

# Patient and/or caregiver experiences of interprofessional team-based primary care

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## Abstract

Due to its current fragmentation, much of the current work being done to reform primary health care is focused on creating continuous, integrated care that incorporates the expertise of professionals from across different professional disciplines. Although attractive in theory, the reality of implementing such change often results in some patients ‘falling through the cracks,’ – that is, not receiving the care they need due to getting lost between different healthcare providers. The only way for these situations to come to the forefront is when individuals and researchers stop to listen to the voices, stories, and experiences of patients and their caregivers. This research sought to better understand patient/caregiver experiences of interprofessional, team-based primary health care. After conducting semi-structured qualitative interviews using interpretative phenomenological analysis, three key themes emerged regarding participant experiences: communication (between patients and their providers), functioning/activities (of the providers direct towards the patient), and roles (of the each of the different healthcare professionals). Communication followed a gradient, with some respondents not aware of any communication between providers, while others had a clear understanding of what occurred. Interprofessional functioning in primary care was perceived as positive as participants felt they had access to a greater array of opinions. The roles of each healthcare provider were generally known by participants. Future research is needed to complement this work with the providers’ perspective to provide a more complete picture of interprofessional primary care.

Addressing complex patient needs has become a key area of focus for healthcare systems in Canada. Reform began by introducing interprofessional (IP) teams of providers into health settings<sup>1</sup>. In theory, having multiple providers can seem favourable as it increases accessibility, efficiency, and can provide holistic care<sup>1</sup>. Yet, it has been noted that introducing more than one provider can lead to continuity problems<sup>2</sup>. Patients can get ‘lost’ between providers, which leaves their health concerns unaddressed. Hence, primary care has been an emphasis when studying integrated care, as these settings are often the first point of contact for patients and act as ‘threads’ to keep care continuous across the vast healthcare system<sup>1</sup>. This study aims to understand patient and/or caregiver experiences of receiving IP team-based primary care.

*Keywords: interprofessional, primary care, team-based, experiences*

**Conflict of Interest Statement:** The authors declare no conflict of interest.

## Methods

### Setting

Recruitment was done at the Northern Connections Medical Clinic, located in Winnipeg, Manitoba, as well as through the Manitoba Primary and Integrated Healthcare Innovation Network (MB PIHCI) email newsletter. Northern Connections is an interdisciplinary primary care clinic and teaching site which integrates family physicians, family medicine residents,

nurses, a registered dietitian, a pharmacist and a social worker. MB PIHCI is a network of patients who have identified themselves as being interested in being recruited for future research.

### Recruitment and Sample

Meetings were held with clinic staff to inform them of the study. Staff were supportive of the initiative and were provided with a recruitment script. Study posters

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were also displayed. The researchers went to the clinic on two separate afternoons to speak to potential participants and conduct on-site interviews. Any interested participants recruited from MB PIHCI contacted the researchers directly by email to arrange for a virtual interview.

Convenience sampling of patients and/or caregivers was used to select participants based on those who agreed to an in-person or virtual interviews. All successful participants had to have been receiving (or caring for someone who was/is receiving) IP, team-based primary care from at least two providers from different professional disciplines. Written consent or verbal assent was obtained. All participants were given a \$20 gift card to thank them for their time.

### Data Collection and Analysis

Interviews were recorded and transcribed by Zoom or Microsoft Word software. The data was anonymized using a date-numbering system and stored on a secure hard drive. Seven key domains were prompted during the interview: 1.) general definition and role of the team, 2.) family caregiver involvement (as applicable), 3.) accessing other team members, 4.) personal and professional interactions, 5.) access and coordination across the continuum, 6.) patient-centred care processes, and 7.) team and individual responsiveness. Refer to Appendix 1 for the complete interview guide.

The data was analyzed using interpretive phenomenological analysis (IPA). IPA is a qualitative methodology that concerns itself with the examination of the personal and lived experiences of participants by looking at each individual interview/case in detail for key themes and codes<sup>3</sup>. Once each participant's lived experience has been examined, IPA looks for patterns across all the interviews<sup>3</sup>.

This study has been approved by the Health Research Ethics Board at the University of Manitoba, Research Ethics Bannatyne Campus, Ethics number: HS25146 (H2021:318). Additional approval from Shared Health was obtained to conduct the research at Northern Connections Medical Clinic.

### Results

A total of seven interviews were conducted, two on site at Northern Connections Medical Clinic and five done virtually over Zoom. The average age of the participants was 58.1 years with five being between 63–90 and the remaining two being 22 and 28. One identified as a male and six as female. Two participants were caregivers to a family member and five were patients. The participants averaged 8.4 clinical visits within the last year and took an average of three medications per day. The primary healthcare providers (PHC) seen by the participants included family physicians, a sports medicine physician, physician assistants, a geriatrician, nurses (including registered nurses, nurse practitioners, and psychiatric nurses), dietitians, an occupational

therapist, a social worker, a respiratory technologist, a psychologist, and a massage therapist.

### The Strata of Communication

#### *On the Other Side of the Door*

Participants described not knowing about the communication between providers because much of it happened 'on the other side of the door' – that is, it did not happen during a time/place that allowed the participant to be aware of it. Participant 15-1 indicated that they did not know if a report was sent after the initial referral from the physician to the dietitian to update the other provider. The feeling was also described by a caregiver who was not present in the same appointment when information was being conveyed by a healthcare provider. Even when the two providers were physically present in one appointment, communication was sometimes done on the other side of the door, leaving the patient unaware of what was being discussed. When asked about whether they saw the interactions between two providers providing the care, participant 14-1 responded "not really, 'cause usually they leave the room and talk." When asked about whether they observed two providers coming to a common decision about their care or having differing opinions, participant 25-1 expressed that it was something they would not be aware of, and that decisions were simply communicated to them.

#### *Assumptions of Communication*

Communication between providers was assumed (but not confirmed) by some participants. For example, participant 25-1 indicated that after they no longer had need for home care, they had "presumed" that the clinic they were going to was notified of the change. In other circumstances, patients were aware that communication should have taken place, but they did not observe it themselves and were left presupposing that it had happened. It was often communicated with participants when they were being referred by one provider to another, but whether the referral was sent and reviewed, and how it was sent was often unknown. Participant 24-1 indicated that their provider "says she's going to do it [send a referral], and I assume that she will." In another instance, when commenting on the interactions between the nurse and the physician in the same clinic, they mentioned that "I just don't know specifically ... I assume that she actually spoke with her personally, but it could have been by telephone it could have been an email ... there was communication, I just don't know how it happened." Similar sentiments were echoed by participant 25-1, who could not cite "a specific example of how that's done, or how [they knew] about it" with regards to the communication between the physician and physician assistant, but who had "expectations" that they communicated as it was their "impression."

These assumptions about providers dialoguing with each other were often made by participants due to diverse observations of other aspects of their care. Participant 14-2 cited physical co-location between the oc-

cupational therapist and doctor as the reason they surmised that there were interactions between them regarding their care. Participant 24-1 anecdotally described their experience of communication between the nurse and the physician by saying that they knew “that the nurse noticed something because she mentioned it to me. So, I’m assuming that she consulted with the doctor later because the prescription was telephoned into the pharmacy that I use.”

Based on the conversations participant 25-1 had with each provider separately, they deduced that the physician and physician assistant were communicating. Each provider was aware of 25-1’s situation, it was clear to them that they were communicating “back and forth.”

#### *Patient as Intermediary, Caregiver as Coordinator*

It was found that as an intermediary, patients are sometimes the ones monitoring the communication between providers (such as following up on a referral) or facilitating the exchange of information between providers (informing one provider of what was done/discussed with another provider). Participant 24-1 indicated that once a referral is sent, they will follow up if they have not heard anything within three months to check “with the office just to make ... sure the referral actually went out.” When steering between a family doctor and sports medicine doctor, participant 16-1 recalled having to repeat their medical history to both practitioners and being asked similar questions by both regarding a stress fracture that they had sustained. Although it is sometimes normal for different providers to ask similar questions, this patient felt that the repetition was an indication that their providers had not communicated adequately regarding their case. In addition, one of the providers specifically asked the patient to independently follow up with their family doctor regarding some concerns around blood work and medication interactions. When the patient went to go see the family physician, they discussed “what [the] sport medicine doctor was concerned about.” The participant cited being the one to bring this information forward to their family physician. Participant 16-1 had similar experiences with their psychologist and family physician, stating that: “I’m kind of relaying whatever the other person says, and any information I get from my GP I usually bring to my psychologist to work through. But that’s all done myself.” It should be noted, however, that participant 16-1 also cited that being an intermediary between different providers “empowered” them to “take that step in [their] own health.” They believed that it was their job to follow up with the providers and that being able to repeat their medical information allowed them to explain their condition in their own words instead of through a clinical note.

For caregivers, being an intermediary also manifested itself as being a coordinator for the care of their family members. When asked about whether they felt as though their family member had fallen through the cracks, participant 21-1 stated that it would be more difficult to navigate the healthcare system for those not

familiar with how it operates. It would be more likely that ‘balls would drop’ in between the cracks. Caregiver 15-1 also felt as though they “held the pieces together” and within their parents’ specific clinic, were accepted as “part of the care team.” They also described their role as being a “connector” between the doctor and the dietitian. Upon reflection, they reported that they were not sure if the interactions between the dietitian and physician would have “gone very far” had they not been acting as a caregiver/connector and “been the dialoguing person” between the two of them. It was also speculated that because they were doing a lot of the “collaborating” between the providers, there was not as much collaboration between the providers themselves.

#### *Evidence of Communication*

Clear communication between the different health care providers was made evident to patients in a variety of ways. For some, the providers explicitly told the patients of the communication that had taken place. Participant 14-2 recounted this when describing the method by which the occupational therapist told them that they were keeping the doctor updated. For multiple participants, provider dialogue and the passing on of information was done through clinical notes. The occupational therapist was also making notes that the physician could see later, another way that participant 14-2 knew that there were exchanges happening between the two of them. Information on medications was communicated through clinical notes for participant 16-1 and any background information on the patients was relayed through the patient chart according to participant 25-1. When two or more providers were both in the room during a patient’s appointment, communication was also evident to the participants. Participant 21-1 described it as having “both players on the team [having] the same information.” This was deemed beneficial because if one provider needed something followed up on by another, they would both be “working from the same starting point.” In participant 14-1’s experience, when two providers were in the room, one was taking notes and the other was speaking to them directly. They felt as though the right questions were being asked when it was done this way.

In a more complex pathway, communication was described as a “chain” by caregiver 21-1. Between the nurse and the geriatrician, the nurse would do an assessment of the patient before the appointment, relay the results to the geriatrician, and then they would both be present in the appointment room together. In other circumstances, the nurse would follow up with the patient on their medications and then communicate that information to the geriatrician as needed. Some clinics have more robust communication – for example, one caregiver (15-1) was aware that the clinical staff on site had large, regularly scheduled team meetings, as was told to them by one of the nurses. They would discuss each of their patients amongst each other, and the caregiver stated that: “I never felt that I had to call the doctor and tell her anything because she would have heard it from, from the other doctor, as they were

discussing the case very often.”

## Functioning/Activities

### *Ease of Co-location*

Three different participants (15-1, 21-1, 24-1) commented on the benefits of all their PHC providers being at one location. Knowing where to go each time and what was going to happen, rather than having a new experience each time they saw a different provider, was perceived as easier for the patients by their caregivers. Not only did it allow for many different services to be accessed and coordinated in one spot, but it was also said to lower anxiety and aid patients who may get their sense of location distorted. In one instance, the familiarity grew to the point that the atmosphere at the clinic “felt like family” (15-1). Participant 24-1 had a differing opinion as to why different providers being in the same place was beneficial. They believed that “close physical proximity makes a difference because they’re more likely to be reminded that they have to pass the information along.” They stated that busy providers can be reminded to exchange information when they see other professionals.

### *Inter-provider Expertise*

Positive comments were made about the diversity of perspectives that interprofessional collaboration (IPC) brings to patient care. There was confidence that patient concerns were being looked at from “different angles” (16-1) because each provider focuses on different aspects of health. In addition, there was a consensus that each professional cannot know everything, making the diversity of providers an asset to patients.

### *Addressing Patient Needs*

When asked about the ability of IPC to provide patients with care that adequately addressed their needs, perceptions were positive. When speaking about their family member, caregiver 15-1 mentioned that having more than one PHC provider allowed them to “[look] after more of their basic needs than if they would have been in a setting where there was only a doctor.” One caregiver (21-1) attributed the patient’s needs being met to providers having access to the same information when they were both present in the appointments, stating that they “valued that both of [the providers] did have access to information because I think that really does help provide better care. If [providers] have their information ... in silos and don’t connect, things get lost.” The same participant also indicated that having the professionals in the room at the same time made their family member more comfortable sharing their concerns, providing a more accurate picture of their medical condition. It was considered a safe space where they could ask questions. With all relevant providers in the room at the same time, participants expressed not having to repeat their medical information, making the process simpler.

When asked why IP primary healthcare (PHC) was used in their care, participants perceived two distinct reasons. Some believed IPC was utilized because

providers needed the expertise of their colleagues. Others believed IPC was employed because one professional needed the support of another due to time constraints. This meant that more professionals were needed to provide the patient with the care they needed. For example, participant 21-1 indicated that the nurse conveyed certain information about a cancer diagnosis because the doctor could not be present at the time. Similar observations were mentioned by two other participants who talked about how providers often do not have the time to do everything the patient needs. The role of professions like that of the physician assistant was perceived as being in support of the doctor if they could not take on a particular task. Any teamwork that participant 14-1 saw between the physician and physician assistant was them dividing tasks, such as one provider making notes during the appointment while the other was speaking to the patient and asking them questions. This complements the experience of participant 14-2 who stated that the physician often relied on the dietitian to provide support to the patient regarding their diet, as well as the occupational therapist to assist the patient with managing their pain.

### *Reference Providers*

Despite the benefits of having an IP group of providers looking after their care, it was also revealed that one provider (often the physician) is seen as the most trusted for the participant and was often the one leading their care. For example, when opinions differed between a physician and a dietitian, participant 14-2 trusted the physician over the dietitian, stating that: “maybe, Dr. X knows ... exactly ... what to look for as a doctor.” There was also a preference towards specialist physicians for health conditions that were perceived by the patient to be more niche. Participant 16-1 mentioned that they were more confident in going to see a sports medicine doctor rather than their general practitioner for an issue related to their foot, indicating that they would not have been “confident going to [their] family doctor for a stress fracture or an orthopedic related injury.” In particular, family physicians were found to oversee a patient’s care, with participant 21-1 stating that: “it was a family doctor that was sort of in charge of all the care.”

## Roles

Many participants could clearly articulate the role that each provider played in their care, citing specific examples related to their diagnoses. However, it was noted that many participants did not know the exact role or title of the provider they were seeing. This was most common among the different nursing specialties. Participant 15-1 stated that they saw “some nurse” when asked about the different providers they interacted with. Participant 21-1 did not know whether the nurse they were seeing was a nurse practitioner or an advanced practice nurse, and participant 24-1 could not tell whether their nurse was a nurse practitioner or a psychiatric nurse. When asked about their role in pro-

viding care, participant 25-1 was unable to state what the role of the nurse was in the home care process. The same participant had a limited understanding of the role of the physician assistant, assuming that by virtue of their title, they were accountable to the doctor.

## Discussion

Roles, functioning/activities, and communication were the three key themes that emerged from this research. Within communication, four main strata were uncovered: on the other side of the door, assumptions of communication, patient as intermediary/caregiver as coordinator, and evidence of communication. Preliminary research from Denmark on collaborative communication (CC) between general practitioners (GP), care managers (CM), and psychiatrists during a mental health intervention uncovered additional strata of communication that exist between providers<sup>4</sup>. Communication was categorized as either making a report (a transfer of information from one professional to the other), communication by proxy (one provider attending a meeting and briefing the providers not in attendance), and communication that develops as a result of shared knowledge (using the information from the other provider to arrive at a more complete perspective of the patient during a peer-to-peer discussion)<sup>4</sup>. Communication via making a report and by proxy were observed. For example, participant 14-2 noted that communication between the occupational therapist and physician often occurred through clinical notes, and participant 16-1 noted that any updates regarding their medications were often communicated by the doctor via notes as well. Information was also shared by proxy, with caregiver 21-1 describing information transfer from the nurse to the geriatrician as being like a 'chain'. The nurse would often meet with the patient first to gather the information that would then be relayed to the doctor (who was not present during the first half of the appointment). Communication that develops because of shared knowledge was rarely experienced. Although participant 15-1 explained that they were aware of regularly scheduled meetings that happened between the doctor and the nurse, they could not comment on how the providers were using the information from other providers to arrive at a more complete perspective of the patient. They merely described that these meetings would be an opportunity for information to be shared by proxy, as described by Overbeck et al. (2019)<sup>4</sup>. Similarly, other patients that experienced communication between providers only saw it as a means of sharing information or as a vehicle for dividing the workload (14-1, 16-1, 25-2). Even if communication did develop because of shared knowledge, none of the patients were privy to that information. Speculation as to why that was case can be difficult to determine, but it may be because it either did not happen between providers, or if it did, it was not shared with the patient.

It should also be noted that ideal communication or activities as defined in the literature may not be

applicable in practice for a variety of situational and interpersonal factors. For example, time is often limited during appointments, making robust communication pathways between an IP group of professionals and the patient difficult and unsustainable. Findings from Overbeck et al. (2019)<sup>4</sup> confirm this, citing that care managers sensed that GPs wanted reporting systems that did not take long but that still provided the relevant details. Depending on the medical condition being addressed, more than one provider might not be needed to care for the patient. Judgements around what warrants an IPC versus single provider care are likely made by the provider, and more research is required to determine the nature of such decisions. Despite what is recommended in the literature, some providers have actually been found to prefer more "informal, unplanned communication 'in the doorway' because they felt this was flexible and reflected their working style"<sup>4</sup>. Patient preferences must also be considered. Depending on their education, familiarity with the healthcare system, and health status, patients may refuse or feel no need to discuss their medical conditions with another provider<sup>5</sup>. Their cognitive ability to repeat their medical history may also have implications for the communication that happens both during and after an appointment<sup>5</sup>.

To improve patient-centred care, continuity of care should be considered with regards to the functioning within PHC<sup>6</sup>. Defined as the extent to which distinct healthcare events are experienced as cohesive for the patient, continuity of care is often broken down into three key areas: informational continuity (providers know what has happened previously), management continuity (an agreed upon plan), and relational continuity (patients knowing who will care for them in the future)<sup>7</sup>.

Informational continuity is the common link between one patient and their various providers<sup>7</sup>. As was discussed prior, the degree of communication required between providers depends not only on what may be recommended in the literature, but on several factors specific to each individual. Whether or not patients have to repeat their medical history (and their desire to do so) is often implicated in informational continuity. For example, patient 16-1 felt empowered when they would repeat their history to more than one provider, citing that it felt as though it was their responsibility to do so. This was a sentiment shared by caregivers as well. 15-1 felt that they were often 'holding the pieces together' of their family member's care, which made them feel like a member of the care team. Despite these circumstances, many patients were often not aware of communication that had or had not occurred between their healthcare professionals. It was assumed or inferred based on external factors, such as when patient 14-2 assumed that the doctor and the occupational therapist communicated simply because they worked in the same office. This was the same for caregiver 25-1 who assumed that the clinic was informed when home care for their family member was stopped. Informational continuity, or a lack thereof is perceived

differently by different patients/caregivers, and largely depends on their capacity and willingness to be the intermediary.

Management continuity involves delivering flexible and timely healthcare services in ways that complement each other and reflect a clear plan<sup>7</sup>. These findings revealed that patients perceived two reasons that an additional provider was required for their care. Either more expertise was needed (such as the doctor relying in the dietitian and occupational therapist to provide more support to patient 14-2), or the referring provider did not have enough time (such as in the case of participant 21-1 where the nurse conveyed information regarding the diagnosis because the doctor could not be present). More research is required to look at the different circumstances in which another professional is utilized for their knowledge/skills versus time constraints. In situations where management continuity is broken (such as when two providers have different opinions), the findings of this current study suggest that patients often defer to one provider, which is often the physician. This was discussed in greater depth in the Reference Provider section of the results. Deferring to a single provider is likely done because patients need to feel that they have one person who is in control to help mitigate the dissonance they may be experiencing. Despite its function, this may lead to the construction of hierarchies with the physician on top. More research would be required to explore this phenomenon further.

Relational continuity provides patients with a sense of “predictability and coherence”<sup>7</sup> when the same providers are seen over long periods of time and ongoing relationships are established. This level of continuity may not always be required for every patient, as it depends on their health condition. For example, someone who is young and healthy and only interacts with the healthcare system sporadically for routine checks is less likely to need an IP group of providers looking after their care. This compares with someone who has a chronic condition with many comorbidities and requires more healthcare services, a larger number of healthcare visits, and a greater diversity of providers. Further research to explore the extent of the need for IPC given the complexity of patient cases would be an asset to the literature.

Although the results highlighted four strata of communication, four domains of functioning/activities, and information regarding roles, optimal communication, functioning/activities, and roles were things that participants could not speak to. This research focused solely on patient/caregiver experiences, which are limited in only being able to describe what happens on one side of the door. That is, there might be more collaboration between providers that was not described by this research because of its emphasis on patient perspectives. More research is needed to complement this work, using provider perspectives to give a clearer understanding of what happens on their side of the door, as well as the qualities, infrastructure, and activities needed for optimal collaborative practice in primary

care.

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## Appendix 1

### Interview Guide

*Eliciting perceptions as well as substantive, concrete examples of team-based care and how it was experienced in a primary healthcare setting.*

#### 1. General definition and role of the team

- a. Can you tell me about all the different health care providers you see and what role they play in your care?
  - i. Tell me about how those people come together to solve your problems? Was the advice the same? Were they talking in the same way? Did they have the same info and the same understanding of what was going on?
  - ii. Did they solve your problems?
  - iii. Do they address your needs?

#### 2. Family Caregiver Involvement (as applicable)

- a. How does your role as a caregiver for your family member/friend interact with the role/function of the members of the healthcare team?
  - i. Do you have input?
  - ii. Do they take your concerns into account?

#### 3. Accessing other Team Members

- a. Do you feel that you are able to access other healthcare providers in a timely manner? Please explain why or why not.
  - i. Are you given adequate information on different providers?
  - ii. Do you know what other providers do outside of the ones you are currently seeing?

#### 4. Personal and Professional Interactions

- a. How well do the interprofessional providers that provide care to you interact with/communicate each other?
  - i. Do they communicate often?
  - ii. Do you have to repeat your medical history each time?
  - iii. Are they properly briefed on your case?

#### 5. Access and coordination across the continuum

- a. Do you feel that your health care is continuous/coordinated? Please explain why it is, or is not.
  - i. Do you get your test results and are your providers aware of your results?
  - ii. Does your primary care provider know about the other appointments you have had and the outcomes of those appointments?
  - iii. Do different providers give you different opinions?
  - iv. How do you know that a referral has been sent and that you have an appointment with a different provider?
  - v. Do you feel “lost” between the cracks of the healthcare system?
  - vi. Think about a time when you were sent to get a test result back: did you get results fast, etc.?

#### 6. Patient-centred Care Processes

- a. If you needed to see another health care provider, is that another appointment or would you have same-day access to a consultation? How far would you have to travel to see another health care provider? How convenient is it for you to see another health care provider?

- i. Have you encountered a time when you needed to see another provider, tell me about that experience?
- b. What role do finances or insurance coverage have in being able to access other team members?
- c. If you experienced limitations, what other options were available to you?
- d. Do all of the different team members provide information to you? Are your questions answered?
- e. Were you usually aware of the next steps in your care? The overall plan? Did you feel like the care you would receive from other health care providers was well mapped out?

**7. Team and Individual Responsiveness**

- a. How timely are your healthcare providers in responding to your healthcare needs, either minor or urgent (non-emergency) concerns?
  - i. What do you do when you have a minor injury?
  - ii. What do you do when you have an urgent concern that does not need hospitalization?

**8. Wrap up**

- a. Is there anything that has come to mind that you would like to go back to, share or discuss/question further?



**Patient and/or Caregiver Experiences of Interprofessional Team-Based Primary Care**

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**Funder / Sponsor:** Not Applicable

You are being asked to participate in a research study involving participation in an interview. Please take your time to review this consent form and discuss any questions you may have with the student investigator.

**Purpose of this Study**

This research study is being conducted to provide a better understanding of patient and/or their caregivers' experiences of team-based, primary health care in a large primary care clinic based in Winnipeg, Manitoba.

**Participants Selection**

A total of 20 individuals from one clinical practice site will be asked to participate. The clinical practice site is the Northern Connections Medical Clinic.

**Study Procedures**

The method of data collection for this study will be through one-to-one interviews lasting approximately one hour. The interview will be conducted by Miray Eskandar, who will ask you to complete a short demographic form (approximately 5 minutes) followed by a number of questions regarding your experiences with team-based care.

The interviews will be conducted online or in-person at Seven Oaks General Hospital, based on each individual's preference and in compliance with pandemic-related regulations (evidence of vaccination, symptom-free, wearing a mask and physical distancing). The interview will be recorded and transcribed by a professional transcriber, who will sign a form stating that he/she will not discuss any item on the tape with anyone other than the researchers.

Your name will be removed from all the transcripts. The audio will be stored securely in the Dept of Family Medicine Research Office (with Dr Halas) after being transcribed. Tapes will be destroyed after the analysis is completed and the transcripts will be deleted at the end of the study. If you would like to review your transcripts, you can arrange a time with Dr. Halas.

If you decide to participate in the study, a summary of the study will be provided to you on request.

**Risks and Discomforts**

There are very few risks for participating in this study. If at any time during the interview you feel uncomfortable with the questions being asked, you can choose not to answer those questions without any negative impact. You are also encouraged to contact any member of our research team should you experience any negative feelings after the interview. If you have concerns with the care provided at the clinic or have questions regarding your ongoing care, you are encouraged to speak with your primary care provider(s).

**Benefits**

There may be no direct benefits to participating in this study. The information from this study will be summarized and may be used to develop initial recommendations for enhancing the quality of team approaches to patient care.

**Costs**

There is no cost to you to participate in the focus group.

**Payment for Participation**

You will be given a \$20 gift card in appreciation for your time to complete the interview. Any incurred parking expenses will also be reimbursed.

### **Confidentiality**

We will do everything possible to keep your personal information confidential. Your name or other identifying information will not be used or revealed. A list of names and addresses of participants will be kept in a secure file, separate from any data. Audio files of the individual interview will be typed and used to prepare a report. The audio files and typed notes will be kept in a secure data server and/or locked file cabinet within the Dept of Family Medicine Research office. Only Dr Halas will have access to them and know your name and will only be accessible only by the two above-named researchers. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law (i.e. illegal or dangerous situations).

Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy. These people are members of the Health Research Ethics Board of the University of Manitoba, which is responsible for the protection of people in research and has reviewed this study for ethical acceptability. If any of your research records need to be submitted to the Health Research Ethics Board of the University of Manitoba any of the above, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

This study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available here: <https://explore.zoom.us/docs/en-us/privacy.html> While the University of Manitoba Health Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers.

All records of your participation in this project, including paper records of transcripts and communication notes will be destroyed 5 years following the completion of the study.

### **Permission to Quote:**

We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:		
Yes	No	I agree to be quoted directly if my name is not published (I remain anonymous).
Yes	No	I agree to be quoted directly if a made-up name (pseudonym) is used.

### **Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your participation or discontinuance in the study will not be known to anyone at the clinic and will not affect your care in any way.

### **Questions**

If any questions come up during or after the study contact the study supervisor, Dr. Gayle Halas at (204) 977-5666 or by email at [Gayle.Halas@umanitoba.ca](mailto:Gayle.Halas@umanitoba.ca). For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

### **Consent Signatures:**

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

**I would like to receive a summary of the study findings upon completion.**

- **By email** \_\_\_\_\_
- **By postal mail** \_\_\_\_\_

**(If in-person) Participant signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(day/month/year)

**Participant printed name:** \_\_\_\_\_

**I, the undersigned, believe that the participant named above has had an opportunity to discuss this research study and has knowingly given his/her consent.**

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
(day/month/year)

**Signature:** \_\_\_\_\_

**Role in the study:** \_\_\_\_\_