and trusted. That Nora is able to do these home visits also increases the number of access points the patient has to the health care system. Based on these criteria, Nora’s visits that first appear as casual check-ins actually achieve the triple aim of health care.

In early stages of team-based care implementation, patients see value in access to an interprofessional team. Sometimes, being able to see a health care professional who is not the regular provider allows a patient to expand her narrative or change the “front” (Goffman, 1959) she presents, and is able to access needed services. Patients value interprofessional team members’ roles in helping them navigate the health care system for themselves and loved ones. Interprofessional team members can help patients and families understand referral systems and help them to access resources and supports they were previously unaware of. Patients reported appreciating meeting team members at a time when they understand their health may deteriorate, but that they still have control over deciding among choices for care and what options they might select to access in the future. Finally, patients reported valuing knowing and seeing someone they trust.

The interprofessional team offers opportunities for patients to improve, recover, or maintain their health. In many instances, the resources or support they provide as functions of their role serve to reinforce or sometimes temporarily replace the resources and supports of the patient. For example, if family or friends are unable or unavailable to help a patient with things like taking medication, driving to appointments, or performing range of motion exercises, these activities are performed by interprofessional team members. This is how team-based care is delivery of primary health care. Patients who improve or recover their health regain their equilibrium, and resume their everyday
activities. They can rely once again on their own resources and supports. Some patients will require ongoing primary care, and some patients will require ongoing primary health care. However, who needs what type of care and when can only be determined by genuine understanding of the patient’s situation over time.

**Summary**

The ways in which interprofessional team members establish and maintain relationships with patients over time is different compared to primary care providers. These differences are in part a function of the role, duration, frequency, intensity, setting, and purpose of the relationship between patient and team member compared to the relationship between patient and primary care provider. This chapter focused on examining some of these differences, as well as how these differences may be experienced by patients.

Similar to primary care providers, the ability of interprofessional team members to draw on their skills and knowledge in their role to perform the everyday functions of their work depends in part on the volume and complexity of patients seen. Unlike primary care providers, however, particularly those in fee-for-service offices, interprofessional team members may have little control over the volume of patients requiring team-based care, as well as little control over the administrative tasks assigned by their manager or required by their employer. The overall capacity of the team to see patients influences when and with whom patients can seek follow up care.

As volume increases, capacity may decrease because interprofessional team members are also working in an environment where expectations as to the performance of their role is undergoing transformation. The cumulative effect of these changes can
impact the confidence and competence interprofessional team members have in their abilities to perform well and manage their workload. As demands for service increase, and capacity of the team decreases, one way of coping for interprofessional team members is to focus more narrowly on specific tasks for patients, instead of performing to the broadest scope of their practice ability. These practices that recur as high demand for care of complex patients persists result in greater adherence to specialized knowledge, rather than a shift towards generalism. This can hinder the development of a broad base of generalist practice by interprofessional team members, which is one of the desired outcomes of team-based care. Instead, it may reinforce professional silos, encumbering efforts of the health authority’s intent to dismantle such silos with transformational change in primary care delivery.

As interprofessional team members establish their own practices of connection to facilitate therapeutic relationships with patients, four situations are identified that may help to uncover some of the advantages of team-based care that have not previously been considered. These situations can be defined as “valuing discontinuity”, “explaining the system”, “making suggestions”, and “checking in”, and are in addition to the more clearly defined roles and functions expected of an interprofessional team. These situations are distinct in that they likely would not transpire within the patient-provider dyad, they take into account some of the factors that affect the therapeutic relationship between patient and interprofessional team member, such as setting, and draw on the ways in which interprofessional team members apply clinical judgment to the patient’s particular situation in a manner that is different from primary care providers.
By “valuing discontinuity”, it can be understood that there may be times that a health issue is only uncovered when the patient has a chance to step outside the boundaries of how she is known within the confines of the patient-provider dyad. Rather than always viewing the repeating of health history as duplication, it can be understood as an opportunity to share different information. This is an important finding to add to the discourse of continuity which is often discussed as an assumed good. Understanding that patients may value access to the interprofessional team in order to see a different health care professional who is unknown to them or who can know the patient differently, is also a consideration for primary care providers who are gatekeepers to the rest of the interprofessional team.

Interprofessional team members become involved in a patient’s care specifically because existing strategies, supports, resources, and interventions available to the patient and primary care provider have been optimized. The role of the interprofessional team member may be in part to know about other resources and supports or strategies within the community and health system that can help to restore or maintain the health of a patient or family member. “Explaining the system” is one aspect of how interprofessional team members are able to engage patients to increase patient or family understanding of how to access, use, and navigate different resources or supports. With knowledge and understanding of many formal and informal supports or resources both within and outside the health system, interprofessional team members can help patients understand and improve their journey and experience through a complex network of discrete services.

Interprofessional team members often see patients in their home environment, and this can contribute to interprofessional team members evaluating the health of the patient
comprehensively, incorporating understanding of social and medical facets of health. Interprofessional team members are able to assess the patient’s living situation, income status and stability, family or relationship dynamics, and hobbies or interests, both tacitly and explicitly. This accumulation of knowledge helps interprofessional team members to anticipate in part the trajectory of a patient’s health and make suggestions for future care. These suggestions are how interprofessional team members consider the situation of the patient by taking into account the factors that currently influence the patient’s health. The suggestions also offer opportunity for patients to foresee how the interprofessional team members may have a continued or future role in the patient’s care that will be different from the role of the primary care provider.

“Making suggestions” is also a type of anticipatory guidance that gently reminds some patients that their reliance on supports and resources within the community and the health system may increase over time. In this way patients may align their expectations regarding their prognosis with the knowledge of the interprofessional team member. “Making suggestions” is also a strategy of care planning that explicitly involves the patient and incorporates patient preferences at a juncture that is early enough in the patient’s illness trajectory that the patient can be actively involved in decision-making about their future care.

Finally, interprofessional team members engage in practices of connection by “checking in” with patients. This is a practice that intentionally incorporates the temporal variation of involvement in patient care with the interprofessional team. It is also the practice that most clearly identifies how an interprofessional team can provide primary health care.
“Checking in” might be by phone or in person, and with one team member visiting to report back to the broader team, or the patient may receive a visit by multiple interprofessional team members at once. The purpose of “checking in” might be to assess how the patient is tolerating changes to medication, if the safety bars installed are being used correctly, or if family members have fulfilled their promise to the homebound patient of dropping off groceries. During these “check ins”, interprofessional team members assess the patient’s particular situation and engage in therapeutic dialogue to help determine what intensity, duration, or type of care may be required at a particular point in time. The variability of these encounters attest to the abilities of the interprofessional team to be flexible and adaptive based on needs of patients, and to deliver responsive, comprehensive care that addresses many of the determinants of patients’ health. In this way the interprofessional team may be able to move beyond limitations of primary care to improve a patient’s health, and rather shifts care of the patient into the realm of primary health care.

The four situations described here demonstrate how team-based care goes beyond what was initially promoted to primary care providers by the health authority (Northern Health, n.d.) regarding services of the interprofessional team. In addition to performing the regular and expected functions of their roles, interprofessional team members can deliver primary health care. With a broad conceptualization of health understood in the context of a patient’s everyday life, interprofessional team members help to improve the conditions of a person’s particular situation in order to improve health outcomes.
Chapter Eight: Contributions of Knowing in Team-Based Primary Care

The preceding chapters have uncovered and explored how knowing patients and team members influences aspects of negotiating team-based primary care. The research questions of this study were addressed through distinguishing the detail of practices from the whole of team-based primary care. This final chapter will frame discussion in order to draw out implications of the study. How practices of connection facilitate key aspects of feeling known, and how these practices can ultimately influence team-based primary care attributes and outcomes, is the focus of this last chapter.

The key findings of this study revolve around feeling known and how knowing contributes to understanding who needs team-based primary care. First, although team members may already know one another, transitions or changes in practice structure and process can disrupt established relationships. Second, the way in which patients feel known, and primary care provider practices of knowing patients, influences how and when the interprofessional team may be involved in the patient’s care. This impacts how primary care is negotiated in terms of who is provided with team-based care.

The findings illustrate that even when primary care providers know patients very well, this information may not be shared with interprofessional team members. How primary care providers and interprofessional team members know and understand one another can influence what and how information is shared, which can affect how care is planned and coordinated. Finally, the results of this study help to illuminate how interprofessional team members know patients differently than primary care providers, and that while all professionals involved in a patient’s care establish therapeutic relationship through practices of connection, this is achieved differently based on the
role, function, duration, frequency, setting, purpose, and understanding of the relationship between a health care professional and patient. Understanding these nuanced differences helps to demonstrate how interprofessional teams can provide primary health care for and with patients through negotiation of team-based care.

To explicate these findings and explore implications, what follows is not an explanation or narrative, but rather interpretation of the circumstances uncovered in this study (Moules et al., 2015) in light of the areas of attunement for this research in addition to some of the principles of team-based primary care. Possibilities for future education, practice, and research are presented for consideration.

**Knowing the Team**

The findings of this research highlight the extent to which previously existing professional relationships can be disrupted by changes to role, organizational structure, and the process by which providers and team members interact with one another. Even when team members already know and like one another, when there is a significant change to the way in which different team members will perform their role, increased opportunities to informally and formally negotiate new relationship boundaries and understanding through conversations are necessary. When teams are not co-located, misunderstandings about the role or performance of team members can influence primary care provider practices in terms of connecting patients with the interprofessional team. These practices may remain unchanged for long periods of time when teams are not co-located, because there is little chance for or comfort with dialogue between primary care providers and team members to correct or address errors in interpretations of role, function, or expectations.
When providers and interprofessional team members do not know one another, there may be concern about involving an unknown professional in a patient’s care. Primary care providers wish to understand what the role, abilities, clinical judgment, and level of responsibility interprofessional team members have in sharing care for a patient. Not knowing team members may cause delays in involving the interprofessional team in a patient’s care, and it can affect what information is shared about the patient. Providers who know little about team members may feel hesitant to share sensitive patient information. A secondary issue is that providers who are uncertain of the specific role of different team members may be unsure what information is most relevant to assist the team in caring for the patient. These issues can significantly impact the timeliness and effectiveness of patient care, highlighting the necessity of providers and interprofessional team members being able to get to know one another in their professional role.

In contrast to not knowing, when clinicians understand “each other’s world”, it can enhance communication and information sharing. When team members know one another it increases the likelihood of informal dialogue amongst the team. While this seems a rather simplistic finding, it deserves special consideration when teams are not co-located, as opportunities for informal dialogue may have to be deliberately sought. In this study, there were few opportunities for the two “sides” of the team to learn about one another.

For continued planned implementation of interprofessional teams, efforts to encourage, plan, and allow primary care providers and interprofessional team members to learn and know about one another through a variety of mechanisms can be helpful. Ongoing opportunities for team members to have frequent, informal, shared
communication are critical factors to the success and sustainability of interprofessional collaboration and practice in primary care teams (Morgan et al., 2015). Joint visits (Brown et al., 2016), joint case conferences, and either planned or spontaneous drop ins at the primary care providers’ offices may be helpful to get to know one another’s strengths, preferences, and system of relevances (Wagner, 1970). When team members and primary care providers learn about each other’s ways of working in primary care, it becomes easier to understand what information about patient care is meaningful to different team members, and this can improve the relevance of information sharing or transfer in planning and delivering patient care.

In the context of early implementation of team-based primary care, issues of communication and feedback loops can be understood to be related in part to how clinicians know one another. It is anticipated and hoped that some of these issues resolve as team-based primary care becomes established, through the efforts of interprofessional team members and primary care providers to understand each other’s practice world. The implications and understandings discussed in the remainder of this chapter, however, are relevant regardless of the stage of primary care transformation. The discussion is now broadened to consider how knowing patients and understanding who needs a team can help to create and sustain a high quality primary care system.

**Knowing in the Patient-Provider Dyad**

People who feel healthy tend to take this state of being for granted (Gadamer, 1996). Through everyday living, individuals are socializing, working, playing, and engaging in other thinking and actions in an environment that helps them maintain health without even noticing. When this equilibrium becomes disturbed, health or ill-health is
noticed. People take action to restore health based on their capacity and agency to do so. Actions to restore health reflect a number of inter-related factors such as their perceived health status, their previous experiences with the health system, and their personal health practices (Andersen, 1995). Individuals in this study activated support systems, strategies, and/or resources to restore health, such as relying on friends or family, or engaging in health promoting practices such as attending a fitness class. These actions may satisfactorily achieve the goal of restoring or maintaining health. Alternately, an individual may seek primary care. Primary care is also a support and resource to people, but it is a formal entry to the health system, and this is where people transition to the role of patient.

The role of the patient is an alteration to the identity of an individual. Giddens (1991) suggests securing identity begins with the formation of basic trust. Being able to trust is a safeguard against chaos, and creates a framework for ontological security (p. 44). This security and trust in the world is reinforced through ritualistic day-to-day life, so that our daily routines in effect offer coping mechanisms through which we are able to socially manage our anxiety about the world (Giddens). Trust is a social practice (Solomon & Flores, 2001). Through this lens, it can be appreciated that the primary care encounter is a unique situation that may be rife with uncertainty for an individual in the role of patient, yet it is seldom explicitly considered in this way in everyday practice. Issues of trust and identity influence care-seeking practices of patients, for example Adam, who sees his primary care provider only if he has physical injury.

In establishing self-identity, individuals maintain a particular narrative (Giddens, 1991): who they are, the roles they enact, and the memberships they have in their various
communities. Schutz identifies these components as an individual’s *biographically determined situation* (Wagner, 1970). In attending a primary care encounter, these components, represented by both ontological security and self-identity have the potential to be threatened or disrupted.

For many individuals, deciding to consult a primary care provider about a particular concern is not part of routine day-to-day life. This in itself may cause an increase in anxiety, and anxiety may be exacerbated if the primary care provider is a relative stranger. Based on the work of Giddens (1991), it then becomes necessary to achieve trust, so that anxiety can be overcome, ontological security can be re-established, and the encounter can be productive. These findings were echoed in this study through Diane’s interview, as she discussed the process of her decision-making that led to disclosure of her eating disorder.

The tensions that were navigated in the primary care encounters in this study include protecting or continuing a self-narrative, managing power imbalances, and maintaining or projecting a particular role and identity. These tensions are complex, yet tend to be completely taken-for-granted, and remain covered up in most patient-provider interactions. The potential for these complex tensions to be uncovered or addressed within a patient-provider encounter are determined by the tasks of achieving trust and maintaining the patient’s ontological security through therapeutic dialogue. This was observed throughout the patient-provider encounters of this study, for example the way in which Isaac talked with his patient about her alcohol use to help her sleep. The way in which primary care providers engage in conversation with patients to help patients feel known may be central to determining not only the outcome of a single visit but also
subsequent plans for seeking care and attempts of the patient to maintain or restore health.

While it has been previously acknowledged that patients desire a trusted clinician who knows them well (Cheraghi-Sohi et al., 2008; Phillips-Salimi et al., 2011), the practices that providers engage in with patients to help patients feel known have been largely overlooked. In this study, patients identified four qualities embodied and enacted by physicians that contribute to feeling known. Patients who feel known describe that their physicians display a personable manner, patients are treated as partners to the extent they wish to be included in their care, the physician discloses some amount of personal narrative during an encounter, and the personhood of patients is acknowledged through methods of inquiry into, for example, hobbies or family. These qualities can be understood as a way of knowing through conversation to validate identity as part of the social practice of the primary care encounter. Practices of connection enacted in part through language and conversation demonstrate particular skills that are experienced by patients as patient-centred practices that can help to relieve uncertainty and facilitate provision of high quality primary care.

In analyzing how these four qualities enacted through practices of connection may be important precursors to delivery of high quality primary care, further examination is required to articulate how knowing in the patient-provider relationship can have implications towards improving core attributes of primary care: access, comprehensiveness, continuity, and coordination. These attributes are selected as they represent key pillars of the GPSC (2016) PMH model, and remain the pillars that can be directly influenced through patient-provider encounters. Others have identified equity as
an important attribute of primary care (Haggerty et al., 2007; Wong et al., 2014), and although it is not included in the PMH model, equity is included here to capture some of the significance in thinking about who may benefit from interprofessional team-based care.

If knowing patients is considered a starting point, and improving health outcomes and patient experience is the desired end point, the space between these points is the patient-centred primary care encounter. This study, with its focus on practices, allowed for direct observation of the negotiation of primary care. The primary care consultation transpires whereby aspects of patient satisfaction and improved outcomes at an affordable cost are determined while providing the patient some degree of access, comprehensiveness, continuity, equity, and coordination of care.

**Access**

Access is not foregrounded in this study, although the care-seeking practices (Andersen, 1995; Andersen et al., 2011; Dunn, Hammond, & Roberts, 2009) of patients are taken under consideration in terms of acknowledging how patients may activate their own “team” that may or may not initially include primary care providers when seeking to restore or maintain health. For patients who seek primary care at the office of the primary care providers of this study, access is addressed through offering same day appointments and longer time slots for those with complex needs. While this approach may have originated as a way to improve efficiency of the practice, there is an equal benefit to patients. This approach to booking in conjunction with MOAs who know the patients well helps to accommodate patients who may have preferences for particular times of day or difficulties such as securing transportation to and from the office.
Although patients of the primary care provider office in this study followed the established routine in the community of accessing either walk-in, after-hours clinic, or the emergency department when the office is closed, it is notable that patients of these providers did not wait days or weeks for appointments. A shorter wait for patients to access their regular primary care provider has potential health system benefits, as patients do not need to delay care-seeking to the point where they become so unwell they must seek help through the emergency department. In terms of patient satisfaction, on the day of their primary care appointment, patients did not languish in the waiting room long past their appointment time to see their provider. The role of the MOA, the structure of the practice, and the process of seeing patients may help patients feel their time is of value, and can improve patient experience in primary care. This in turn impacts future decision-making about care-seeking and personal beliefs in the value of including the primary care provider as part of the patient’s “team” in helping to restore or maintain health.

**Comprehensiveness, continuity, and patient-centredness**

The pillars of comprehensiveness and continuity are tended to within the patient-provider encounter. The degree of comprehensiveness of care and continuity is related in part to therapeutic relationship (Hjortdahl & Laerum, 1992; Hjortdahl & Borchgrevnik, 1991; McWhinney, 1998). Therapeutic relationship can be understood to develop in the context of an encounter where the primary care provider embodies the four qualities identified above by patients as contributing to feeling known: Primary care providers are personable, they treat patients as partners, they disclose or are willing to disclose some personal narrative, and they are interested in the patient as a person. Skill in enacting these qualities through practices of connection can help to create conditions for further
therapeutic dialogue that may result in therapeutic relationship being established, however these practices alone will not necessarily result in a therapeutic relationship being established or maintained.

The second question of this research concerned how therapeutic relationships between patients and primary care providers can be developed and sustained. The findings of this study indicate that therapeutic relationships that incorporate key features of being safe, longitudinal, and patient-centred may rely on consistent and intentional aspects of therapeutic dialogue. Specific features of effective therapeutic dialogue used by primary care providers that were observed in this research include: asking patients specific questions about their habits, hobbies, and preferences; not only seeking causes but asking about reasons; not “glossing” over patient statements; apologizing for misunderstandings; willingness to address sensitive topics or issues; not interrupting if the patient is tangential; using a conversational style versus a rigid interview style; asking about the patient’s goals.

Practices of connection that foster therapeutic dialogue are valuable to assist providers to successfully integrate components of the patient-centred clinical method (Stewart et al., 2014) into primary care encounters. As such, exploring health, disease, and the illness experience; understanding the whole person; and finding common ground (Stewart et al.) can be achieved through practices of connection that foster therapeutic dialogue. The features of therapeutic dialogue rely on the primary care providers’ use, choice, and timing of language, and can serve to incorporate the fourth component of the patient-centred clinical method, which is to enhance the patient-clinician relationship (Stewart et al.).
The nuance or prominence of particular features of therapeutic dialogue is expected to be different with different patients. Engaging in therapeutic dialogue relies on the interest and ability of the primary care provider to have a genuine conversation with the patient. Gadamer (1960/2011) described how people fall into conversation without knowing in advance what might come out of it, and that “a genuine conversation is never the one we wanted to conduct” (p. 385).

Therapeutic dialogue requires primary care providers to consider their own biases and agenda for a primary care encounter in order to meaningfully interpret what the patient says. The possibility for therapeutic dialogue to take place calls on the skill of the primary care provider to enact the features of therapeutic dialogue as well as the ability to remain open to what the patient is saying. When the patient’s agenda is addressed in a way that helps alleviate a patient’s uncertainty about their health or the reason for their visit, understanding can be reached and care can effectively be planned to assist the patient to restore or maintain their health.

The way in which primary care providers remain open to a patient during a primary care encounter is through consistent application of clinical judgment in tangent with their stock of knowledge at-hand (Wagner, 1970), which includes the different types of knowledge a primary care provider has at-hand in a given situation. Drawing on these ways of knowing, primary care providers are distinguishing and choosing among possibilities (Gadamer 1960/2011) in how the patient’s particular situation addresses them. Through conversation, primary care providers are seeking to understand the salient details of a patient’s circumstances and history at a particular point in time. Primary care providers must choose when to be silent and when to probe, whether to explore multiple
issues or prioritize among issues. These decisions are made in light of the primary care provider’s horizon in terms of past experiences with the patient, the overall structure of the provider’s day, such as time pressures, and other internal processes, such as energy level or feeling hungry, or being pre-occupied with a previous patient’s issues.

The information that is uncovered by a primary care provider within a primary care encounter must be sorted and requires rapid decision-making as well as demonstrating some type of reaction to the patient. This process of distinguishing does not conclude with ending the conversation with the patient, but carries through to help determine an appropriate plan of care for the patient that must take into account best available evidence, patient preferences and choices, as well as other system and context factors such as health benefit coverage and availability of specialized resources.

Through the unfolding of these complex features taking place within a primary care encounter, primary care providers engage in practices of connection through which patients determine whether or not they feel known. Feeling known can influence what patients choose to disclose in a visit. This in turn affects how primary care providers engage in therapeutic dialogue, and determines the extent to which genuine conversation may occur. Genuine conversation has the potential to further help patients feel known and resolve uncertainties about their health. Genuine conversation resulting from therapeutic dialogue fosters therapeutic relationship, and over time, therapeutic relationships can contribute to improving key aspects of primary care for patients, such as comprehensiveness and continuity.
Coordination

Coordination is the fourth pillar of high quality primary care that can be directly influenced by patient-provider interaction. While all the pillars discussed in this section are inter-related (e.g. access will influence continuity), it is continuity, especially management and informational continuity, that most directly overlap with coordination. Informational continuity underpins coordination (Banfield et al., 2013), which is why effective, timely coordination of team-based primary care is connected to primary care providers having a therapeutic relationship with patients. Ongoing therapeutic relationship helps to foster better understanding of a patient’s situation over time, and this allows more information about the patient, in areas beyond the biomedical realm, to be known. It is this information that will cue the provider to identify when team involvement is necessary, and it is the information that can be shared with the team to help coordinate care. This research helps to articulate how therapeutic relationship impacts coordination of care.

Over time, coordination has been devalued at the expense of disease management (Bayliss, Balasubramianian, Gill, & Stange, 2014); another indication we may have allowed the evidence-based medicine paradigm to dominate too much of the planning and delivery of primary care. This is beginning to shift, however, as there is increasing realization that multiple chronic conditions cannot be treated in one patient as distinct occurrences, and as the need for team-based care increases. With more attention to coordination, there have been numerous attempts to define it, and debate continues over how to measure it (Schulz et al., 2013).
For the purposes of this discussion, coordination is defined as the “deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care” (McDonald et al. 2007, para 1). This definition is chosen in part because it is being used by Northern Health as attempts to improve coordination in primary care are undertaken.

Primary care providers in this study, who are the gatekeepers to the interprofessional primary care team, must make decisions not only when to involve the interprofessional team, but also what information to share. Coordination is not achieved passively by simply having the right information. The appropriate and timely sharing of information relies on the practices of first the primary care provider, and then the interprofessional team.

It is noted that patients experience continuity as opposed to coordination; when patients feel confident and supported, they assume clinicians involved in their care are communicating (Haggerty et al., 2013). It is only when there is a disruption experienced that patients become aware that clinicians may not be sharing the relevant information (Haggerty et al.). Both these situations were experienced by patients in this study.

As the supports and resources offered by primary care providers are increasingly optimized by patients who require more support, the interprofessional team will likely become involved in the patient’s care. In team-based primary care, involvement of the interprofessional team is an occurrence necessitating coordination and sharing of
information. Here we see that coordination hinges not only on what information is known, but also what is done with it.

In coordinating care, patients do not expect their care to be seamless (Haggerty et al., 2013). However, involvement of the interprofessional team represents a transition in care for the patient. Thus, it is timely to elucidate some discussion about how knowing patients and team members can influence negotiation of primary care, particularly in terms of coordinating care within an interprofessional team.

*Information in transition*

Data collected for this research took place during the early stages of implementation of Northern Health’s first interprofessional primary care teams. Structurally, many issues impeded transfer and sharing of information. Some of these issues, such as the interoperability of the nine information systems used in various primary care settings, continue to be pervasive and will require prolonged efforts to reconcile and resolve. Other issues, such as inconsistent feedback loops, and the Service Request process, are persistently monitored and evaluated with efforts to improve the process over the short term. These issues are a reminder about how structures and processes do significantly impact practices of documentation and information sharing.

When the primary care provider and patient make a decision that it is time to involve the interprofessional team, information about the patient is transferred to the interprofessional team. The word “transfer” is more appropriate than “share” in this case, because the information moves from one “side” of the team to the other without interpersonal involvement. There is very rarely a conversation between the primary care provider and interprofessional team to give context to the information or to augment the
information that is written down, as can be observed in “hallway consultations”, for example, to discuss unarticulated concerns. Instead, the information transfer is passive.

The practices of primary care providers recording information to be transferred to the interprofessional team are widely variable, despite the designated process of the Service Request. Forms and processes alone cannot change practices. This may be particularly true when the impact of practices, e.g. transferring inadequate or insufficient information, remains invisible to the practitioner.

Rather than attempting to name a cause of inadequate information transfer, this research helps to articulate some of the reasons why the information transfer process does not consistently facilitate coordination of care. These reasons are identified primarily by observing practices. Although the issue that primary care providers and interprofessional team members have little chance to share information through conversation is important, there are other reasons contributing to poor informational continuity, that influences coordination of primary care. One reason is time constraints; when primary care providers fill out a Service Request quickly between seeing patients, the information that is written, selected, or “tagged” to be included with the Service Request may be less compared to when providers do not feel rushed.

Patient privacy is another reason primary care providers may avoid including some patient information, particularly around topics usually considered sensitive, such as finances, or family dynamics. Complicating this issue is if the primary care provider does not know the team member well; there may be additional concern about how the team member might incorporate this information with the patient, and the provider may wish to avoid the patient’s dismay or shock realizing a team member the patient has not met
before is privy to intimate details of his life. The obverse to this, of course, is that issues of financial capability, or difficult family dynamics, frequently prompt team involvement in the first place. Much of the guessing and uncertainty about what might happen to information that is transferred could be eliminated with conversation between primary care providers and team members.

A final reason that inadequate information may be transferred to the team, which is to say the information is known by at least the primary care provider but not shared with the team, comes from a distinct manner of making decisions about sharing information pertaining to a patient’s care. The primary care provider may not include information that a patient, for example, copes with an adult son who drinks too much and refuses to move out. This type of information may rarely be the sole focus of a primary care visit, and so while a primary care provider may be aware of this dynamic, it may be information that fades to the background of the primary care provider’s awareness and is not included on a Service Request. Yet for an interprofessional team member who will visit the home, knowing that the son lives at home or may be intoxicated during a visit is information that is desirable to receive in advance of a visit to the home.

This last reason helps to explicate why the ability of providers and interprofessional team members to “know each other’s world” is fundamental to coordinating care. Primary care providers rely in part on clinical judgment to distinguish between all the information they know about a patient to discern what might be the most useful information for the team to receive, rather than framing it as the most useful information that can be provided from the primary care provider’s perspective. To provide coherent and connected care, especially for a patient transitioning from primary
care to team-based care, understanding and providing the information another team member would find useful and pertinent is important. In other words, primary care providers may need to learn to think like a team member.

Sharing information that is most relevant to the team member who will see the patient next can be applied bi-directionally. As team members become involved in a patient’s care, they will need to determine what information the primary care provider may find helpful in planning and staying updated about the patient’s ongoing plan of care. It can be expected that there may be both principles to guide understanding of sharing relevant information within a non-co-located team, and also idiosyncrasies. This is to say that while most team members will appreciate relevant social information about the patient to be shared, there may be some team members who believe it does not change their approach. Similarly, while most primary care providers wish to be apprised of changes or new information regarding a patient’s health or plan for care, there will be some who prefer to ask the patient themselves.

To address the idiosyncrasies so that care can be optimally planned and coordinated, clinical leadership is required to establish principles for sharing information, as well as to persistently ask what is best for the patient. Principles to sharing information can guide a process to facilitate practices so that patients do not have to repeat their story or receive conflicting advice. This will help ensure care is coordinated and patient-centred, rather than sharing information based only individual team member or primary care provider preferences.

When the interprofessional team becomes involved in the care of a patient, it is not only the practices, but also the timing of information transfer that facilitates
coordination. When a primary care provider sends a request for team involvement it must contain adequate information, but it is also beneficial, when possible, to send the request at a time before the patient deteriorates or is in crisis. If the team meets a patient for the first time when the patient is in crisis, it is very hard to get to know the patient, there is no “baseline” to evaluate to what degree a patient is returning to “his old self”, and making sense of the plethora of information that is usually forthcoming when a patient has a health care crisis is time consuming. If the primary care provider is able to anticipate that team involvement may be necessary in the future for a patient, it is prudent for the primary care provider to consider the timing of this information transfer. With adequate advance notice, the primary care provider, interprofessional team, and patient may be able to more deliberately prioritize and plan for increasing care needs in the future.

When informational continuity is not maintained, the consequences can affect patient experience, engagement, and outcomes. These consequences may be amplified when the patient is in transition, between receiving care within the patient-provider dyad, to participating in care as as part of an interprofessional team. Appropriate clinical judgment and decision-making when applied to coordination of care, means knowing and selecting the information that is relevant to the team member(s) receiving the patient and sending the information at a time before the patient is in crisis, when possible.

**Equity**

Provision of equitable care in a patient-provider encounter can be a natural outcome of comprehensive, continuous, and coordinated care. With adequate understanding of patient circumstances, providers can identify inequities and take action to address them. This is one way that involving an interprofessional team helps to
improve equitable care. When primary care providers recognize, in a timely way, which patients need more in terms of supports and resources, team involvement can be facilitated so that patients are able to receive increased service and care, to help reduce disparities in health.

This section has illuminated how practices of connection, knowing patients, and establishing therapeutic relationship through therapeutic dialogue and genuine conversation influences the way in which five attributes of high quality primary care can be appropriately addressed as pillars within the PCH model. This process is illustrated by Figure 2, below.

Figure 2: How Practices of Connection Can Improve Primary Care Attributes. Author: E. Wilson
Figure 2 helps to illustrate the dynamic process whereby knowing patients influences how primary care can be negotiated within a dyadic relationship. The features described here are based on the findings of this study, and could be helpful within many patient-clinician relationships. However, a key difference in considering this Figure as representing the patient-provider dyad is how each feature: Practices of Connection, Helping Patients Feel Known, Fostering Therapeutic Dialogue, and Fostering Therapeutic Relationship, can be strengthened over time to improve delivery of primary care in a way that aligns with the key attributes of primary care: Access, Comprehensiveness, Continuity, Coordination, and Equity.

As patients and primary care providers know each other over time, the different features of the Figure may be reinforced or overlooked, and a change experienced by the patient in any of the features will affect the overall process, experience, and outcome. The process illustrated in Figure 2 represents how the relationship between the patient and provider, as well as the relationship between practices of connection and negotiation of primary care, are always “in play” (Grondin, 2015), and how many taken-for-granted features of knowing patients within a primary care encounter are inextricably linked to outcomes.

The way in which primary care providers know patients influences how decisions are made to involve the interprofessional team. This in turn greatly influences the way in which the PCH model is operationalized. Before shifting the discussion to explicate the care that team members provide within the PCH, it is prudent to consider how the PCH model could provide a very different type of care if the importance of knowing patients was overlooked or underestimated.
Not Knowing the Patient

In this study, the way in which primary care providers know patients is largely tacit. This is, in part, what makes the patient experience of care so nuanced. To explore how primary care experience and delivery can be affected when patients are not known, some barriers to knowing the patient within the primary care encounter are considered.

First, practices of connection can be impeded if a primary care provider’s clinical judgment is inadequate. Poor clinical judgment detracts from the provider’s ability to recognize what is salient about a patient’s situation, and this can hinder therapeutic dialogue. While there are many facets influencing how clinical judgment is developed and exercised, ranging from the personal, such as biases that clinicians bring to encounters (for example see Bloch, Rozmovits, & Giambrone, 2011), to structural, such as time pressures (for example, see Sharman et al., 2010), clinical judgment is rarely articulated in discussions of therapeutic relationship. It remains covered up and perhaps even devalued due to the predominant discourse of evidence-based medicine (Epstein, 1999; Peile, 2014). Understanding how to develop and maintain therapeutic relationship with patients might be better aligned with drawing on the same skills used to make a diagnosis versus setting it apart from the clinical reasoning process whereby patient feelings or expectations may be assessed, but not acted upon or incorporated into a plan of care.

The second barrier to knowing the patient in primary care is lack of attention to, or failure to recognize the importance of the therapeutic relationship. A recent news article featured Scott Robertson, a health researcher, claiming that access is more important than seeing the same primary care provider (Canadian Broadcasting
Corporation, Oct. 31, 2016). The access versus continuity debate is long-standing (Gerard et al., 2008; Haggerty et al., 2008; Locatelli et al., 2014; Stange, 2011). Delving into the claims made by Mr. Robertson, he draws on American examples of patients who seem to be accessing team-based care in a manner that is intended to address a demand/capacity gap, rather than provide patient-centred care. Specifically, patients might visit or call in to have a particular issue addressed but the “level” of the issue is addressed by the team member with the narrowest applicable scope of practice first. Only as problems are more complex or unresolved might they be “elevated” to the attention of a primary care provider. The argument made by Robertson is that this approach allows all team members to work to the full scope of their practice. Implicit in the article that is not transferable to many Canadian contexts is that these teams are likely very large, they are likely co-located, and they likely share an EMR or have high interoperability of their information systems. Assertions that primary care “tasks” might be delegated or otherwise spread out among different team members may not be applicable or desirable within the PCH or the PMH model.

Others have proposed similar solutions to improving team-based care delivery in ways that overlook the therapeutic relationship of the patient-provider dyad. Bodenheimer and Smith (2013) propose that non-clinician and non-licensed personnel are “seriously underused” (p. 1882). This statement is accurate in many ways, but the framing of the statement is worrisome. Bodenheimer and Smith suggest aspects of primary care such as education, coaching, medication refills, and other routine reasons for primary care visits can be tasks assigned to team members whether through standing orders or regulated scope of practice. They advocate for “kiosks” of treatment of
competent adults with uncomplicated urinary tract infections (p. 1884). No human effort required. This presents a number of new problems in the primary care environment.

If uncomplicated patients are “out-sourced” to team members who are not the primary care provider, there is a question of when do primary care providers get to know the patient. Waiting until they have multiple chronic conditions or are in crisis is not advantageous for patient or provider. Patients want to know that their primary care providers have a vested interest in them and know them, so that care can be tailored and meaningful. An approach to team-based care that neglects the primacy of the patient-provider dyad may initially reflect through metrics that it is high performing primary care, but it may not be high quality primary care. To increasingly ensure that the lowest paid and least educated members of the team spend the most time with patients is not equitable care. With this approach, comprehensiveness, continuity, and coordination may suffer.

The approach promoted by Bodenheimer and Smith (2013) is not a vision of team-based care to endorse; it is reverse-engineered primary care. Ensuring multiple people see patients for issues normally addressed within a patient-provider encounter is not effective team-based care, and prompts questions about how much primary care can be cleaved from a visit to be distributed through a multiple-provider model. Attention to the value of therapeutic relationship within a patient-provider dyad may lessen the temptation to chop primary care delivery into small pieces, and maintain the worthwhile pursuit of generalism (Reeve et al., 2013).

When circumstances impair the robust application of clinical judgment in a patient-provider encounter, or when the value of the therapeutic relationship becomes
covered up, patients experience care differently. Based on these findings in this research, strict attention to evidence-based medicine may be a barrier to genuine conversation within the patient-provider encounter. As patients develop multiple chronic conditions, time in an encounter may be increasingly taken up with attention to screening, explaining results of regularly ordered investigations, monitoring and adjusting treatments according to evidence. There is likely a trade-off between adhering to evidence-informed practice and knowing a patient by, in part, exhibiting qualities such as expressing interest in the patient as a person.

To resolve such quandaries that may in fact contribute to moral distress (Pauly, Storch, & Varcoe, 2011) or personal dissatisfaction with the role of primary care provider (Bodenheimer & Sinsky, 2014), Greenhalgh, Howick, & Maskrey (2014) offer important advice about “real” evidence-based medicine. Real evidence-based medicine asks, “what is the best course of action for this patient, in these circumstances, at this point in their illness or condition” (Montgomery in Greenhalgh et al., p. 3). Real evidence-based medicine tends to ethics and morality, finding out patient values and preferences, and takes patient agency into account (Greenhalgh et al.). Rather than adherence to the “rules” of evidence-based medicine, real evidence-based medicine includes application of judgment, imagination, and common sense, while valuing continuity, empathy, and the patient-provider relationship (Greenhalgh et al.).

The suggestions offered by Greenhalgh, et al. (2014) demonstrate the possibilities of incorporating both evidence-based medicine and therapeutic relationship into encounters with minimal trade-offs. The ability to draw on sufficient clinical judgment to
achieve this balance appears necessary. Accomplishing this may be challenging for many primary care providers, yet evidence of these skills are reassuringly present in this study.

Regardless of the type or cause of the barrier that may hamper knowing the patient, the consequences are two-sided. First, the patient may feel known to a lesser extent. This in turn may influence care-seeking practices, or what the patient chooses to disclose during an encounter.

The second consequence of not knowing patients well is that the primary care provider will understand less about the patient. Decreased awareness of patient agency, resources, supports, or interests will result in a different understanding of the patient’s health. This may then delay the involvement of the interprofessional team, particularly if the issue is primarily in the social realm of health. Further, care plans for the patient may be less robust, with less tailoring to the patient’s preferences and values. When the primary care provider is not fully aware of the patient’s circumstances, less information will be available to share with the team.

Practices of connection that are limited by inadequate clinical judgment, poor therapeutic relationship, or over-emphasis on biomedical aspects of the patient’s presentation can prevent comprehensiveness, impair continuity, and impede coordination for the patient to receive team-based primary care. In addition to provider-level attributes, structural attributes that devalue the patient-provider relationship can also shape the way primary care is negotiated and delivered, as with models that seek to divide aspects of primary care among numerous clinicians. In this study, however, practices of connection in the patient-provider relationship and the structural reforms informed by characteristics of the PMH and the PCH model led to the interprofessional team being involved in a
particular way, that can best be articulated through describing how team-based primary care is offered and delivered to patients.

**Team-Based Care**

Initial access to the interprofessional team for patients in primary care is through the primary care provider. Considering the patient’s journey between encountering ill health and seeking care, Andersen’s (1995) Health Belief Model helps draw attention to how patients engage in restoring or maintaining health prior to seeking primary care. Andersen’s model highlights how it is the patient’s perceived or evaluated health status, predisposing characteristics, or personal practices that influences care-seeking. This is true in describing how patients access primary care services. However, the decision to seek care from an interprofessional team is a step beyond accessing primary care. Thus, it becomes the primary care provider’s perception of the patient’s status, the provider’s predisposing characteristics, and the personal practices of the provider that primarily determines team involvement for the patient. This is one reason it may be of increasing necessity to uncover practices and decision-making of primary care providers, towards improving the effectiveness and understanding the operationalization of team-based primary care.

Access to the interprofessional team is requested for a wide variety of reasons. It would be misleading to only identify what is written on the Service Request to summarize why interprofessional teams become involved in patient care. While some of the Service Requests do hint at the complexity involved with the patient’s care, others might simply read “help with meds”, or “Lifeline”. The key to understanding who needs a team is looking beneath these requests to consider why the patient requires help with
their medication or the Lifeline service installed. During the period of data collection, the interprofessional team regularly addressed issues of guardianship, power of attorney, housing, disability, uncontrolled disease, decreasing competence, financial capability, mental health, addictions, self-care, home support, family dynamics, medication interactions or side effects, mobility, differing levels of service involvement for different diagnoses, transportation, and safety.

The interprofessional team addresses all aspects of health, understood broadly to incorporate medical and social dimensions. The interprofessional team becomes involved to assist patients through major transitions in recovering or maintaining health, and sometimes in the transition of increasing burden of illness to death. Thus, the patients who need a team are those who are no longer best served by delivery of high quality primary care; the answer to who needs a team is those who require primary health care.

This understanding of team-based primary care as part of a primary care home sets the interprofessional team deliberately outside the patient-provider dyad. This can result in more appropriate use of the interprofessional team versus a model that advocates for many primary care services such as medication refills or coaching or chronic disease management to be performed by the team and not the primary care provider. The interprofessional team is not an extension of the primary care provider, implemented to relieve the burden of the primary care provider in caring for complex patients. Rather, the interprofessional team is an added layer of skill and expertise that is poised in the community setting to help patients with complex co-morbid conditions continue to care for themselves by addressing health issues that can extend far into the social realm.
To further consider how patients and providers negotiate team-based care, and explicitly the transitions between primary care and primary health care, Figure 3, below, may be helpful. This figure represents team-based care as it was interpreted in this study, and highlights features, such as patient agency, that are not captured in the PCH model.

Figure 3: Patient Resources for Health and Health Care. Author: E. Wilson

Figure 3 illustrates the essential feature of patient agency as it influences the patient’s ability to access supports and resources prior to contact with the formal health system. When patients do not have health, before they are able to engage with supports and resources that are available to them, which may include their primary care provider, the patient must have agency to meet the level of engagement required. In this way, it is first patient agency, and then the availability of supports and resources that can influence when and why patients seek primary care.
Considering how patients define “team” in relation to what helps patients restore and maintain health, Figure 3 attempts to represent why upstream initiatives outside the formal health system to assist patients need to be of continued interest and investment to health care planners. Helping people to develop and optimize both their own agency, as well as formal and informal supports and resources, such as sense of belonging and community, stable housing and employment, or friendships and hobbies, can help individuals maintain their health, sometimes without entering the formal health system. Such initiatives can also bolster primary care services in terms of primary care providers having a greater pool of resources and supports to draw on, to help patients with limited agency or awareness of available resources that may help to restore health. A population orientation is necessary to conceptualize and operationalize a successful model of primary care.

Next, Figure 3 illustrates primary care as a service that can be delivered in conjunction with patients drawing on their supports and resources. Primary care also overlaps with care provided by the interprofessional team, yet primary care providers remain on a distinct “level” within the Figure. In part, this is to distinguish that not all patients need an interprofessional team, and many attributes of high quality primary care can be delivered by the primary care provider in the context of therapeutic relationship with patients who feel known.

Although numbers of patients with multiple chronic conditions are expected to increase over time, the levers to ameliorate the complexity that these patients will present to primary care providers should not be such that they disrupt the longitudinal therapeutic relationship between a patient and their primary care provider. Rather, efforts to increase
job satisfaction of primary care providers are necessary. These efforts do not necessarily need to be tied to financial incentives (Denis et al., 2013). Systems that reward through provision of external goods “risk undermining those goods internal to the practice and ultimately the practice itself” (Kesselring et al., 2010, p. 8). Primary care providers are most satisfied when they believe they have done well by their patient (Bodenheimer & Sinsky, 2014), and when they are able to be part of patients’ lives over time (Stange et al., 2014).

To preserve the value of knowing patients and therapeutic relationship, efforts could instead be directed towards removing or re-assigning tasks that are not associated with direct patient care, and allowing for increased time to engage in activities primary care providers find meaningful (Halvorsen, Edwards, Aaraas, Aasland, & Kristiansen, 2013). Future research might further examine what practice-level activities primary care providers do or do not find meaningful. Direct observational methods may be valuable in these endeavours (Epstein, 1999; Morgan et al., 2015), to uncover the real time spent on activities such as coordination or information transfer. Results from such researches can help inform meaningful structural changes at an organization level.

Observation of practices can also assist in understanding how primary care providers make decisions about how and where to spend their time in everyday practice. Cognitive science has a role in primary care research. Future studies can help to explicate practices that contribute to primary care provider satisfaction, as well as uncover decision-making processes involved regarding involvement of interprofessional teams.

To return now to the last “level” of Figure 3 is to turn attention to the interprofessional team. The interprofessional team becomes involved when the strategies,
supports, and resources pooled by the patient and primary care provider no longer suffice to help the patient maintain or restore health. Figure 3 illustrates that the interprofessional team is not an extension of the primary care provider office. The interprofessional team is a group of professionals who provide care to the patients who are the most complex and require the most in terms of time and service. The time and resources it takes to provide primary health care to patients with complex health and social needs is an alert to again recognize that the more that patients can be helped to maintain or restore health earlier in their illness trajectory, the more capacity there will be for the interprofessional team to care for those who are unable to achieve this.

Capacity within the interprofessional team is a significant concern. Beginning with the initial Service Request, interprofessional team members begin the work to distinguish the care the patient will require. When there is insufficient information transferred via the Service Request, team members will spend extra time attempting to create a clinical picture of the patient. Information being sought from one another or those on the team who might already know the patient is centred on understanding patient agency, and access to or use of existing resources and supports.

Questions the interprofessional team members may ask one another as they plan care for patients are inquiries that focus on understanding patient agency, which demonstrates team members’ use of clinical judgment to inform their assessment of how patients may be able to engage in care that is planned or offered. Second, these conversations indicate how the interprofessional team is able to work as a team, synthesizing information to refine and improve coordination of care for the patient. Yet,
increased demands on the team that decreases capacity negatively influences these practices.

The interprofessional team have knowledge of one another’s roles, areas of expertise, and preferences. The practices of team members that are a result of knowing one another contribute to improving attributes of primary care for patients. The patient has an access point to an interprofessional team member, often through the team member visiting the patient at home. Comprehensiveness is improved when the team member is able to inquire about the patient’s health or function outside the team member’s particular scope, such as when the occupational therapist asks a patient if they are managing their medication, or when the mental health clinician notices there might be a fall risk for a patient. This in turn facilitates management continuity, as the team member can share the information learned during the visit with another team member to determine if further action is necessary. The resulting plan of care is then coordinated for the patient, and it is done so in an anticipatory manner, for example when the occupational therapist can visit the patient to help install a raised toilet seat before the patient falls.

The practices enacted when team members know one another are muted when interprofessional team members are overwhelmed with high patient volume, as the findings of this study demonstrate. This may have a lasting deleterious effect on the confidence and competence of the interprofessional team to fulfill their roles and meet patient care needs effectively. Increased demands on the interprofessional team for service from primary care providers raises questions about the appropriate duration and intensity of team involvement in patient care. While there have been some initial studies to examine what the appropriate panel size for a primary care provider might be
(Muldoon, Dahrouge, Russell, Hogg, & Ward, 2012), there is scant literature to guide thinking about empanelment of patients for interprofessional primary care teams, or how team members might optimally structure their workday or plan to see patients. For example, there is work underway to help identify patients at risk for frailty by Wong, Williamson, and Katz (BC Primary Health Care Research Network, 2016), but this may be of marginal benefit to interprofessional teams such as the one in this study, given that a significant amount of team member resources are used to address mental health and social issues of patients, who may also be frail. Problem-focused identification of patients suitable for interprofessional team involvement may be of limited helpfulness in identifying the actual scope of work required with many patients who have multiple chronic conditions.

When patients become involved with the interprofessional team, it is between the patient and team member(s) to determine the length and intensity of team involvement; the primary care provider is minimally involved in this negotiation. However, as demands on interprofessional team members increase related to patient volume and need, team members are distressed about the type and amount of care they want to offer patients, and what they are able to provide. As demand outstrips capacity, questions about repatriation to the primary care provider arise. There is again very little evidence to inform coordination of the patient’s transition from an interprofessional team when it is determined that the patient’s health is restored to a degree that primary care services, rather than primary health care services, will suffice.

If health is not restored, and ongoing interprofessional team involvement is required, further questions arise about the nature of therapeutic relationship between
patient and team member. Considering the features of therapeutic relationship within the patient-provider dyad, there are different structural influences to examine within longitudinal therapeutic relationships between team members and patients over time. First, interprofessional team members are unionized employees of the health authority. As such, high turnover within and throughout interprofessional teams is expected and is already taking place. This impairs the development and maintenance of therapeutic relationship between patient and team member over time.

The second structural aspect that maintains differences in therapeutic relationship compared to the patient-provider dyad is the functionality of the EMR. The overarching care plan for each patient resides in the patient’s PCH, where primary care providers are located. Thus, while interprofessional team members may be closely involved in the care of a patient, it is intended to be for an aspect of the patient’s care, such as mental health. Attending to just one or two aspects of a patient’s care may not be how the interprofessional team functions in practice, yet interprofessional team members do not have access to all other components of the patient’s care plan. For example, care or advice provided by specialty services, or care provided by the primary care provider, is not easily available to the interprofessional team unless it is explicitly shared by the primary care provider. Based on these two structural influences, and the amount of information that can be gained or lost through staff turnover or the way information is stored affects how team members know patients in a therapeutic relationship. Some of the features of therapeutic relationship may be more difficult to attain for interprofessional team members compared to a primary care provider with a stable practice over many years and access to a fulsome longitudinal record of the patient’s care.
The transition of repatriation from interprofessional team to primary care is of special interest to interprofessional primary care teams, because the information that is learned about a patient and known by interprofessional team members may be very helpful to primary care providers, yet there is not always a clear understanding or process to share this information. This situation is complicated for teams that are not co-located because primary care providers and interprofessional team members have little opportunity to have conversations with each other. Of particular interest in terms of knowing the patient is the fact that interprofessional team members commonly see patients in their home environment.

A change in setting or context of care frequently offers up new information about the patient’s situation that could change how decisions are made for the patient’s care, yet primary care providers may be unaware of information or changes to the patient’s situation as assessed by interprofessional team members. Further work to refine processes of information sharing beyond the time of initial interprofessional team involvement is necessary. Feedback loops and information sharing during intervals of team involvement and during any transition (Haggerty et al., 2013) are essential for primary care providers to be able to maintain understanding of the patient’s situation.

Patient participants in this study had minimal opportunity to interact with the interprofessional team as it was so newly implemented. As more patients have access to team-based care, further inquiry into patient experiences of feeling known and sustaining therapeutic relationship with team members, as well as outcomes of team-based care, will be useful to determine future health service planning and delivery. The family experience will also be important to consider in future research, as many patients of the
interprofessional team can be expected to be quite ill and may not be able to report fully about their experiences or satisfaction with team-based primary care.

As interprofessional primary care teams continue to be implemented in Northern Health and elsewhere, vision and intent is required at an organizational level to promote the sustainability and effectiveness of these teams. With ongoing concerns about capacity and demand, it may be tempting to address these concerns by limiting or restricting the activities of interprofessional team members through policies and protocols. The risk of implementing protocols to guide a health care professional’s practice is that knowledge can no longer be applied to the concrete case. Instead, a protocol is designed to ensure the same care is provided uniformly to all patients.

Limiting the ability of interprofessional team members to engage in situational decision-making erodes the equitable base of primary health care. “As all work in modern life becomes organized as a business, increasing rational forms correspond to neglected ability and autonomy of formation of judgment and action … The more strongly the sphere of application becomes rationalized, the more does exercise of judgment along with practical experience in the proper sense of the term fail to take place” (Gadamer, 1996, p. 17). In health care, proper exercise of judgment cannot be over-estimated as it is a base from which practices are developed and enacted.

One reason it can be tempting to organize and standardize processes that might otherwise be determined through professional judgment is that it offers a means to cope with uncertainty. As the health care system and patient needs become increasingly complex, seeking approaches to reduce uncertainty may be appealing to patients, providers, regulators, and health care planners. Current thinking and approaches,
however, tend to land within an existing paradigm that continues to embrace positivism. As such, adherence to evidence-based guidelines, benchmarking against performance measures, and treating disease-specific conditions are dominant practices within our current system to attempt to address uncertainty and reassure ourselves that we are doing the right sorts of things, even if outcomes do not reflect the cost or intensity of such efforts.

The findings of this study draw attention to aspects of negotiating primary care that are already in place, but have not been articulated very well or paid as much attention in current primary care research or practice. Through practices of connection, this research illuminated how feeling known, and the development of therapeutic relationship can facilitate understanding of the way team-based primary care is negotiated. The findings of this research explicate the value and implications of knowing patients and knowing one another as part of an interprofessional team.

Practices of connection help people to feel known. Feeling known creates space for genuine conversation, and through genuine conversation relationships can be maintained that help address uncertainty during times of change and transition. Feeling known also contributes to the way primary care is negotiated, in terms of how key attributes of primary care can be influenced, as well as guiding decision-making about who needs team-based care. Finally, the degree to which patients feel known and are able to maintain therapeutic relationships with their primary care provider impacts the type of care that can be provided by an interprofessional team. When patients receive comprehensive primary care from their primary care provider, interprofessional team members are able to address patients’ health and social needs beyond primary care, in the
realm of primary health care. Operationalization of the PCH model in this way may have benefits beyond the original conceptualization of the model.

**Lessons for Moving Forward and Summary of Implications**

The implications of this research summarized below may be helpful to health care professionals, educators, health care planners, and researchers. The implications are intended to be helpful to specific groups, however there are also several key lessons learned from this study that are of broad interest to those planning initial or next steps in implementing and integrating interprofessional teams as part of the PCH model. The lessons will be outlined first, followed by the implications.

**Key messages**

This study demonstrated how practices of connection help people to feel known. Feeling known matters for patients and within teams. For patients, feeling known influences decisions about when to seek care. Further attention to care-seeking practices of patients is needed. This may include redefining access to incorporate what patients may access in terms of resources for health at the community level prior to or in conjunction with accessing primary care.

Between primary care providers and team members, feeling known influences decisions about when to involve the team in a patient’s care, and when the patient might be repatriated to the primary care provider. In this way, feeling known can influence how patient-centredness, access, continuity, and equity are enacted in primary care delivery. Knowing team members also increases trust. Efforts to identify mistrust and address it while affirming professional identities can help team members and primary care providers to feel known, particularly during times of transition.
The ability of team members and primary care providers to know patients and one another is influenced by personal, organizational, and structural factors. These factors affect how information that is known about a patient is shared between team members. When team members are not co-located, there is risk for the gap between what is known and what is shared to widen, and intentional strategies to reduce this gap are necessary to improve coordination of care. Strategies can be multi-faceted but need to include face-to-face time for conversation between all team members.

Attention to skill mix within interprofessional teams is important, to balance experience and workload of individual team members. Ongoing evidence-informed evaluation of workload demands and the capacity of interprofessional teams is essential to measuring success and preventing team dysfunction. Critically, understanding of the teams’ anticipated and actual function is necessary.

To integrate interprofessional teams successfully, clear understanding of the primary care provider workforce is necessary, as team roles and function is influenced by the services requested by primary care providers. For teams with primary care providers who are experienced and provide full service primary care, interprofessional teams may be more likely to be called upon to care for patients who are medically and socially complex. Other primary care providers may anticipate drawing on the team to perform primary care tasks to “free up” the time of the primary care provider to attend to a higher volume of patients. These parallel views of team-based primary care are of philosophical and practical significance in terms of achieving transformation of a primary care system. Further discussion of shared vision in this area needs to take place to improve successful integration of team-based care.
Implications for health care professionals

Health care professionals working as part of an interprofessional team can engage in practices of connection with patients and one another. Practices of connection are evident in action, but also in language and text. Primary care providers and team members can be intentional about planning opportunities for conversation, both formal and informal. This is especially important if teams are not co-located.

Ideas for planning face to face dialogue include attending a joint visit or joint home visit together, making preferences known, for example asking team members to text when requesting a quick telephone conversation, and also planning for periodic rounds or case conferences for shared patients. Health care professionals can learn to “think like a team member” so that information about patient agency, or what supports and resources a patient has tried or is currently engaged with, can be useful for team members who do not know the patient.

All members of the interprofessional team should participate, with assistance of organizational leadership as necessary, in discussing and coming to an understanding about preferences for timing, style, and consistency in sharing information and documenting patient care or plans for care. Although EMR interoperability can be a barrier, opportunities to improve the content, relevance, and timeliness in terms of communication feedback loops can be deliberately sought. Principles for documenting and sharing information particularly during times of patient transition is key.
Efforts towards primary care providers and team members being able to know one another are important, especially for teams that may have high turnover or other causes of instability. Discussions of what having a shared vision actually means, as well as attention to team members’ strengths, preferences, competencies, and scope of practice will facilitate understanding of how to provide high quality care to patients.

In terms of patient care, primary care providers and team members can intentionally strengthen practices of connection to help patients feel known. Attention to features of therapeutic dialogue in conjunction with ongoing reflection of how to maintain therapeutic relationship with patients that are safe and patient-centred is helpful. Thinking about what patients may feel uncertain about can assist health care professionals in considering how particular practices of connection may address some uncertainties for patients.

**Implications for educators**

A shift to the PCH model of interprofessional team-based care has significant implications for educators. Despite increasing recognition of the value of interprofessional education, it can be difficult to find appropriate timing in a curriculum as well as a group of students who are near the same level in their professional education to learn together about team-based primary care. Efforts to increase opportunities for interprofessional education, for example through case-based simulations with different professions represented as team members, may help to better prepare future health care professionals working in a community-based team environment.

Further attention is needed in education to help students of the health professions to understand one another’s scope of practice and expectations for role within an
interprofessional primary care team. As team-based primary care becomes the norm in Canada, the functions of particular roles can be expected to change, and educators may need to revise course content to keep up with the evolution of team in practice. For example, in nursing, courses continue to be taught by topic area, such as mental health, or pediatrics. Nurses who are currently novices to the profession in BC have had very little preparation to work as a team member in a primary care setting, where the expectation is to be a competent generalist.

Lastly, educators interested in preparing students to work in interprofessional primary care environments may wish to look closely at clinical sites chosen for student placements. It is timely to re-visit the way in which preceptors are selected and remunerated in primary care for all professions. “High standards need strong sources” (Taylor, 1992, p. 516), and in terms of selecting preceptors, students deserve access to preceptors who are interested in teaching, providing meaningful feedback, and helping to perpetuate practices of connection in primary care.

**Implications for health care planners**

At the organizational level, there is great uncertainty during a time of transformational change. Middle managers and leaders of health care organizations can expect to be called upon to address uncertainties that will persistently arise from various groups and locations. In anticipation of this, managers may identify that knowing team members and the value of genuine conversation to address uncertainty can be helpful outside the patient care setting. In order for managers to create space for genuine conversation, a significant degree of openness to others in conversation is necessary, and
this may take more time compared to meetings where the primary objective is to convey information or a particular agenda.

Engaging in conversation to address uncertainty requires managers to be skilled in understanding the organizational vision while recognizing the everyday pressures of clinicians. Managers often have an overview of the workflow of interprofessional team members, and they may recognize when imbalances are occurring between how much time team members are learning new processes and workflows versus how much time is spent seeing patients. Managers can be key in helping to determine scheduling structure and capacity of team members. Better understanding of how much time team members should spend at meetings, seeing patients, or on other administrative tasks is critical to facilitating optimal team capacity, satisfaction, and success. For example, managers can help to determine the amount of duplication in documentation by team members, and if it is found to be significant, elevate this issue to a level of priority to be addressed at an organizational level.

Managers can help to address the uncertainty of team members that is accompanied by significant change in terms of planning orientation of new team members. During early implementation, much of the orientation process was not planned. However, in planning for staff turnover, it is timely to attend to a process by which new team members can be introduced and get to know the other team members, including primary care providers. Currently, it may be that team members are not given enough time to orient into their new position while learning new documentation practices, new electronic systems, and meeting all new patients.
Moving beyond the level of managers to a broader health planning level, it is important to mention the requirement for interprofessional teams to have access to interoperable electronic medical records. Although it is a tremendous task to require that information systems be linked or have a satisfactory degree of interoperability, this cannot be overlooked as a recommendation. It is well known that health information technology lags far behind the private sector, and while it may be somewhat accepted that electronic systems are not as functional as they should be, this is not a reason to normalize it. Along with issues of interoperability, concerns about privacy and confidentiality on a non-co-located team require further analysis and discussion.

For health planners at the system level, there is still much to be done to understand and improve team-based primary care that is sustainable, effective, and satisfactory to patients and providers. To begin, the value of “upstream” initiatives should not be lost in the conversation about primary care reform. Public health was absent from the interprofessional team in this study, and a population orientation is needed to achieve lasting, equitable health outcomes.

The extent to which individuals and families can be assisted to stay healthy in the community setting with minimal health system intervention is a desirable goal. Deciding on initiatives that promote health and increase the availability of supports and resources to individuals and families will be context-specific. However, these initiatives may be more effective when a broad, social definition of health is used to inform initiatives. Thus, strategies such as increasing minimum wage, providing financial assistance to family members who are caregivers of an aging parent or dependent adult child, offering universal coverage for daycare, or innovations to decrease social isolation and foster
belonging at the community level are currently relevant to the population’s needs and may be worth analyzing further. Strategies such as these can provide increased supports and resources for patients and may also act as an adjuvant to enhance patient agency.

**Implications for researchers**

The findings of this study can help to advance the primary care research agenda in Canada. Further study that incorporates direct observation of patient-provider interactions may be helpful to improve understanding of social and structural influences on decision-making and practices. Direct observation of health care professionals working in primary care can also help to identify reasons and causes of clinician dissatisfaction and practices that detract from effective primary care delivery. Improved understanding of how health care professionals inform their decision-making in primary care can help to illuminate why gaps in care persist. This work may then contribute to knowledge mobilization that addresses how to reduce such gaps to improve health outcomes or patient experience.

Meaningful measurement in primary care research is an important topic area that was not addressed through the design or findings of this study. However, this research does draw attention to aspects of primary care delivery that deserves further discussion in considering indicators to assess effective team-based care. Currently, there are two major projects underway attempting to consolidate primary care measures in evaluating primary care, with the hope that such measures could be applied consistently (Brooks et al., 2016; Burge et al., 2016). It is not yet known how or to what extent measures that assess being known from the perspective of patients or clinicians may be incorporated, although Brooks et al. did identify that “being known” was a measure of importance according to the clinician stakeholders of that study.
In 2006, the Canadian Institute for Health Information (CIHI) published a report containing 105 indicators to measure primary health care. Of 105 indicators, only 25 were possible to measure even in part with existing data sources. In 2012, CIHI reduced the number of indicators to 51, but by 2016 only 16 of the 51 indicators had data to support rigorous measurement (CIHI). None of those 16 indicators were related to patient experience of primary care or the role of relationship or feeling known.

With the significant work being undertaken in measurement by Burge et al. (2016) and Brooks et al. (2016), it is hopeful that appropriate measures can be identified to assess the role of therapeutic relationship and feeling known in relation to providing effective team-based care. Other measures may also prove useful yet appear to be overlooked, particularly in the process domain, such as who offers home visits to which patients and how frequently, or what is an appropriate panel size of patients for interprofessional team members, or how to assess coordination of care through patient transitions. Further investigation will be necessary to identify, develop, and refine data sources for these and other measures of interest.

Many data sources for current indicators of primary care performance draw on administrative data, survey data, or interview data. While each of these sources have strengths, and may in some cases be appropriate to evaluate patient experience and feeling known in primary care, these methods will not uncover the reasons that patient experience and outcomes are positive or not. Continued observation of practices and further inquiry into patient-provider interactions, in addition to increased uptake of patient-reported outcomes, is necessary to explicate the reasons behind the findings of any indicator of primary care performance. With these strategies augmenting traditional
measurement approaches, practices can be identified that help to improve team-based primary care and outcomes.

**Conclusion**

In BC, transformation to the PCH model of delivering team-based primary care is just beginning, and implementation of the first interprofessional teams are withstanding scrutiny as others consider how the PCH model can be operationalized. Yet, as Hirschman pointed out, “the architect of social change can never have a reliable blueprint. What can be most usefully conveyed is an understanding of the experience that made it at all possible to build under trying circumstances” (Hirschman, 1970/1987 p. 194). This study provides a nuanced understanding of how negotiation of team-based primary care occurs within the PCH model, and how knowing patients and team members influences key attributes in delivering primary care.

Implications that draw on the findings of this research are actionable at the provider, organizational, and system level. There is potential for improving team-based care through further examination of relationship and processes for decision-making at the practice level. Articulating practices of connection can amplify facets of primary care and protect aspects of relationship-based care that may otherwise be neglected.

This study calls for increased attention to understanding and articulating practices as a way to protect the foundational value to feeling known in primary care. Practices of connection that help patients and team members feel known influences decision-making and alleviates uncertainty. In this way, knowing and feeling known can substantially change the way team-based care happens.
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## Appendix A: Interview Guide

<table>
<thead>
<tr>
<th>Questions for Patients</th>
<th>Questions for Providers</th>
</tr>
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<tbody>
<tr>
<td>1. How long have you lived in this community? When did you first start attending</td>
<td>1. How long have you lived in this community? How long have you been practicing?</td>
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<tr>
<td>the clinic for health care?</td>
<td>Probes:</td>
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<tr>
<td><em>Probes:</em></td>
<td>What brought you here?</td>
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<td>What brought you here?</td>
<td>Has the team (# of providers, different types of providers) changed over time? What</td>
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<td>Have you experienced changes in your health over time?</td>
<td>has your experience been of this?</td>
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<td></td>
<td>Can you think of a time when a particular provider began working here? Can you tell me</td>
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<td></td>
<td>about that experience? (Orientation, fitting in with other team members, seeing</td>
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<td></td>
<td>patients, communication etc).</td>
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<tr>
<td>2. Who do you see when you go to the clinic?</td>
<td>2. Do you have experience working on other health care teams? Who is part of your</td>
</tr>
<tr>
<td>Has this changed over time?</td>
<td>current team?</td>
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<tr>
<td><em>Probes:</em></td>
<td>Probes:</td>
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<tr>
<td>Can you tell me about a time and what happened when you decided to see someone else</td>
<td>Can you give me an example of how you work</td>
</tr>
<tr>
<td>or request the same person for follow up?</td>
<td>with other health care providers as part of a team?</td>
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<tr>
<td>Have you had any difficulty in seeing whom you might request when you call the clinic?</td>
<td>Can you think of an example of a time with a patient where you realized you had to</td>
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<td>Can you tell me about a time when that happened?</td>
<td>involve other team members? Can you tell me more about that?</td>
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<tr>
<td>3. Is there a health care professional who knows you best?</td>
<td>3. What are your thoughts about team-based care? What do you think is going well? What</td>
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<td>What is it about that person who makes you feel known?</td>
<td>could be different or improved?</td>
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<tr>
<td><em>Probes:</em></td>
<td>Probes:</td>
</tr>
<tr>
<td>What is it that he or she does? Can you describe a visit where that happened?</td>
<td>Can you give me an example of a time working as a team went well? In what ways did it</td>
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<td>If you don’t feel known, can you describe some of the things that have happened to you</td>
<td>go well? What else influenced why this worked well?</td>
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<td>where your experience was that the provider did not know or understand you?</td>
<td>What about an example of a time when attempting to provide team-based care it did not</td>
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<td></td>
<td>go well? Tell me what happened. How did your actions influence events in this example?</td>
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<td>4. How would you describe your treatment at the clinic over the past year? Over the</td>
<td>4. Tell me a little bit about how you prepare for your days in the office. What do you</td>
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<td>past 5 or 10 years? Is there a time when someone</td>
<td>consider before seeing or talking with</td>
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<td>---------------------------------</td>
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<tr>
<td><strong>really made a difference? Is there a time that is particularly memorable?</strong></td>
<td><strong>patients? What is important for you to know about the patients you see?</strong></td>
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<tr>
<td><em>Probes:</em> Can you tell me more about that? Can you think of an example?</td>
<td><em>Probes:</em> Can you think of a patient with chronic illness and tell me how you might prepare to see them? What about a patient with mental illness? Multimorbidity? Can you tell me about the last time you met a patient new to the practice? What did you do before, during or after that visit?</td>
</tr>
<tr>
<td>5. If you could imagine a difference in the way some things worked about health care in your community, what would you change?</td>
<td>5. Tell me about the documentation system used in the practice. Would you change anything about it?</td>
</tr>
<tr>
<td><em>Probe:</em> Can you tell me a little bit about your experience that has influenced your suggestions?</td>
<td><em>Probes:</em> Tell me about a time when the documentation helped improve the care the patient received. Can you think of a time when the chart reflected conflicting information about the patient, or it appeared a patient received conflicting advice?</td>
</tr>
<tr>
<td>6. Can you describe your experience the last time you attended the clinic for a health care concern?</td>
<td>6. Are there patients in the practice you consider to know very well? Tell me about that.</td>
</tr>
<tr>
<td><em>Probes:</em> Can you give an example of one patient you know well and describe the events of how you came to know that person?</td>
<td><em>Probes:</em> Can you describe a recent encounter with a patient you don’t know very well? Can you think of a patient you have seen in practice multiple times but do not know very well? Thinking of the last time you saw that patient, how did the visit go?</td>
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<tr>
<td>7. Thinking about a time you did not have your health, what was significant to helping you feel better?</td>
<td>7. Are there patients you have found it difficult to get to know? What do you think makes it difficult to know some patients?</td>
</tr>
<tr>
<td><em>Probes:</em> What did health care providers do? What did others in the community do? Is there a specific occurrence that signified your realization that you were getting better? Can you tell me more about that?</td>
<td><em>Probes:</em> Can you describe a recent encounter with a patient you don’t know very well? Can you think of a patient you have seen in practice multiple times but do not know very well? Thinking of the last time you saw that patient, how did the visit go?</td>
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Appendix B: Ethical Approval

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Erin C. Wilson
CC: Martha MacLeod

From: Michael Murphy, Chair
       Research Ethics Board

Date: June 4, 2014

Re: E2014.0512.031.00
   Towards understanding: Negotiation of primary care with an
   interprofessional team

Thank you for submitting revisions to the Research Ethics Board (REB) regarding the
above-noted proposal. Your revisions have been approved.

We are pleased to issue approval for the above named study for a period of 12 months
from the date of this letter. Continuation beyond that date will require further review and
renewal of REB approval. Any changes or amendments to the protocol or consent form
must be approved by the REB.

If you have any questions on the above or require further clarification please feel free to
contact Rheanna Robinson in the Office of Research (reb@unbc.ca or 250-990-6735).

Good luck with your research.

Sincerely,

Dr. Michael Murphy
Chair, Research Ethics Board
May 28, 2014

Erin Wilson  
School of Health Sciences University of Northern British Columbia  

File #RRC-2014-0011

RE: Towards understanding: Negotiation of primary care with an interprofessional team.

On behalf of the Northern Health Research Review Committee, I would like to thank you for your submission titled “Towards understanding: Negotiation of primary care with an interprofessional team.” The Committee has reviewed your application and your study has met the requirements of the Northern Health Research Review Committee and you may proceed.

Enjoy your work! We look forward to hearing about your findings.

Sincerely,

Les Smith, Chair, NH Research Review Committee