Rapid EVIDENCE Reports

Patient Perspectives on Team-Based Primary Care

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SPOR Evidence Alliance
Strategy for Patient-Oriented Research
Alliance pour des données probantes de la SRAP
Stratégie de recherche axée sur le patient

Strategy for Patient-Oriented Research
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Contents

This Rapid Evidence Report was prepared by the Newfoundland & Labrador Centre for Applied Health Research (NLCAHR) at Memorial University. It was developed through the analysis, interpretation and synthesis of scientific research and/or health technology assessments conducted by other parties. It also incorporates selected information provided by expert consultants in the subject area. This document may not fully reflect all scientific evidence available at the time this report was prepared, as other relevant scientific findings may have been reported since its completion.

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About This Report

About NLCAHR

The Newfoundland and Labrador Centre for Applied Health Research was established in 1999 to contribute to the effectiveness of health and community services in Newfoundland and Labrador and to the physical, social, and psychological wellbeing of its population. NLCAHR accomplishes this mandate by building capacity in applied health research, supporting high-quality research, and fostering the effective use of research evidence by decision makers and policy makers in the provincial healthcare system.

About *Rapid Evidence Reports*

This *Rapid Evidence Report* is a publication of the Newfoundland and Labrador Centre for Applied Health Research (NLCAHR), a research centre in the Faculty of Medicine at Memorial University. NLCAHR contributes to the effectiveness of health and community services in Newfoundland and Labrador by building capacity for applied health research and fostering the effective use of research evidence by decision makers and policy makers in the provincial healthcare system.

Rapid Evidence Reports offer an overview of recent research to support evidence-informed decision making in Newfoundland and Labrador. They synthesize key findings, describe the search strategy and evidence base, and provide a quality appraisal of included studies. *Rapid Evidence Reports* do not provide a comprehensive review of all available literature or contextual factors. Instead, they give decision makers an overview of the scientific evidence in a defined period, highlight the scope and nature of the evidence, and outline areas of agreement and disagreement among researchers, along with some potentially relevant contextual considerations for decision makers in NL.

Funding for This Project

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The NL Centre for Applied Health Research is funded by an annual grant from the Department of Health and Community Services, Government of Newfoundland and Labrador with additional financial support from Memorial University's Faculty of Medicine and from NL Health Services.

Land Acknowledgments

The SPOR Evidence Alliance operates from St. Michael's Hospital, Unity Health Toronto which is located on the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous peoples from across Turtle Island. We are grateful to have the opportunity to work on these lands.

We acknowledge that the lands on which Memorial University's campuses are situated are in the traditional territories of diverse Indigenous groups, and we acknowledge with respect the diverse histories and cultures of the Beothuk, Mi'kmaq, Innu, and Inuit of this province.

Our Project Team

This project was initiated in response to a research question submitted to the SPOR Evidence Alliance by Cris Carter, the Project Co-Lead for this report.

Cris Carter, Project Co-Lead | Cris Carter lives in St. John's, NL where she engages with the healthcare system as a Patient Partner on the Newfoundland and Labrador's Support for People and Patient-Oriented Research and Trials Unit (NL SUPPORT) Patient and Public Advisory Council (PPAC). She joined the Council in 2016 and helped roll out patient-oriented research training for researchers, medical personnel, and prospective patient partners to promote patient engagement in NL. Since then, Cris has served on several national Patient Advisory Councils, including the Canadian Institutes of Health Research (CIHR) and the Health Research Data Network (HDRN), and has contributed as a community representative on the NL Health Research Ethics Board (HREB). When the COVID pandemic began in 2020, Cris became a member of the team investigating *"Through the Looking Glass: The impact of COVID-19 isolation on Long-Term Care facility residents – a visitor's perspective,"* a project initiated by the NL SUPPORT Patient and Public Advisory Council. Cris is a retired training and human resources professional and a certified life coach.

Rosemary Lester, Patient Partner | Rosemary Lester recently relocated from St. John's, NL to the United Kingdom. A former nurse with experience in both Canada and the UK, she spent nearly two decades with the Seniors' Resource Centre of Newfoundland & Labrador (now SeniorsNL), serving as Executive Director from 1992 to 2008. Since retiring in 2008, Rosemary has remained deeply engaged in volunteer work, joining the NL SUPPORT Patient and Public Advisory Council in 2015. Through her involvement with the PPAC, she has reviewed research proposals, contributed as a patient partner on multiple projects, and served on various committees. Most recently, she also served as a member of the team investigating *"Through the Looking Glass: The impact of COVID-19 isolation on Long-Term Care facility residents – a visitor's perspective*" (2020–2024).

Researchers from NLCAHR | Researchers from the Newfoundland and Labrador Centre for Applied Health Research who worked on this project were: Sarah Mackey, Master of Public Health, Research Officer & Patient Engagement Coordinator with the Contextualized Health Research Synthesis Program (CHRSP), Emily Granter, Master of Public Health, Research Officer with CHRSP and Dr. Rick Audas, Professor of Health Statistics & Economics in the Division of Population Health and Applied Health Sciences at Memorial University's Faculty of Medicine and the Director of the NL Centre for Applied Health Research.

Our Project Consultant

Dr. Sabrina Wong, RN, PhD, FCAHS, FAAN | Our research team benefited from the advice and expertise of Dr. Sabrina Wong, a researcher whose work examines primary healthcare services and patient-reported quality of care. Dr. Wong is a professor at the University of British Columbia's Centre for Health Services and Policy Research and the UBC School of Nursing. More information about our Project Consultant can be found in Appendix A.

Acronyms Used in This Report

CHRSP	Contextualized Health Research Synthesis Program
FCT	Family Care Team
GP	General Practitioner
MDT	Multidisciplinary Team
NLCAHR	Newfoundland and Labrador Centre for Applied Health Research
NLHS	Newfoundland and Labrador Health Services
NL SUPPORT	Newfoundland and Labrador's Support for People and Patient-Oriented Research and Trials Unit
SPOR	Strategy for Patient-Oriented Research

Glossary of Terms

Integrative Review	A review that brings together findings from diverse literature to provide a holistic understanding of a phenomenon or healthcare problem. An Integrative Review provides an overall understanding of what is known about a specific topic or healthcare issue to help inform research, practice, and policy by summarizing diverse evidence in one place.
Multi-level factors	Factors that influence outcomes within different levels of a system, including factors at the patient level, the contextual level and the organizational level.
Patient Perspectives	For the purposes of this report, "Patient Perspectives" is an umbrella term we have used to encompass patient experiences, perceptions, attitudes, preferences, and views related to team-based primary care.
Primary Care	Foundational, first contact, ongoing healthcare that manages daily health needs, including diagnosis, treatment, and prevention. Primary care is ideally patient-centered and focused on overall wellness. Primary care providers include physicians, nurses, and other healthcare professionals.
Team-Based Primary Care	A model of primary care delivery where interprofessional team members work collaboratively and to the top of their scope of practice to meet the needs of patients.
Systematic Review	A literature review, focused on a specific and explicit research question that applies a systematic methodology to identify, appraise, select, and synthesize published and unpublished research evidence relevant to that question.

Project Co-Lead and Patient Partner Reflections

Cris Carter
Project Co-Lead

Rosemary Lester
Patient Partner

Across communities, primary care teams, including family physicians, nurse practitioners, pharmacists, and other allied health professionals, work to provide coordinated quality care. Yet too often, one essential voice is missing from conversations about how these teams function and how they can improve: the patient's.

Patient perspectives are essential. Access to care cannot be assessed solely by appointment availability or panel size. Patients can tell us whether they feel able to obtain timely care, whether after-hours supports are effective, and whether virtual or in-person options truly meet their circumstances. Continuity of care is best understood through lived experience. Patients know what it means to retell their history versus being recognized immediately. They know the reassurance of hearing, "*I remember you*," and the anxiety of navigating a system where no one seems to hold the whole picture. The personal relationship with a family physician has traditionally been at the heart of primary care. The relationship between patients and their family doctors is widely regarded by patients as being irreplaceable. It is a relationship that is often grounded in trust and shared understanding of a patient's medical history, family context, and personal values. While team-based models of care can enhance scope and capacity, patients see these enhancements as being most effective when they strengthen the continuity and relationship with their trusted primary care provider. From the patient perspective, new team-based models of primary care will have to recognize the importance of building meaningful connections and relationships across the care team.

This report recognizes that to strengthen primary care teams, we must meaningfully incorporate patient voices. Understanding what patients think of the care they are receiving—what works, what does not, and what matters most to them—is crucial if we seek to improve primary care delivery. By elevating patient perspectives alongside clinical expertise and system metrics, we move closer to a model of care that is not only efficient and evidence-based, but compassionate, continuous, and truly centered on those it is meant to serve.

Why is This Topic Important?

Canada's primary care crisis is affecting patients' ability to access care when and where they need it (1–3). According to the 2023 Canadian Community Health Survey, 83% of adults reported having a regular healthcare provider, leaving approximately 5.4 million (17%) Canadians without one (1,4). Across Canada, primary care access was lowest among young adults, lower income groups, residents of the territories, and people living in the Atlantic provinces, including Newfoundland and Labrador (1,4).

> *While team-based primary care models aim to improve access and meet patients' primary care needs, understanding how patients experience them is critical to ensuring success and identifying opportunities for improvement of these models.*

To address the growing number of Canadians living without a regular primary care provider, several provinces have introduced team-based primary care models as a key strategy for primary care reform. Team-based primary care models involve family physicians working collaboratively with nurses, nurse practitioners, pharmacists, social workers, dietitians, and other allied health providers to deliver high-quality, coordinated care (2,3).

Evidence increasingly highlights the need to integrate patient perspectives into healthcare evaluation and planning (5–8). However, recent evidence on primary care models suggests patient perspectives remain underexamined (9). While team-based primary care models aim to improve access and meet patients' primary care needs, understanding how patients experience them is critical to ensuring success and identifying opportunities for improvement of these models.

How Was This Research Topic Chosen?

In 2023, the national Support for Patient-Oriented Research (SPOR) Evidence Alliance hosted a Patient and Public Health Research Topic Priority-Setting exercise in which patients and public partners from across Canada were invited to submit topics on current and pressing healthcare and health system gaps. All submitted topics would then be considered for research funding through the Alliance. Final topics were selected by a 15-member steering panel that included patients and public partners alongside health system decision makers. The initiative was aimed at connecting patients and members of the public with a dedicated SPOR Evidence Alliance research team "to ensure research outcomes are both scientifically robust and reflect patient experiences and perspectives" (10).

Cris Carter, a Patient Partner with the NL SUPPORT Patient and Public Advisory Council, submitted a request for research that would identify barriers and facilitators related to primary care access. Her submission was selected as one of 20 priority topics to receive funding from the SPOR Evidence Alliance. NLCAHR was then matched as the research team to work with Cris Carter, Project Co-Lead and with Rosemary Lester, Patient Partner, to carry out an evidence synthesis.

Our Research Question

Patient perspectives on primary care have implications for decision-making in Newfoundland and Labrador in light of recent primary care reform and the establishment of Family Care Teams in the province. Within this policy context, Project Co-Lead Cris Carter, Patient Partner Rosemary Lester, and researchers at NLCAHR began working together to focus the topic for this study on patient perspectives as they relate to team-based primary care. Working in consultation with a subject matter expert, the Project Team arrived at the following research question for this *Rapid Evidence Report*:

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

A Note on Terms | In this report, we use the term "*patient perspectives*" as an umbrella term encompassing patient experience (including patient-reported experiences[1]), perceptions, attitudes, preferences, and views related to team-based primary care.

The literature reviewed included a wide variety of descriptions for interprofessional primary care teams. In this report, we use terms such as *"team-based primary care," "multi-disciplinary care teams"* and "*care delivered by interprofessional teams*" to reflect the literature on primary care teams that included, at a minimum, one primary care physician or one nurse practitioner working collaboratively with at least one other healthcare provider. Please see "*Defining Primary Care Teams*" on Page 17 for more detail on how care teams are defined in the literature.

In this report, the term "*access to care*" generally refers to timely, affordable, and appropriate access to health services that promote, maintain, or restore patient health. Please see details about patient perspectives on access to care starting on Page 27.

We use the term "*continuity of care*" to refer to an experience of healthcare that is continuous, connected and well-organized through a patient's care journey, from care provider to care provider, regardless of the healthcare setting. Please see details about patient perspectives on continuity of care starting on Page 33.

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[1] In the literature, the term "patient experience" is often used broadly. Only a small number of recent primary studies collected *patient-reported experiences* using standardized measurement tools, commonly known as Patient-Reported Experience Measures (PREMs).

What Did the Research Evidence Tell Us? A Summary of Key Messages

Our methodology for locating, assessing, and synthesizing the evidence in this report is outlined in detail in the following sections, as are the details of what the research evidence revealed. The following summary is intended to highlight the key messages derived from a close examination of the research literature about patient perspectives on community-based primary care delivered by interprofessional teams. These messages focus specifically on patient perspectives related to access, continuity, and other relevant aspects of quality of care.

Key Messages:
Patient Perspectives on Team-Based Primary Care

Characterizing the Evidence

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

A Variety of Perspectives

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

Perspectives on Access to Care

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

Perspectives on Continuity of Care

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

Perspectives on Other Relevant Aspects of Quality of Care

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

About the Research Evidence

The Project Team consulted with a Health Sciences librarian at Memorial University to develop a comprehensive search strategy that would enable us to locate research evidence for this report. We searched PubMed, CINAHL, and PsychInfo for peer-reviewed systematic reviews and primary research articles published in English since 2020 (February 2020 - February 2025), limiting our search to the last five years to optimize the relevance of the findings.

How Did We Select Research Evidence for This Report?

The Project Team and Consultant identified the following key parameters and inclusion/ exclusion criteria to select the relevant studies for this *Rapid Evidence Report*:

Table 1: Parameters Used to Select Relevant Research Evidence

Parameter	Inclusion Criteria	Exclusion Criteria
Population	- Adult patients, aged 18 years and older, seeking primary care	- Adults not seeking primary care - Pediatric patients seeking primary care
Intervention	- Interprofessional primary care teams that include at minimum, one primary care physician or one nurse practitioner working collaboratively with at least one other healthcare provider.	- Interprofessional teams working outside the primary care setting - Interprofessional primary care teams that are not led by a primary care physician or nurse practitioner
Comparison	- Solo-based community practice and program-based models of service delivery (if available)	
Outcomes	Patient perspectives on: - access to primary care, - continuity of care, and - other relevant aspects of quality of care	
Setting	- Community-based primary care clinics in rural or urban settings	- Non primary care clinics
Language	- English	
Years	- Published in the last 5 years	

What Kinds of Research Evidence Did We Find?

This report includes research evidence from one integrative review that included the findings from 48 individual primary studies (11). We also include the evidence from 14 primary studies that were published too recently to have been captured in the review literature (12–25).

How Did Included Researchers Collect Data on Patient Perspectives?

In the literature we reviewed for this report, the most common approaches used to collect information about patient perspectives involved conducting interviews, carrying out surveys, or using a combination of methods, such as interviews with focus groups or surveys (11).

Approximately half of the recent primary studies included in this report involved surveys with researchers conducting surveys exclusively or as part of a mixed-methods approach to capture patient perspectives (14–17,21,22,25). Included surveys were conducted either at the clinic level or at the regional level. Many surveys were distributed only to participants who had an email address (14,16,17,25) or who were already registered with a clinic (22). This approach facilitated large and diverse samples, ranging from 404 participants up to 719,137 survey respondents (14–17,21,22,25). Several of the authors reporting on using email-based recruitment noted that this method may have had some impact on who responded (14,16,17,25), potentially influencing participant characteristics and limiting the level of demographic representation among study participants. As well, a few study authors commented that larger sample sizes did not always translate to high survey response rates (17,22,25).

Five included qualitative studies used interviews or focus groups to gather perspectives from patients (13,18–20,24). This approach allowed for in-depth exploration of patient perspectives but involved smaller, more targeted samples, ranging from 16 to 40 participants (13,18–20,24). These studies often recruited patients with specific health or social needs, for example, common mental disorders, chronic low back pain, or social vulnerability. Two of these studies also aimed to capture geographic variation by sampling across urban, rural, and remote practices (13,18).

Two recent primary studies used a combination of surveys and interviews (12,23) to understand patient perspectives. One study recruited participants for surveys (*n* = 287) and interviews (*n* = 14) separately (12). The other study (23) selected its interview sample (*n* = 30) from participants who had completed a survey (*n* = 1,322).

Table 2 summarizes the study designs and the key interventions included in this report, detailing the methodologies used in both the integrative review and the fourteen included primary studies.

Table 2: Study Designs and Interventions Included in This Report

Systematic Review Evidence		
Author, Year (Reference)	**Study Design**	**Intervention**
1. Davidson, 2022(11)	Integrative Review	Interprofessional collaborative practices
Primary Research Evidence		
Author, Year (Reference)	**Study Design**	**Intervention**
1. Abelsen, 2023 (12)	Mixed Methods (interviews and survey)	Primary Healthcare Team Pilot
2. Ashcroft, 2021 (13)	Qualitative (focus groups & interviews)	Family Health Teams
3. Breton, 2024 (14)	Cross-Sectional Study (patient e-survey)	Multidisciplinary Primary Health Care Clinics
4. Cohen, 2024 (15)	Cross-Sectional Study (patient-centered survey)	Primary Care Center Team
5. Deville-Stoetzel, 2024 (16)	Cross-Sectional e-Survey and latent class analysis	Team-based Primary Healthcare Clinics
6. Deville-Stoetzel, 2023 (17)	Cross-Sectional e-Survey hosted on a web platform	Team-based Primary Healthcare Clinics
7. Donaghy, 2024 (18)	Qualitative (in-depth semi-structured interviews with thematic analysis)	Primary Care Multidisciplinary Teams
8. Feryn, 2021 (19)	Qualitative (semi-structured interviews)	Interprofessional Collaboration in a Primary Care Center
9. Goff, 2024 (20)	Mixed Methods (patient survey and semi-structured interviews with health care providers and patients)	Primary Care Networks
10. Haj-Ali, 2021 (21)	Retrospective Cohort Study	Interprofessional Teams
11. Kayira, 2024 (22)	Latent Profile Analysis and Cross-Sectional Study	Primary Care Networks
12. Sweeney, 2024 (23)	Mixed Methods Evaluation (postal survey & individual telephone interviews)	Primary Care Multidisciplinary Teams
13. Vader, 2025 (24)	Qualitative (semi-structured telephone interviews)	Family Health Teams and Community Health Centres
14. Zhong, 2021 (25)	Serial Cross-Sectional Study (e-mail survey)	Family Health Teams

What Was the Quality of the Evidence?

The results of our quality appraisal are summarized in Table 3 below. We appraised the evidence included in this report by using three critical appraisal tools:

- **To appraise the integrative review, we used the AMSTAR tool**, an 11-item instrument that assesses methodological rigor of systematic reviews. The quality of the research is rated as being: Low, Moderate, High, or Very High (26).
- **For cross-sectional primary studies**, **we used a modified Downs and Black checklist** to assess the methodological quality of non-randomized studies. The scale consists of 28 questions about quality of reporting, external validity, internal validity, and statistical power (27). The quality of primary studies is then rated as being: Poor, Fair, Good or Excellent (28).
- **For all other primary studies, we used the SBU Quality Assessment Checklist** for Qualitative Research Studies – Patients' and Clients' Perspectives. This checklist has 21 questions about the study's aim, sample selection, data collection, analysis and results. The assessment of study quality is then rated as High, Moderate or Low (29).

Table 3: Quality Appraisal of Included Evidence

Included Integrative Review	**AMSTAR[2] Quality Appraisal Results**		**Quality Rating**
1. Davidson, 2022 (11)	7/11	63.6%	Moderate
Included Primary Studies	**Downs and Black[3] Quality Appraisal Results**		**Quality Rating**
1. Breton, 2024 (14)	22/28	78.6%	Good
2. Cohen, 2024 (15)	23/28	82%	Good
3. Deville-Stoetzel, 2024 (16)	22/28	78.6%	Good
4. Deville-Stoetzel, 2023 (17)	18/28	64.3%	Fair
5. Haj-Ali, 2021 (21)	22/28	78.6%	Good
6. Kayira, 2024 (22)	22/28	78.6%	Good
7. Zhong, 2021 (25)	20/28	71%	Good
Included Primary Studies	**SBU Quality Assessment Checklist[4]**		**Quality Rating**
8. Abelsen, 2023 (12)	Not scale based, this checklist for qualitative research assesses study aim, sample, methods, and results are compared against criteria for High, Moderate, and Low-quality qualitative research.		Moderate- High
9. Ashcroft, 2021 (13)			Moderate- High
10. Donaghy, 2024 (18)			Moderate- High
11. Feryn, 2021 (19)			Moderate- High
12. Goff, 2024 (20)			Moderate- High
13. Sweeney, 2024 (23)			Moderate- High
14. Vader, 2025 (24)			Moderate- High

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[2] **AMSTAR** scale: **Low** (0-36.4%), OR review fails to score a "Yes" on ALL of items #1, 3, 5, and 7; **Moderate** (36.4% - 63.6%) AND review scores a "YES" on #1, 3, 5, 7; **High** (> 63.6%) AND review scores a "YES" on #1, 3, 7

[3] **Downs and Black** Scale: **Poor** (0-50%), **Fair** (51-70%), **Good** (71-92%), **Excellent** (93-100%)

[4] **SBU Quality Assessment Checklist**: Instead of using a numerical scale, these studies were assessed against criteria for scientific quality in qualitative research and then rated as **High, Moderate**, or **Low**.

Our critical appraisal found that the integrative review along with the majority of the primary studies were of either moderate or good methodological quality (11–16,18–25). Among the remaining literature included in this report, we assessed that the final recent primary study had fair methodological quality (17).

Despite their review being assessed as having moderate methodological quality, the authors of the integrative review pointed out that the overall quality of included primary studies was generally low (11).

Characterizing the Evidence: PICOS Parameters

The populations, interventions, comparators, outcomes, and settings (known as PICOS Parameters) included in each included study are detailed below:

Included Populations

For this report, we focused on studies involving adult patients aged 18 years and older receiving team-based primary care. We excluded studies on pediatric populations and adults seeking non-primary care services. While our focus in this review is on patient perspectives, we note that one of the recent primary studies (20) also explored healthcare provider perspectives. Below, we focus only on the characteristics of patient participants.

Health of Study Populations | Although our inclusion criteria did not specifically target patients with chronic conditions, most of the literature we included captured a proportion of individuals living with ongoing health issues. We found that patients with chronic conditions were consistently well-represented, even in studies that did not explicitly aim to recruit them. This suggests that the research on team-based primary care included in this report may be more reflective of the perspectives of individuals with chronic or complex health needs.

In particular, the integrative review and a few recent primary studies focused on patients with chronic or complex health conditions. The integrative review specifically set out to examine patients with chronic conditions, synthesizing evidence on patients with a wide range of health issues, including diabetes, mental health disorders, chronic pain, cardiovascular disease, asthma, HIV/AIDS, dementia, and cancer (11). Similarly, several recent primary studies purposively sampled populations with specific health concerns, such as patients aged 65 and older with polypharmacy (20), those with mental health concerns (13,20), chronic low back pain (24), or social vulnerability (19).

Although the remaining recent primary studies recruited from general adult populations, these studies often reported that high percentages of their samples had one or more chronic conditions (12,14,16,18,21,23). For example, in two Quebec-based studies, 65% and 80% of participants reported chronic conditions (14, 16). Among the patients in an Ontario study on Family Health Teams, 42.6% reported ongoing health conditions (21). Moreover, survey participants of a primary healthcare team pilot study described a range of physical and psychological concerns, including cardiovascular disease (53.5%), diabetes (36.3%), asthma and other chronic lung diseases (27.5%), mental health concerns (23.2%), cancer (8.8%), and musculoskeletal issues (41.2%) (12).

Demographics of Study Participants | The integrative review described the health conditions of the adult participants in the studies they examined but provided limited detail on participant demographics (11).

In contrast, the 14 recent primary studies in this report offered more detailed information on sample population demographics. Most participants were adults aged 18 or older, though two primary studies included a small number of 16–17-year-olds (21,22). Across the recent primary studies, samples generally skewed older, with some studies reporting mean or median ages in the early to mid-60s (23,24). Others described participant groups where most were over 50 (17) or over 65 (15,20). A few studies had younger patient age ranges such as adults aged 23–50 (19) or 18–45 (20). The majority of study participants were female, although two studies intentionally recruited a gender-balanced sample (18,23).

Included Interventions

Team-based primary care was the main intervention of interest for this report. We aimed to select literature that examined primary care teams comprising, at minimum, one primary care physician or one nurse practitioner working collaboratively with at least one other healthcare provider. However, we found, even when a list of members was provided, many study descriptions lacked sufficient detail on how collaboration among team members was implemented in practice. If a study did not explicitly state that the team was led by a general practitioner (GP) or nurse practitioner, we relied on details in the study methods or description that reasonably implied that a GP or nurse practitioner played a central role on the team.

We aimed to select literature that examined primary care teams comprising, at minimum, one primary care physician or one nurse practitioner working collaboratively with at least one other healthcare provider. However, we found, even when a list of members was provided, many study descriptions lacked sufficient detail on how collaboration among team members was implemented in practice.

We should also note that for the integrative review, a portion of the included studies feature teams with more specialized members or narrower scopes of practice than we intended to capture. This issue was more pronounced in studies from the integrative review that focused on populations with specific chronic health conditions— in particular, teams targeting diabetes care (11), as compared to those studies that explored the general adult experience of receiving team-based primary care. When we selected recent primary studies for this report, we were able to prioritize those studies that evaluated broader, generalist team-based care rather than care teams with more specialist team members.

Defining Team-Based Primary Care | Overall, we found that team-based primary care is described in the literature using a variety of terms. Team-based care in some studies is described using generic terms such as: interprofessional collaborative practice (11,19), multidisciplinary teams (18,23), primary healthcare teams (12), multidisciplinary primary health care clinics (14), team-based primary care (15), and team-based primary care clinics (16,17). Other studies use more specific terms for widely adopted team-based care models in particular settings, such as Family Health Teams (13,21,24,25), Family Medicine Groups (14) and Primary Care Networks (20,22).

> *Recent primary studies highlight a range of team-based care models implemented in various Canadian and international primary care settings...*
>
> *… most of these studies offer general descriptions of teams with few specifying the precise team composition.*

Much of the literature tended to describe the general concept of team-based primary care without offering detailed information on the exact composition of teams. In the absence of a consistent definition, the integrative review examined interprofessional collaborative practice in primary care and based its definition on the World Health Organization’s description (11). According to this definition, interprofessional collaborative practice involves multiple health professionals from different disciplines working together with patients and their families to deliver high-quality care and interventions. The review also commented on the lack of consensus on key terminology in their search, noting that various terms were used to describe team-based primary care across the literature (11).

Recent primary studies highlight a range of team-based care models implemented in various Canadian and international primary care settings. Much like the integrative review, most of these studies offer general descriptions of teams with few specifying the precise team composition.

- Four studies examined Family Health Teams in Ontario and provided varying levels of detail regarding team-based primary care models. Often authors of these studies used terms such as team-based primary care or interprofessional teams when describing this model (13,21,24,25). Two studies similarly outlined Family Health Teams (FHTs) in Ontario and described that these teams bring together family physicians with a range of professionals including nurses, nurse practitioners, social workers, psychologists, consulting psychiatrists, pharmacists, dietitians, and other mental health workers (13,21). One study specified that 92% of FHTs include social workers, 25% include psychologists and 13% include other mental health workers (13). The other study reported that a typical team would include primary care physicians, nurses or nurse practitioners and at least one other health care professional (21). A third study offered a more detailed account of the healthcare disciplines involved in managing chronic low back pain within team-based primary care, including family physicians, physiotherapists, occupational therapists, pharmacists, kinesiologists, registered nurses, and nurse practitioners (24). The fourth study focused on a specific example from a multisite interprofessional primary care team serving approximately 45,000 patients across six clinics in Toronto; however, the exact composition of teams in each clinic were not described (25).

- Out of three studies that explored team-based primary healthcare clinics in Quebec (14,16,17), two note that the landscape of team-based care included 104 clinics (14,16). The studies consistently described the general composition of the teams as a collaboration between family physicians and nurses as well as other primary healthcare professionals such as social workers, and pharmacists. The authors note that services are provided to enrolled patients on a non-geographical basis (14,16). However, none of these studies provided detailed breakdowns of team composition at the individual clinic level.

- Two other studies examined the expansion of multidisciplinary teams in primary care in Scotland. Both highlight a recent shift in the role of the general practitioner (GP), now defined as an expert medical generalist. This redefined role is intended to enable GPs to spend more time with patients with complex healthcare needs (18,23). One of the studies further describes how GPs in their new role lead multidisciplinary teams of professionals that include practice nurses, advanced nurse practitioners, physiotherapists, mental health nurses, pharmacists, and community link workers (23).

- Two studies describe Primary Care Networks in England. According to these studies, Primary Care Networks reorganize general practice into networks that collectively deliver services across multiple practices. Primary Care Networks collaborate across general practices as well as with mental health, social care, pharmacy, and community services to offer more comprehensive, locally tailored care. The skill mix of Primary Care Networks have expanded to include professionals such as clinical pharmacists, physician associates, social prescribers, nurse specialists, healthcare assistants, and other allied health professionals (20,22).

- Of the remaining three studies, two focused on team-based care in primary care centers in Belgium and Sweden, respectively. The study conducted in Belgium described primary care centers as being an interprofessional collaboration, requiring at least a doctor, a nurse, and one other discipline (19). In this model, the primary care center's team would include eight doctors, six nurses, five physiotherapists, two social workers, one health promoter, and three receptionists. The second study (15) did not detail team composition, but the primary care center's website listed a broad team that included doctors, nurses, psychotherapists, physiotherapists, occupational therapists, and administrative staff (30). The third study conducted in

Norway (12) described a primary healthcare team pilot in which general practices were expanded with the addition of nurses. The primary healthcare team included regular GPs, nurses and medical assistants. The pilot involved 17 practices, each comprising 3–17 general practitioners, 1–4 nurses, and 2–6 medical assistants (12).

Included Comparators

Our review sought to identify studies comparing interprofessional team-based primary care to solo practice or traditional models in which physicians work independently. However, we found such comparisons to be rare in the integrative review and lacking in most of the recent primary studies. We did identify one recent primary study that compared interprofessional teams to non-interprofessional care models in Ontario, providing some insight into how patients experience different models of care delivery in that province (21).

[We] sought to identify studies comparing interprofessional team-based primary care to solo practice or traditional models in which physicians work independently. However, we found such comparisons to be rare in the integrative review and lacking in most of the recent primary studies.

While not making formal comparisons, other primary studies did explore patient experiences as primary care systems transitioned toward team-based models. A pilot study conducted in Norway described patient experiences when shifting from single-provider GP care to interprofessional team-based care involving a GP and nurse (12). Two studies from Scotland also captured patient perspectives on changes in general practice following the introduction of the new GP contract to expand multidisciplinary teams (18,23).

Included Settings and Care Contexts

Geographical Settings | Altogether, the 48 individual studies included in the integrative review (11) along with 14 recent primary studies were conducted in primary care settings across at least 14 different countries (12–25).

Half of the recent primary studies in this report were Canadian with four examining Family Health Teams in Ontario (13,21,24,25) and three examining team-based primary healthcare clinics in Quebec (14,16,17). The remaining primary studies were all internationally based with two out of Scotland (18,23), two from England (20,22) and one each from Norway (12), Sweden (15), and Belgium (19).

Table 4 summarizes the geographical settings included in this report and the number of studies from each setting.

Table 4: Geographical Settings Included in the Evidence/ Number of Studies per Setting

What settings were included in the evidence we reviewed?	How many individual studies looked at this setting?	Reference from the literature – # of studies
USA	13	Davidson, 2022* - 13
Australia	11	Davidson, 2022 - 11
Canada	10	Davidson, 2022 - 3 Recent primary studies - 7 • Ashcroft, 2021 • Breton, 2024 • Deville-Stoetzel, 2024 • Deville-Stoetzel 2023 • Haj-Ali, 2021 • Vader, 2025 • Zhong, 2021
UK	11	Davidson, 2022 - 7 Recent primary studies - 4 • Donaghy, 2024 • Sweeney, 2024 • Goff 2024 • Kayira, 2024
Sweden	5	Davidson, 2022 - 4 Recent primary study - 1 • Cohen, 2021
Belgium	2	Davidson, 2022 – 1 Recent primary study: 1 • Feryn, 2021
Netherlands	2	Davidson, 2022 - 2
Norway	2	Davidson, 2022 – 1 Recent primary study: 1 • Abelsen, 2023
France	1	Davidson, 2022 - 1
Italy	1	Davidson, 2022 - 1
New Zealand	1	Davidson, 2022 – 1
Qatar	1	Davidson, 2022 - 1
Spain	1	Davidson, 2022 – 1
Multi European region	1	Davidson, 2022 – 1
Total number of individual studies in this report	62	

*Davidson, 2022: The 48 studies in the integrative review reflect the bulk of research conducted in international settings and included all available studies from the USA and Australia.

In addition to looking at the geographical settings included in this report, contextual information from recent primary studies provides valuable insights into the common and differing features of the included settings, as well as the reforms that have influenced the development of team-based primary care across included studies.

Health System Contexts |The majority of recent primary studies in this report were carried out within single payer universal healthcare systems: in Canada (13,14,16,17,21,24,25), in the United Kingdom (18,20,22,23), in Sweden (15), in Norway (12) and in Belgium (19). These healthcare contexts offer free or low-cost primary care, a factor that could influence both access to, and the structure of, team-based care models. Some other healthcare contexts represented in the integrative review, such as those in Australia and the U.S., have structural differences that may shape the organization of team-based primary care in different ways. However, the integrative review did not examine these contextual differences in any depth (11).

Primary Care Reform | A few recent primary studies described both longstanding and recent reforms supporting team-based primary care to provide context for their study settings. Studies from Scotland and England described recent reforms that involved moving towards team-based primary care after 2018 (18,22,23). A single primary study conducted in Norway explores the shift in general practice from single-profession general practitioner care to a pilot of interprofessional team-based care over the period between April 2018 and March 2023 (12). On the other hand, Canadian studies from Ontario and Quebec describe reforms supporting team-based primary care beginning in the early 2000s, thus providing more longstanding examples of this shift in care delivery (14,16,17). It is therefore evident from the literature that different jurisdictions are at varying stages of development and experience with team-based primary care.

Many of the recent primary studies briefly describe underlying motivations driving primary care reform. While the main impetus for reform seems to vary somewhat between contexts, the descriptions provided by the study authors reveal some similarities.

Many of the recent primary studies briefly describe underlying motivations driving primary care reform. While the main impetus for reform seems to vary somewhat between contexts, the descriptions provided by the study authors reveal some similarities. There was some overlap across settings as the authors outlined motivating factors behind the reforms that are driving team-based care:

- aiming to improve access to primary care (13,17,18,20),
- aiming to improve continuity of care with other parts of the health system or between patients and providers (12,13,15,17,21),
- aiming to support increasingly complex patient care (15,18,24),

- making existing services more sustainable (18,22),
- addressing health inequalities (18,19,23), and
- improving quality of care (18).

Below, we present specific examples from the recent primary literature to illustrate variation in the purposes of primary care reform across various contexts:

- A description of reforms in Quebec describes team-based primary care as being aimed at enhancing care access as well as addressing the need to affiliate patients with a regular family physician in an effort to foster a continuous relationship between physicians and patients (17).

- The move to Ontario Family Health Teams aimed to improve access to comprehensive, person-centred care, enhance continuity with other parts of the health care system, and better address complex patient needs (including the care of aging populations and those with mental health and chronic conditions) (13,21,24).

- In Scotland, the reforms were intended to improve the quality and accessibility of care for patients, with the aim of increasing the amount of time that GPs could devote to their patients with complex needs (18,23).

- Initial calls for reform in England were aimed at encouraging general practices to work together to deliver services to more people in hopes this would lead to the creation of Primary Care Networks. This change was intended to help practices become more efficient, allowing for adequate provision of appointments and improving healthcare sustainability through the sharing of resources and expertise (20,22).

Included Outcomes

This report focuses on evidence from research that examined patient perspectives on the following outcomes related to team-based primary care:

- access to care (see Figure 2),
- continuity of care (see Figure 3), and
- other relevant aspects of quality of care (see Figure 4).

The literature varied in its level of detail when describing outcomes related to access, continuity, and other relevant aspects of quality of care. Some survey-based studies used specific patient-reported indicators, while the integrative review and many recent qualitative studies identified these outcomes more implicitly through themes from interviews and focus groups.

For clarity and consistency, this report uses the umbrella term “patient perspectives” to capture experiences, including patient-reported experiences, perceptions, attitudes, *For clarity and consistency, this report uses the umbrella term "patient perspectives" to capture experiences, including patient-reported experiences, perceptions, attitudes, preferences, and views related to team-based primary care.*

preferences, and views related to team-based primary care. In the literature we reviewed, these terms were often used interchangeably and were not always explicitly defined. As a result, when reporting the findings from individual studies below, we have retained the original terminology used by the researchers.

What Do We Mean By "Quality of Care"? | Across the studies we reviewed, "quality of care" was treated as an overarching concept, shaped by multiple dimensions including access, continuity, and other aspects of care quality, such as patient-centered care. Only two primary studies offered definitions of quality of care (13,19). Although this report primarily focuses on patient perspectives on access and continuity, it also incorporates perspectives on other relevant aspects of quality of care that were commonly examined in the literature.

Access to Care: Patient Perspectives | Most of the literature we reviewed examined access to care, including the integrative review (11) and 12 recent primary studies (12–14,16–19,21–25). Four recent primary studies applied the Levesque and colleagues framework (31) which conceptualizes access as a multi-step process: perceiving the need for care, seeking care, reaching care, obtaining care, and having needs met (14,16,17,24). The remaining primary studies and the integrative review did not apply a formal framework but examined a range of access-related perspectives.

The following themes related to access were most often discussed:

- Availability of care (11–13,19,23); and
- Accessibility and convenience of accessing care (11–14,16–18,21,23–25).

Eight recent primary studies also explored multi-level factors[5] influencing access from the patient perspective (13,14,16–18,22,23,25).

Continuity of Care: Patient Perspectives | The majority of the literature also examined patient perspectives on continuity of care, including the integrative review (11), and 11 recent primary studies (12,13,15–20,22–24).

Three of these primary studies explicitly applied Haggerty's framework (32), a widely used model that distinguishes between three dimensions of continuity (12,16,20).

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[5] For this report multi- level factors refer to factors that influence outcomes, operating at different levels of the healthcare system, namely, patient-level, contextual-level, and organizational-level factors.

While the integrative review and most recent primary studies did not formally define continuity, the outcomes they reported can still be meaningfully understood within this framework:

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

Across the literature, patients described continuity in ways that reflected one or more of these dimensions. Relational continuity (11–13,15,18–20,23) and management continuity (11–13,17–19,24) were discussed most frequently within the integrative review and recent primary studies, whereas informational continuity was least commonly addressed and only described in a few recent primary studies (12,17,18,20).

Four recent primary studies also explore some patient-level and contextual factors that may influence patient perspectives on continuity of care (16,17,20,22).

Other Relevant Aspects of Quality of Care: Patient Perspectives | Apart from issues of access and continuity of care, some of the literature we reviewed also reported on other relevant aspects that influenced quality of care from the patient perspective:

- **The relationship between access and continuity** was discussed in five recent primary studies (12,14,15,20,22). These studies described how changes in one domain (e.g., access) could impact another (e.g., continuity).
- **Outcomes related to holistic and patient centered care** were examined in the integrative review (11) and three recent primary studies (12,13,25).
- **Appointment length and time spent with providers** was examined in the integrative review (11) and five primary studies (12,13,18,23,24).

Strengths and Limitations of the Included Literature

The main strengths and limitations of the literature reviewed in this report are summarized below.

Strengths | We identified several methodological strengths across the included literature. Firstly, the integrative review used a systematic approach, including duplicate screening and quality assessment methods. This approach helps improve the reliability of the review process. The authors also applied broad inclusion criteria, with no restrictions on study design, publication year, or language, which allowed them to capture a wide range of patient perspectives (11).

Several recent primary studies also had methodological strengths. A few studies drew on large samples or administrative datasets, which can strengthen the reliability of their findings (14,16,23). Four studies also included diverse participant groups, such as patients of different ages and diagnoses (12), patients from varied socioeconomic backgrounds (15), and participants from multiple geographic regions (18,23), improving the validity of research findings. Additionally, two primary studies used a mixed-methods design, combining quantitative and qualitative data to provide a more comprehensive understanding of patient perspectives on team-based primary care (12,23).

Limitations | While the studies reviewed in this report offer valuable insights into patient perspectives on team-based primary care, there are also some limitations that should be considered when interpreting the findings.

The integrative review by Davidson et al. identified several overarching methodological concerns, including low overall study quality, unclear and minimal representation of Indigenous, LGBTQIA+, and culturally and linguistically diverse groups, and inclusion of studies where patient experience was a secondary consideration rather than a primary aim. These issues highlight broad limitations in the strength and inclusiveness of the integrative review evidence (11).

Primary studies revealed additional design-specific challenges related to the use of survey and qualitative approaches. Study authors raised recurring concerns about sample representativeness (13,16,17,19,20) and sample selection (12,14,15,17,18,21,23,24). Studies also highlighted inherent limitations in how patient perspectives were measured, including the reliance on self-reported data and the tendency to focus on some preferences or experiences while others may have been underrepresented or unexamined (13–15,19,21,22,24,25).

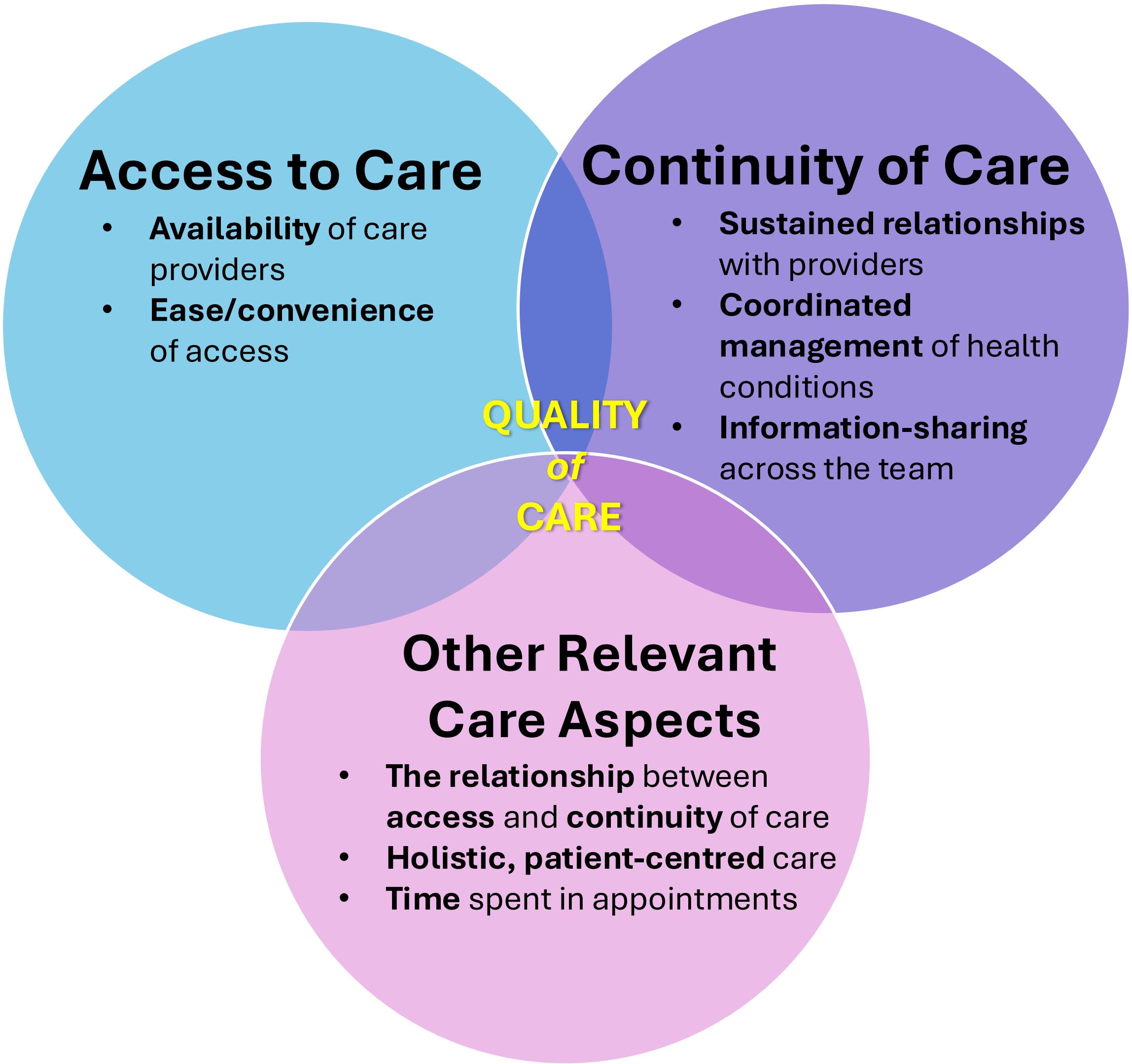
Another frequently cited limitation amongst the recent primary studies was related to the generalizability and/or applicability of the study findings. Some study authors cautioned that their findings might not be applied to other populations, settings, or contexts based on factors such as single-site study designs (15,19) and geographic or contextual differences, particularly variations in health systems and team-based care models. For example, studies conducted in Ontario (13,24), Quebec (16,17), Norway (12), Scotland (18,23) and England (20) reflected these regional and system variations. Additionally, some research was carried out under extraordinary circumstances, such as during the COVID-19 pandemic (18,24), further limiting generalizability.

What Did the Research Evidence Tell Us? A Detailed Look

Taken together, the research evidence suggests that patients generally have positive experiences with team-based primary care. Studies reported that patients perceived many aspects of team-based primary care as being acceptable, appropriate, or improved; however, patient perspectives also varied, with some studies noting challenges or areas where the quality of patient care could be improved.

Patient perspectives on access, continuity, and other relevant aspects of quality of care as described in the research literature are outlined in detail on the following pages with the key themes and sub-themes summarized in the figures below.

Figure 1: Summary of Key Outcomes Included in This Report



Access to Care

- **Availability** of care providers
- **Ease/convenience** of access

Continuity of Care

- **Sustained relationships** with providers
- **Coordinated management** of health conditions
- **Information-sharing** across the team

QUALITY of CARE

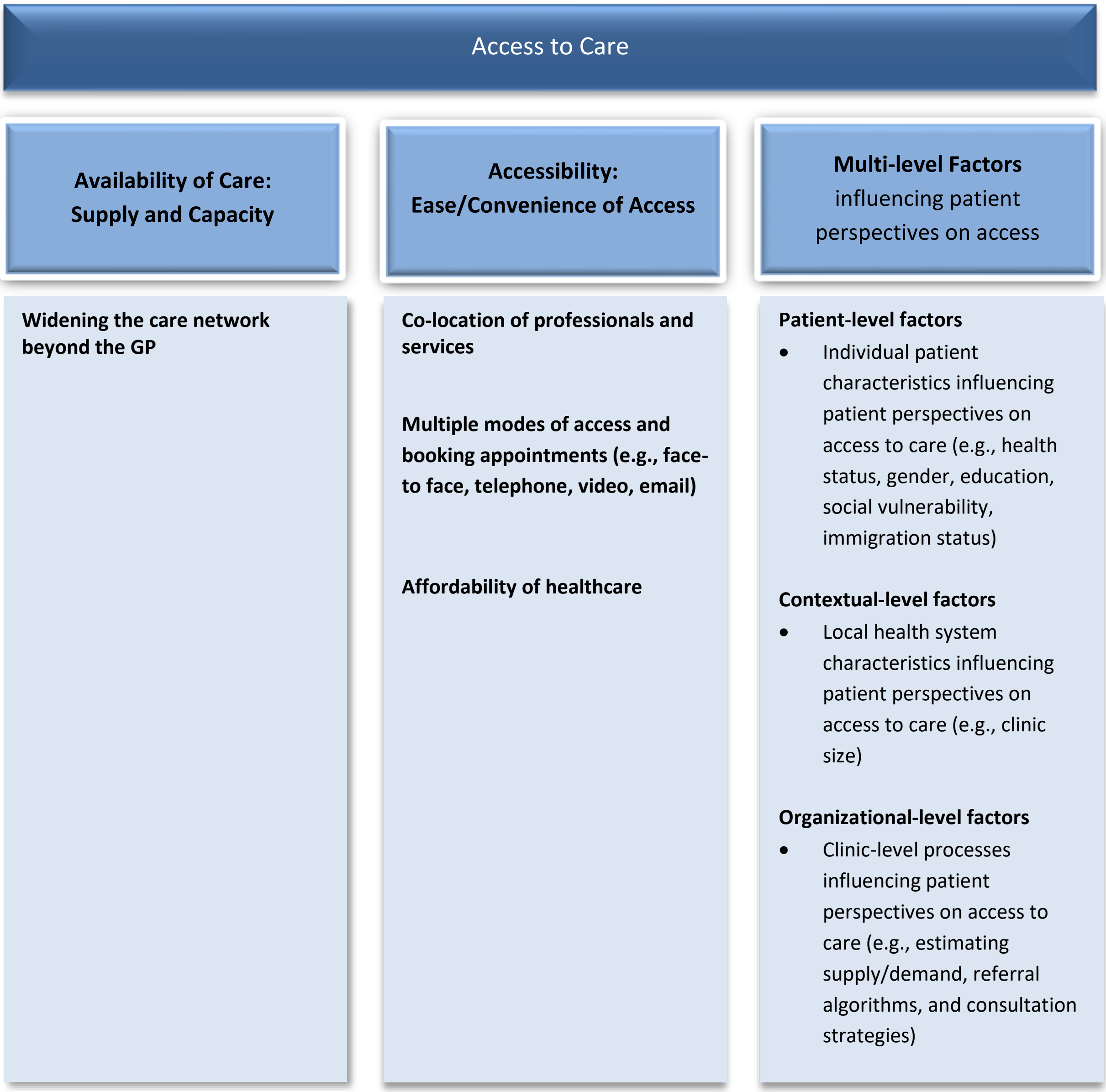
Other Relevant Care Aspects

- **The relationship** between **access** and **continuity** of care
- **Holistic, patient-centred** care
- **Time** spent in appointments

Access to Care: Patient Perspectives

Access to care is an important consideration for patients; the majority of the research evidence we located, including the integrative review (11) and most of the recent primary studies (12–14,16–19,21–25) reported on patient perspectives about access to care. The following figure summarizes the themes and sub-themes from the literature on patient perspectives on access to care through team-based primary care models.

Figure 2: Access to Care: Themes and Sub-Themes



Access to Care

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

Most often, patient perspectives addressed access to team-based primary care related to the availability of care (i.e., supply and capacity), and accessibility to care (i.e., the ease/convenience of accessing care or services). Some recent primary studies also explored multi-level factors influencing access to care at the patient level, the contextual level, and the organizational level.

Availability of Care:
Supply and Capacity

The moderate-quality integrative review examining individuals with chronic conditions explored how patients experienced the availability of their primary care under the subtheme, ‘Widening the Network.’ According to the review authors, patients described how interprofessional collaborative practice (IPCP) expanded their care network beyond their general practitioner (GP) to include nurses, allied health providers, specialists, community and social services, and informal supports such as family, friends, and carers. This broader team was seen by patients as addressing gaps often found in more traditional solo-GP care (11).

A few recent primary studies described similar improvements to access through the widened network while also noting some limitations. A Norwegian pilot study found that patients experienced improved access when general practice was expanded to include nurses who were more readily available than GPs (12), while patients from a study in Scotland perceived increased appointment availability and found benefits in enhanced expertise such as access to physiotherapy for musculoskeletal issues (23). In Belgium, adults in vulnerable situations also appreciated the availability of care from a range of different professionals and noted the usefulness of a direct connection to social workers at their primary care center. At the same time, some patients noted the absence of more specialized services such as dentistry, gynecology, and pediatrics as a limitation (19). In Ontario, patients described how embedding mental health professionals into Family Health Teams facilitated access to mental healthcare for people with common mental disorders. Despite recognizing these meaningful benefits, some patients also noted concerns around the availability of some mental health services, resulting in a cap on psychotherapy appointments, which was seen as being disruptive to their care (13).

Accessibility:
Ease/Convenience of Access

The literature emphasizes that another central aspect of patient perspectives on access to care is the ease or convenience with which individuals can engage with professionals and receive necessary healthcare. The integrative review (11) outlines this concept under the theme ‘valuing convenient healthcare’ and this theme is similarly represented throughout the findings from recent primary studies (12–14,16–18,21,23–25). Most often, patient perspectives emphasized the key factors that influenced the convenience of accessing team-based services, particularly in relation to:

- co-location of professionals and services,
- multiple modes of access and booking appointments, and
- affordability of healthcare.

Co-location of professionals and services | A key finding highlighted in the integrative review is the benefit of co-located professionals for patient care. Patients described that having providers situated in the same location improved communication, teamwork, and availability of services such as pharmacy, x-ray, mental healthcare and allied healthcare (11). Findings from interviews and focus groups in two recent primary studies from Ontario Family Health Teams also reported the benefits of co-location. Adults with common mental health concerns in one study described the improved convenience and ease of access to care when mental health providers were available in the same location as their family physician. Participants described it as being easier to seek mental health support when providers were co-located, as this reduced concerns about stigma. Patients in rural areas without integrated on-site psychiatry described the challenges of travelling long distances to access mental healthcare (13). In another study, patients managing chronic low back pain described how having co-located providers made care easier to access. Being able to schedule multiple appointments back-to-back within the same clinic reduced the need for repeated travel and offered patients a sense of comfort and familiarity with their care environment (24).

Multiple modes of access and booking appointments | The integrative review and two recent primary studies provide evidence on how patient experiences booking appointments affected accessible care in terms of the modes of access for booking appointments, timely access to care, and other challenges encountered in the booking process (11,12,24).

In terms of the options available for patients to access care, the evidence shows that providing different ways to communicate, such as by phone, email, or video can make it easier for patients to connect with their care teams. The integrative review found that patients described connecting with professionals using multiple modes of communication such as face-to face, telephone, and email. Patients appreciated having easier access, especially for quick questions that did not require formal consultation. They described a sense of comfort in knowing support was readily available to them (11). Two recent primary studies also highlighted how patient access to care was enhanced by multiple communication channels and service options being available. Patients in Norway described improved access through increased accessibility on phone and digital platforms as well as the provision of home services (12). Patients with chronic low back pain receiving care from Ontario Family Health Teams also reported that the virtual technologies introduced during the COVID-19 pandemic, such as telephone, video, and web-based platforms improved ease of access to interprofessional, team-based care. These virtual options made it easier to receive care without the need for travel (24).

The importance of timely access to care is highlighted by patients in two studies from Ontario. Patients managing low back pain described the importance of receiving timely access to care during an exacerbation or flare up of their pain. While some patients reported being satisfied with how quickly they could access care in team-based primary care, others experienced delays in access that posed challenges to effective back pain management (24).

Another study compared timely access to care and after-hours access to care between patients receiving care from interprofessional teams versus those receiving care from non-interprofessional teams. Findings from this study showed that patients being seen by interprofessional teams self-reported more timely access to care and less walk-in clinic use, though no significant differences were found in self-reported after-hours care access or emergency department use (21).

Two other primary studies from Scotland highlighted the challenges patients may face, even when a range of appointment booking and enquiry systems are made available. Patients from this study described the difficulty getting through to a receptionist to book a medical appointment in the morning, encountering long telephone wait times and fully booked schedules by the time their calls were answered (18). Additionally, patients reported mixed attitudes around reception signposting, which was defined in this study as the practice of being asked about your health issue by receptionists when you call to make an appointment (18). While most patients accepted this signposting as a part of the new system, some felt uncomfortable being asked about their health issue by receptionist staff. This was particularly pronounced in patients with multimorbidity living in deprived urban areas and was seen by some patients as a barrier to first-contact multidisciplinary team care (18,23).

Affordability of healthcare | The integrative review included another sub-theme related to the convenience of care access: ‘affording healthcare.’ This finding was also reported in two recent primary studies. Participants generally reported positive experiences when insurance coverage or external funding were available to subsidize health professional appointments and healthcare programs. However, affordability became a challenge for some patients when they had to commence or continue treatment after such subsidies or financial incentives had ended. People with lower socioeconomic status and pensioners faced greater difficulties affording team-based healthcare services. When they could not afford to pay for care, they either cut back on other expenses to offset their healthcare costs or they stopped treatment altogether (11). Two primary studies of Family Health Teams in Ontario further underscored the importance of affordable care. Patients with common mental disorders and those managing low back pain both emphasized that having no out-of-pocket expenses was critical to maintaining access to the services they needed (13,24).

Multi-level Factors
influencing patient
perspectives on access

While findings from the integrative review provide a focused look at patients with chronic conditions, several recent primary studies explore additional patient-level, contextual, and organizational factors that may influence patient perspectives on access to team-based primary care. These are outlined in the section below.

Patient-level factors | Several recent primary studies explore how individual characteristics may shape patient experiences of accessing primary care. In Quebec, one study explored the different access experiences of patients registered at team-based primary healthcare clinics according to their social vulnerability profiles.[6] Patients were categorized as having no vulnerability, low vulnerability or high vulnerability. The study found that patients in higher vulnerability groups were more likely to report experiencing difficulties related to accessing the clinic than patients with no vulnerability; moreover higher vulnerability patients were two times more likely to report feeling abandoned by the health system. Patients from the low vulnerability group were three times more likely to report consulting the ER because they perceived their family physician as unavailable or because the next appointment was too far away (17).

A separate study from Quebec identified patient profiles based on nine components of access to care and continuity experiences to explore how these profiles are associated with patient-level characteristics. Certain patient characteristics such as female gender and poor perceived health were linked to greater access challenges. Women and individuals with poor perceived health were 1.5 times more likely to fall into profiles associated with access difficulties. Booking difficulties were more common among recent immigrants, and/or those with lower education levels (18).

In Ontario, a third study examined patient-reported access to multi-site Family Health Teams across six subgroups, including gender, income quintiles, and self-rated health. The findings revealed that patients with lower incomes and poorer self-rated health reported poorer access even after adjusting for other sociodemographic variables. Paradoxically, disparities appeared to worsen following system-wide improvements in after-hours access. The authors suggested that additional barriers may make it challenging for those with poor self-rated health to access after-hours care. For example, the authors noted that patients could not be guaranteed to see their usual physician when accessing after-hours care; this might have deterred some patients with poorer self-rated health who value continuity of care over timeliness (25).

On the other hand, a final study from Quebec examining various patient-level factors found that having at least one chronic condition was the only factor significantly associated with fewer reported difficulties in obtaining appointments with a regular primary healthcare provider. In this study, other factors such as age, social vulnerability, and self-reported physical and mental health status were not significantly linked to patient experiences of care. The authors suggest that this divergence from commonly observed individual influences (such as those listed in the paragraph above) may be less relevant in settings where patients are already attached to a primary healthcare professional (14).

A lack of patient awareness emerged as another potential patient-level factor influencing patient perspectives on access to team-based primary care in three other recent primary

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[6] This study “used existing questions from the social vulnerability index (SVI) developed by Haggerty et al. (2020, 2023) based on social support, perceived financial status, education, language spoken at home as a proxy for limited language proficiency and new arrivals. Social vulnerability profiles were derived from the SVI. The three groups included: no vulnerability (SVI score = 0), low vulnerability (SVI score = 1) and high vulnerability (SVI score = 2–4)” (17).

studies, particularly in contexts where team-based care had been recently introduced or expanded. These studies emphasize that access to care depends not only on the presence of healthcare providers, but also on patients' awareness of the services and professionals available to them. For example, a Scottish study reported that many patients were generally unaware of recent GP contract reforms and instead attributed service changes to the COVID-19 pandemic (18). Further analysis from a second study in this setting revealed variation in patient awareness of multidisciplinary team (MDT) roles. The study found patients were generally more familiar with physiotherapists and nurses, with lower awareness of link workers, mental health nurses, and pharmacists. The awareness of all MDT roles also varied based on geography, socioeconomic groups, age, and multimorbidity health status. Patients in rural and socioeconomically disadvantaged areas often reported greater familiarity with all MDT roles than those in more affluent urban settings. The exception was nursing staff, whose roles were similarly recognized across all groups (23).

A study on Family Health Teams in Ontario found that patients had varying levels of awareness about the range of mental health services, with some only learning about the extent of mental health care service variations in Family Health Teams during focus group discussions (13).

Contextual factors |Three recent primary studies explored how clinic size may be associated with patient experiences of access to care. In Quebec, an analysis comparing small, medium, and large multidisciplinary primary health care clinics[7] found that patients in medium-sized clinics were less likely to report difficulties booking appointments with their regular provider than those in small clinics (14). Another study from Quebec profiled patterns of patient experiences of access and continuity and found that patients registered at clinics with more than 15,000 patients were more likely to experience difficulties booking appointments (16). Similarly, a study in England examined small GP-reliant practices (mean list size = 7,432), medium-sized practices with MDT input (mean list size = 15,775), and large multidisciplinary practices (mean list size = 35,709). This study indicated that patients in small GP-reliant practices reported better access to care compared to those in larger or more complex team-based settings (22).

Organizational factors |Primary care professionals working in multidisciplinary teams in Quebec identified several organizational practices that improved patient experiences accessing care, such as estimating the supply and/or demand, using referral algorithms in collaboration with administrative staff, and using adaptive strategies to optimize consultations. Interestingly, setting aside 20% of schedules for urgent cases was linked to poorer patient experiences getting an appointment with their regular provider. The study authors suggest this possibly resulted from physicians interpreting this practice as reserving time for walk-in patients rather than for their own patients. The study also found that for heavy service users (patients with more than five visits in a year), none of the organizational factors examined were linked to their access experiences. With this in mind, the study

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[7] According to information provided by the study authors, the clinic sizes are based on the weighted number of attached patients, which varied from about 6,000 to 25,000 (14).

authors suggest the need for qualitative research to understand what shapes perspectives of those who frequently use services (14).

Continuity of Care: Patient Perspectives

The following figure summarizes the research literature related to patient perspectives on continuity of care provided through team-based primary care models.

Figure 3: Continuity of Care: Themes and Sub-Themes

Continuity of Care

Relational Continuity	**Management Continuity**	**Informational Continuity**	**Multilevel Factors** influencing patient perspectives on continuity of care
Connecting with professionals Importance of meaningful relationships across the care team **Valuing the GP role** Reflecting the crucial role of a trusted primary care provider on the team	**Managing chronic conditions collectively** Providers working together as a coordinated team **Care planning creates structure** Use of formalized care plans and structured follow-up **Care coordination** Designated coordinator helping to guide and connect patients across their care.	*No sub-themes were identified under this category, which relates to the transfer of necessary patient information across the care team to make current care appropriate for each individual patient.*	**Patient-Level Factors** Individual patient characteristics influencing patient perspectives on continuity of care (e.g., gender, education, social vulnerability, perceived health status) **Contextual-Level Factors** Local health system characteristics influencing patient perspectives on continuity (e.g., scale and size of clinics)

The majority of the studies we reviewed including the integrative review (11) and most of the recent primary studies (12,13,15–20,22–24) reported on patient perspectives of continuity of care. Much of this evidence, including the integrative review (11) and four primary studies (12,13,20,24) examined continuity through the lens of patients with chronic conditions. However, other recent primary studies add nuance by illustrating how continuity is experienced across different patient groups and care contexts.

The following sections are organized accordingly to reflect how the literature we reviewed for this study describe how continuity of care is perceived and experienced by patients.

Relational Continuity

The integrative review highlighted two overlapping but distinct aspects of relational continuity under the subthemes (1) *connecting with professionals*, which emphasizes the importance of meaningful connections and relationships across the care team, and (2) *valuing the GP role,* which reflects the crucial role of a trusted primary care provider in providing ongoing relational continuity (11).

Connecting with professionals | Patients consistently emphasized the importance of trusting, supportive relationships and feeling connected to their care team. The integrative review found that patients with chronic conditions who described a strong relationship with the professionals involved in their care reported more positive care experiences. Those who were motivated and able to self-advocate were more likely to perceive stronger connections to the team than those who were not (11).

Recent primary studies provide more detail on how these relationships work in practice. In Norway, patients with complex health needs experienced improved relational continuity from establishing bonds with multidisciplinary staff such as nurses. Patients described forming one-to-one relationships with the nurse on their care team, and many referred to the nurse as a link between them and their GP (12). In contrast, many patients in England perceived a decline in relational continuity after the expansion of Primary Care Networks. The exceptions, however, were patients with chronic conditions who developed relational continuity with specialist nurses (e.g., with a diabetes nurse) through more regular contact. The study authors suggest the possibility that patients with greater health needs may be better able to sustain relational continuity in team-based models, while those who are less vulnerable may be more likely to experience its loss (20).

Another recent primary study examining the perspectives of patients with common mental disorders in Ontario found "*overwhelming agreement within and across all focus groups and individual interviews that trusting relationships with providers in primary care are essential for mental health care.*" (13) However, patients in this study also reported a wide range of relationship experiences with their providers. For example, some described feeling pressured to use medical jargon to earn the respect of, and to be taken seriously by, their care providers, a factor that created barriers to trust and open communication (13). These experiences highlight the importance of communication that aligns with patient preferences for building trusting relationships, especially for more vulnerable patients.

Valuing the GP role | Evidence from the integrative review (11) and six recent primary studies (12,13,15,18,19,23) indicates that while patients were generally open to receiving care from other team members, an ongoing relationship with their GP remained crucial to their care. The integrative review found that when challenges or changes occurred in team-based care, patient satisfaction remained high if the GP relationship was positive and built on trust. This rapport made patients feel more comfortable voicing concerns and more engaged in care decisions. In contrast, when patients felt their GP had a poor attitude, this created barriers to open communication (11).

Recent primary studies across several contexts provide evidence consistent with the integrative review. For example, most patients in both a Swedish survey (15) and a Scottish qualitative study (18) expressed a preference for seeing a specific GP, underscoring the value patients place on being known by a trusted provider. This preference was especially strong among older adults aged 65 and older in Sweden (15). In the Scottish study, patients associated a positive GP relationship with greater satisfaction and improved health outcomes, especially among those living in deprived areas and those with complex health needs. Some Scottish patients also indicated they remained satisfied with changes in their care (e.g., switching to telephone consultations) if they had a pre-existing good relationship with their GP (18).

A few recent primary studies further illustrate the importance of the relationship with a trusted physician for patients experiencing mental health concerns or social vulnerability. In Ontario, for example, patients with common mental disorders reported that strong relationships with physicians in Family Health Teams fostered open communication, enhanced shared decision-making, and helped reduce patients’ fear of judgement or stigma (13). Similarly, in Belgium, patients in vulnerable situations valued the confidential relationship with their physician, whom they often turned to with concerns that extended beyond health, such as housing, income, employment, and social networks (19).

Furthermore, in Scotland, patients with mental health concerns were reluctant to share sensitive issues with unfamiliar providers, and many reported they would rather wait several weeks to see their usual GP than accept an appointment with a provider they did not know (18).

Three primary studies examined patient perspectives in settings where health systems have recently transitioned from a traditional solo-GP model to team-based primary care (12,18,23). These studies further reinforce that while patients generally accepted team-based primary care, they continued to value the relationship with their regular GP. Evidence from Scotland shows that patients did not view the expansion of multidisciplinary teams as a substitute for their GP (18,23). In Norway, despite frequent consultations with nurses, patients trusted that it was their GP who controlled what happened to them in the clinic (12). Across these studies, patients expressed a preference to see their GP for serious or complex concerns (12,18,23), while care from other providers was considered more suitable for straightforward or task-focused issues (23).

Management Continuity

The integrative review highlighted management continuity within three sub-themes: (1) *managing chronic conditions collectively,* where providers worked together as a coordinated team; (2) *care planning creates structure*, where formalized care plans and structured follow-up supported patients; and (3) *care coordination***,** where a designated coordinator helped guide and connect patients across their care.

Findings from recent primary studies support these themes while adding nuance, showing that some patient groups continue to face gaps or disparities in how management continuity is delivered in team-based primary care settings.

Managing chronic conditions collectively |Teamwork consistently emerged as a central element across the evidence, considered crucial for maintaining management continuity. In the integrative review, patients described their care teams as taking a collective approach to managing both the physical and social challenges of living with a chronic condition. They reported more positive experiences when team members were on the same page (11). Two recent primary studies echoed the importance of interprofessional collaboration for management continuity. In Norway, patients with complex conditions described their GP and nurse working together as a functioning team to manage follow-up care. Some patients noted that the GP and nurse set aside joint consultation time, which enhanced satisfaction and gave them a stronger sense of being cared for (12). Similarly, in Ontario Family Health Teams, patients with chronic low back pain expressed gratitude for access to an interprofessional team because they perceived this care to be more coordinated. One patient described how they were receiving better care because “it was coordinated amongst the entire primary care team” (24).

Collaboration was also important outside the context of chronic conditions. In Belgium, patients with social vulnerabilities highlighted the benefit of close collaboration between physicians and social workers in primary care centers, as this allowed medical and social issues to be addressed simultaneously. Patients (such as recent migrants) who were facing socioeconomic challenges or complex legal and administrative barriers often reported physical health problems caused by the stress of navigating complex health and social systems. Having both a physician and a social worker involved in their care meant that medical and social issues could be addressed together, leading to concrete improvements in patients’ health and daily lives. Study authors also emphasized the importance of ongoing dialogue between professionals to ensure collaboration extends beyond referrals to genuine shared objectives in managing patient care (19).

Care planning creates structure | Across the integrative review and some primary studies, patients described care planning as critical for team-based care and a key driver of management continuity. In the integrative review, patients with chronic conditions valued formal care plans because they brought clarity and structure. Such plans outlined: which professionals were involved, clarified roles, set timelines for follow-up, improved access to allied health services, enabled self-management, and were associated with more positive care experiences (11).

Recent primary studies support the integrative review's findings that patients appreciate structured care planning. In Ontario Family Health Teams, patients with common mental disorders emphasized that regular follow-up was an essential and meaningful component of care (13). In Norway, patients with chronic diseases experienced systematic, planned follow up, including alternating GP-nurse consultations. Some patients also experienced adapted systematic processes, for example, some elderly patients with multimorbidity reported nurse home visits as part of their care plan. Patients reported that the follow-up they experienced made them feel that their health was being more closely monitored, created a sense of safety, made their care feel more tailored, improved their understanding of their conditions, and motivated self-management (12). Similarly, patients with chronic low back pain in Ontario being treated by Family Health Teams welcomed and appreciated coordinated care plans established by the interprofessional team, with some describing relief in having a clear plan in place to support the management of their condition (24).

Notably, not all experiences with care plans were positive. In the integrative review, some patients reported that while mental healthcare plans facilitated access to psychological services, the care they received was not beneficial, revealing a gap between care planning intentions and practice (11). Evidence from Ontario Health Teams echoed this concern, as some patients with common mental disorders reported difficulty securing regular follow-up; all emphasized that they had to take the initiative to arrange follow-up themselves (13).

Taken together, these findings suggest that patients consistently valued structured care planning, but that some gaps remain for certain patient groups, particularly those with mental health concerns where care plans often failed to translate into meaningful care (11,13).

Coordinating care | Patients also emphasized the importance of having someone designated to coordinate their care. Evidence from the integrative review showed that patients with chronic conditions had more positive experiences with care coordination when a central care coordinator was present. Patients described various professionals in care coordinator roles including their GP, nurse, occupational therapist, diabetes educator, counsellor, or mental health worker. Overall, patients reported positive experiences with various health professionals, stating that what was crucial was the presence of their care coordinator. Reported benefits of a care coordinator included access to a consistent contact person, a hub for medical advice and information, and someone to guide their care when patients were unable to do so themselves (11).

A pilot study from Norway showed that nurses often carried out many of the functions of a care coordinator in Primary Health Teams. Patients with complex needs described nurses as approachable and available for longer consultations, which gave them more time to participate in treatment planning than they would have with a GP. Nurses also provided advice, advocacy, regular follow-up, and served as a reliable contact person who could liaise with the GP and involve other providers when needed (12).

Despite patients reporting positive experiences with various professionals taking on the role of care coordination, the integrative review indicated that some patients preferred their GP in this role, perceiving their physician to be a problem solver and the most knowledgeable professional (11). A pair of recent primary studies provide similar perspectives around the GP as care coordinator. In Belgium, patients with social vulnerabilities described their GP as key actors, guiding them to other professionals both inside and outside the primary care center. They had confidence in their GPs competence and felt reassured when referred to other providers, such as social workers or psychologists (19). Similarly, in Scotland, patients felt more comfortable seeing other members of the multidisciplinary team when those referrals came directly from their GP (18).

Finally, one primary study highlighted inequities in how patients experience care coordination. In Quebec, patients from high-vulnerability groups were twice as likely as others to report feeling abandoned by the healthcare system, often stating “no one was in charge of their file”(17). This underscores the importance of having a trusted professional responsible for coordinating care, particularly for vulnerable patients, to ensure their care is consistently managed and they do not feel abandoned.

Informational Continuity

Although not formally covered in the findings of the integrative review, four recent primary studies provide some insight into patient perspectives on team-based care and aspects of continuity in terms of the effective sharing of information. A study from Norway found that older patients with multimorbidity and mental illness experienced improved informational continuity through team-based care. Information-sharing among team members reduced the need for patients to repeat themselves and contributed to feelings of safety and being well cared for (12).

Findings from three other studies suggest that some patients may be more likely to encounter challenges with informational continuity when receiving team-based care. For instance, a study in Quebec grouped patients into distinct profiles that were based in part on their experiences with continuity of care. Certain experiences with informational continuity played a role in predicting a patient’s membership in the ‘easy access and continuity’ profile. Patients grouped in this profile were less likely to receive contradictory information and had a reduced likelihood of having to repeat details that should have been previously documented. (16). In contrast, the ‘challenging continuity’ profile was associated with patients needing to repeat previously-stated information and team members being unaware of each other’s decisions (16).

Another Quebec-based study examined differences in patient experiences of care continuity according to social vulnerability profiles. In terms of informational continuity, this study found that patients in both low and high vulnerability groups reported significantly more issues related to receiving contradictory information than those in the no-vulnerability group. Notably, patients with a lower vulnerability index were more likely to report that care team members were unfamiliar with their recent medical history, although this was not a major concern across the overall sample (17).

Similarly, some patients in Primary Care Networks in England briefly mentioned experiences of poorer informational continuity in primary care networks (20).

Multi-level Factors influencing patient perspectives on continuity of care

While much of the literature included in this report reflects the perspectives of patients with chronic conditions, some recent primary studies explore additional patient and contextual-level factors that may influence patient perspectives on continuity of care across different populations and care settings.

Patient-level factors | Evidence from Quebec suggests that all patients may not experience continuity of care equitably. One recent primary study found that certain patient-level sociodemographic characteristics, including being female, having poor self-perceived health, lower educational attainment, limited social support, and financial strain were associated with belonging to profiles marked by continuity difficulties (16).

Another patient-level factor influencing perspectives on continuity of care was illuminated in the study mentioned above in which researchers in Quebec examined social vulnerability profiles.[8] This study found that patients in the high-vulnerability group were more than twice as likely as those with no vulnerability to report the sense that no one was in charge of their file, while patients in the low-vulnerability group often noted that team members did not know their recent medical history. Across both groups experiencing social vulnerability, patients also reported significantly more difficulties related to receiving contradictory information from team members, with these challenges gradually increasing with vulnerability level (17).

Findings from England further indicate that continuity can also decrease for some patients as practices expand. The development of Primary Care Networks improved coordination and information sharing for patients with chronic or complex needs but often weakened relational, informational, and management continuity for those outside of these target

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[8] Social vulnerability profiles were derived from the Social Vulnerability Index (SVI). The three groups included: no vulnerability (SVI score = 0), low vulnerability (SVI score = 1) and high vulnerability (SVI score = 2–4) (17).

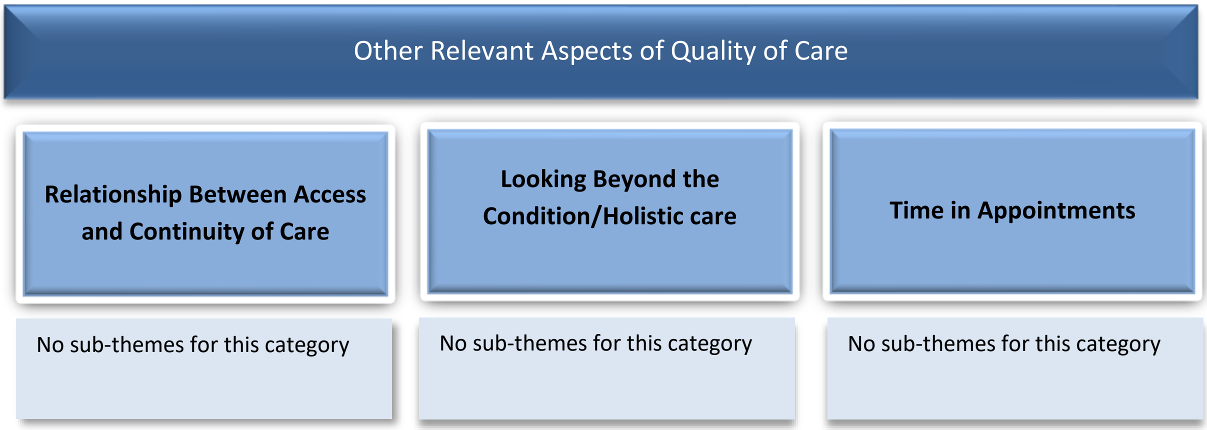
groups. The study authors suggest that without attention to how continuity is experienced across different patient populations, initiatives aimed at improving continuity for patients with more complex needs may unintentionally reduce continuity for those seeking more episodic or acute care (20).

Contextual factors | The broader organization of team-based primary care may also influence patients' experiences of continuity. Evidence from England suggests that the scale and configuration of clinics can shape how patients experience continuity. This study examined practice profiles according to clinic size and found that care continuity was stronger in smaller-GP led clinics than in larger multidisciplinary ones, where patients were less likely to maintain relationships with familiar providers (22).

Other Relevant Aspects of Quality of Care: Patient Perspectives

While access and continuity remain a central focus of this report, patients in the literature also described other relevant aspects of quality of care as outlined in the figure below.

Figure 4: Other Relevant Aspects of Quality of Care



Relationship Between Access and Continuity of Care

Patient perspectives from five recent primary studies describe how access and continuity may interact to influence aspects of quality of care.

For example, two recent primary studies describe how access and continuity interact to impact patient perspectives (12,15). In Norway, patients with chronic conditions reported that Primary Health Teams improved access by reducing wait times and expanding nursing roles. Patients with complex needs particularly valued this approach, noting that nurses were more available and easier to contact than their GPs. In this context, facilitating access enabled relational continuity, as nurses' increased availability enabled patients to form one-on-one relationships with them while also strengthening their ongoing relationship with the GP (12). Similarly, a Swedish study examined relational continuity in primary care centers defining it in terms of (1) proportion of patients with a preference for a certain GP, (2) the importance of having a regular GP, and (3) accessibility to that GP. Nearly half of respondents reported having access to their GP "always or most of the time," indicating that patients view the ability to access their GP as an important part of continuity of care.   According to the definition used by authors of this study, having limited access to a regular GP would impede relational continuity. However, the authors also note that providing high levels of relational continuity and access simultaneously poses practical and resource challenges, particularly across different care contexts and patient needs, highlighting the difficulty of balancing access and continuity of care (15).

… balancing access and continuity within team-based primary care is essential to improving the patient's experience.

Two additional primary studies underscore the challenges of balancing both access and continuity within team-based primary care. In England, a study examining practice profiles found that smaller, GP-reliant practices tended to outperform larger multidisciplinary teams on both access and continuity, indicating a potential trade-off in which larger practices may improve appointment capacity but weaken the relational aspects of care that patients value (22). Another study on the expansion of Primary Care Networks in England found that pooling GPs across practices increased appointment availability but reduced opportunities for patients without chronic conditions to see their usual GP. Patients with ongoing or complex needs, however, were less affected and often reported more positive experiences as mechanisms were in place to better coordinate their care across networks (20). Overall, the authors of this study suggest that larger, more integrated Primary Care Networks can provide well-coordinated care for patients with complex needs, but may require additional effort to maintain continuity, and can result in more complex or less personalized processes for other patients (20).

Finally, in discussing their findings, a study from Quebec examining individual, organizational, and contextual factors associated with patient experiences of access suggested that some organizational strategies are associated with a better access experience (e.g., use of a referral algorithm, and strategies to optimize consultations) while others, may improve access at the clinic level (e.g., clarifying roles and responsibilities of team members) but weaken continuity of care from the same primary care provider, particularly when patients expect to see their regular physician. The authors suggest that balancing access and continuity within team-based primary care is essential to improving the patient's experience (14).

Looking Beyond the Condition/Holistic care

Some evidence suggests that patients' overall quality of care experience is also shaped by the extent to which they perceive their care as being patient-centred or holistic. Under the subtheme of 'looking beyond the condition,' the integrative review highlighted mixed patient experiences and perceptions of holistic care. Participants described how they received and experienced holistic care that included physical, mental, social, and spiritual well-being. Contributing to the perception of holistic care was the integration of various care providers, including medical, behavioral, and complementary care practitioners. In some studies, patients felt their care was holistic and looked beyond their conditions while in others, patients requested access to more holistic care. When care was described as holistic, patients felt treated as both a patient and a person; whereas the patients who requested more holistic care felt their care was "diagnosis-focused and did not incorporate their broader needs". Taken together, the integrative review authors suggest that patients do not want to be labelled/ treated on the basis of their disease profile; rather, they prefer to be viewed as a whole person (11).

A few recent primary studies reinforce the importance of the need to look beyond the condition to meet patients' diverse needs through team-based care. In Norway, patients reported receiving clearer, more practical advice from nurses, which helped create a better personal fit and connected them to local healthcare and support services (12). Patients in another study emphasized the need for primary care teams to provide mental health services that reflect patients' diverse needs related to gender, culture, ethnicity, and language, thereby improving experiences of whole-person care (13). A third study examining Family Health Teams in Ontario explored patient-centered care as involving opportunities to ask questions, patient involvement in care decisions, and having adequate time with providers. Patients with poor or fair self-rated health reported greater improvements in their ability to ask questions compared to patients with excellent self-rated health; however, those with poor self-rated health and those living in low-income neighbourhoods consistently reported lower levels of patient-centredness in their care (25).

Time in Appointments

Patient perceptions of how much time they had with a care provider during appointments were often linked to their experiences of holistic care. Adequate time with providers enabled them to feel heard and understood. The integrative review and five recent primary studies reported similar findings regarding patient perspectives on appointment length. In the integrative review, this was explored under the subtheme "sharing space and time." Patients noted differences in the time availability of GPs as opposed to other health professionals such as nurses, allied health and community health workers. Participants described that GPs often had limited time for the kinds of in-depth conversations that other professionals were able to provide. Patients felt “listened to and able to communicate their issues” as appointment length increased (11).

All five recent primary studies similarly found that patients recognized the greater time pressures faced by GPs compared to other team members (12,13,18,23,24). Patients from Norway emphasized that having increased time with a nurse for follow-up facilitated opportunities to discuss their health issues, to participate in treatment decisions, and to carry out treatment. Whereas when consulting with the GP, patients felt they had to focus more on communicating medical issues as the result of having limited time (12). Similarly, In Ontario, patients receiving care for common mental disorders within Family Health Teams perceived the length of appointments with physicians as being inadequate, which may have discouraged some patients from initiating conversations about their mental health (13).

Two studies from Scotland reported that patients experienced longer consultation time with new MDT staff and that patients benefited from reduced time pressure in appointments (18,23). One of these studies investigated GP consultation length in particular and reported that although over half of the patients interviewed felt their appointment time was sufficient, others expressed dissatisfaction with appointment length (18).

In another primary study, patients seeking care for their low back pain who received their care from Ontario Family Health Teams described the value of being heard and understood by healthcare providers, a finding reflected in the results of the integrative review. When patients did not feel heard or understood by a healthcare provider on their primary care team, this was perceived as a time issue, most often related to feeling rushed within appointments and not having sufficient time with their family physician (24).

Conclusion

Across Newfoundland and Labrador and other Canadian jurisdictions, health systems are transitioning to team-based primary care models to help address pressures related to access to care. For this report, we aimed to highlight patient perspectives on this important transition in healthcare delivery. We synthesized available research to highlight patient perspectives on access, continuity, and other key elements of care quality in team-based primary care settings.

Overall, much of the evidence we reviewed focused on the perspectives of patients with chronic or complex conditions. Among these studies, patients generally have positive experiences with team-based primary care, with many aspects of care being seen as acceptable or improved. However, patient perspectives also varied, with some reporting challenges or areas where their care could be improved. This variability underscores the importance of seeking ongoing patient input to support continuous improvements in access, continuity, and overall care quality.

Regarding access to care, the evidence suggests that patients value expanding the care network beyond the traditional general practitioner (GP) to include nurses, allied health providers, specialists, and community and social services. This broader network helps address gaps often found in solo GP practices. The findings also indicate that patients appreciate ease and convenience of access, including co-location of professionals and services, multiple modes of access and appointment booking, and the affordability of care.

As primary healthcare provision transitions to team-based models in Newfoundland and Labrador and across Canada, patient perspectives will be an important consideration.

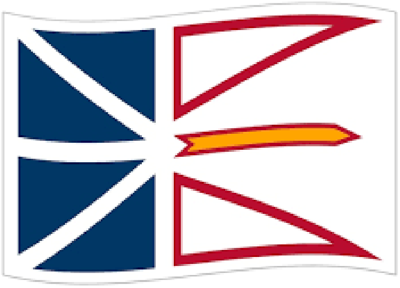
With respect to continuity of care, patients consistently emphasized the importance of trusting, supportive relationships and feeling connected to their care team. Although patients were generally open to receiving care from other team members, many described their ongoing relationship with their general practitioner as crucial to their care. Other commonly valued aspects of care continuity included care coordination, providers working as a team, structured care plans, regular follow up, and seamless information-sharing across the care team.

While access and continuity were central to this report, patients described other relevant aspects of quality of care, including the relationship between access and continuity, the importance of looking beyond the health condition to provide holistic care (i.e., looking at the whole person), and the importance of having adequate time during appointments to outline and describe health concerns.

As primary healthcare provision transitions to team-based models in Newfoundland and Labrador and across Canada, patient perspectives will be an important consideration. The evidence in this report underscores access and continuity of care as critical determinants of overall care quality from patient perspectives. As health systems work to achieve these goals, incorporating patient perspectives will be essential to improving patient experiences and outcomes. Given the limited research on patient perspectives of team-based primary care, further consultation with patients and more patient-centred research will be needed to better inform policy and decision-making.

Considering the NL Context

Decision makers will wish to consider not only the key findings from the scientific literature outlined in this report, but also *how* these key findings might potentially be impacted by, or applied within, the healthcare context in Newfoundland and Labrador. Since research evidence is usually generated in places that are quite different from our province, evidence cannot always be directly applied here. Local characteristics, capacities and qualities that may have an impact on the research evidence are called 'contextual factors.' While not exhaustive, this section highlights selected contextual factors that may be relevant to applying the evidence in NL.



Access to Primary Care | Accessing primary care services in Newfoundland and Labrador continues to be a challenge for many patients. In 2024, only 74.8% of NL patients reported having a regular healthcare provider, compared to 82.6% nationally, and this proportion has been gradually declining over the past decade (33,34). Recent reforms such as the provincial rollout of Patient Connect NL[9] and Family Care Teams aim to improve access to primary care services across the province. Since November 2023, the number of patients connected to a Family Care Team has increased from 51,030 to 82,922. However, demand remains steady as the waitlist for Family Care Teams remains above 40,000, with over 2,000 new patients registering each month (35).

Health Workforce Challenges | NL continues to navigate longstanding challenges with the recruitment and retention of family physicians and other healthcare professionals (34,36). Since the launch of Family Care Teams in 2023, the province has been actively recruiting physicians, nurse practitioners, registered nurses, licensed practical nurses, social navigators, allied health professionals, and support staff to support team-based care (37). A recent update of NL health human resources highlights that although vacancies within Newfoundland and Labrador Health Services (NLHS) have decreased, staffing needs persist in some areas, particularly in rural and remote communities. The update also identifies factors influencing recruitment and retention including provider education and training capacity, work-life balance, and burnout. According to this analysis, addressing these workforce challenges will be important to support the continued development and sustainability of high-quality care across the province (38).

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[9] **Patient Connect NL** is a provincial list of individuals who have identified as being without a Primary Care Provider (Family Doctor or Nurse Practitioner) in NL. The information provided on Patient Connect NL will be used to plan and improve access to primary health care in NL, with the goal of connecting individuals to a Family Care Team or a Primary Care Provider as soon as one becomes available in an individual’s area.

An Aging Population with High Burden of Chronic Disease | As of July 2025, 25.2% of NL's population were aged 65 and older, compared to 19.5% across Canada (39). The province is aging rapidly; provincial projections show the median age is expected to rise from 47.8 in 2024 to 49.3 by 2044. Over that period, the number of people aged 65 and older is expected to increase by 18%, and those aged 75 and older by nearly 60% (40). In addition, NL faces a high burden of chronic disease, with 41.2% of adults aged 40 and older reporting having two or more chronic conditions, compared to 36.4% nationally (41).

Distribution of the Population Across Rural and Urban Communities | Newfoundland and Labrador is geographically distinct, with a small population dispersed across a large geographic area. Access disparities between rural and urban communities are evident as shown by reports showing that only 66.6% of patients in rural/remote communities have a regular health care provider, compared to 83% of patients living in urban areas (33). Continued urbanization, rural population decline, and rapid aging outside major centres are expected to further challenge equitable primary care access in this province (40).

Patient Engagement | Meaningful patient engagement is an important component of primary care, as it helps to ensure that services are designed and delivered in ways that genuinely reflect patients' needs, priorities, and lived experiences. Findings from the 2025 OurCare National survey show that while 27.9% of respondents across Canada reported at least one opportunity to participate in improving primary care in their community or region, only 20.1% of respondents in NL reported the same (42). As Family Care Teams continue to expand across NL, engaging patients to understand their perspectives will be important for monitoring how the model is functioning in practice. Several initiatives are underway to support this, including piloting patient experience surveys, community engagement mechanisms outlined in the Family Care Teams Policy Framework, and ongoing research through the provincial networks highlighted below:

- NL Health Services (NLHS) is piloting patient experience surveys in a Western Zone Family Care Team using Txt Squad, a communication tool that sends survey links to patients after appointments. The intent is to expand this approach across all Family Care Teams, using insights from the pilot to guide rapid, continuous quality improvement (43).

- The Family Care Teams Policy Framework for NL outlines mechanisms to engage communities and citizens in the co-design and quality improvement of Family Care Team service delivery, including Community and Population Health assessments, Community Advisory Committees and Regional Wellbeing Networks, and a Strategic Health Network for Primary Care (44,45).

- Additional feedback channels include the NLHS Patient Relations Office, which accepts patient feedback for all zones, and MyVoiceNL, a program that collects system-wide experience data to inform planning and quality improvement projects (46,47).

- Various studies and evaluations led by researchers at Memorial University are being conducted to support the implementation of Family Care Teams, some of which examine patient perspectives in the local context. (See Appendix B for a list of compiled resources related to Family Care Teams in NL.)

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Appendix A: Our Consultant

Dr. Sabrina Wong is a leading expert in the area of primary healthcare in Canada and internationally. She uses mixed methods to examine and evaluate context, mechanisms and outcomes most relevant to primary care service delivery. Patients, communities and clinicians are her partners, as she carries out research at a regional, pan-Canadian and international level. She has expertise in survey and self-reported tool development, qualitative methods and using “big data” including administrative and electronic medical record data. Dr. Wong is the co-chair of the Canadian Primary Care Research Network, a founder of the Canadian Primary Care Research Consortium, and provides oversight for the BC Primary Health Care Research Network. Her work contributes to informing practice and system level interventions that seek to decrease health and healthcare inequities. Dr. Wong lives on the unceded territory of the Musqueam and Coast Salish peoples and is a professor at the University of British Columbia Centre for Health Services and Policy Research and the School of Nursing.

Appendix B: Resources Related to Family Care Teams in NL

Overview of Family Care Teams (FCTs) in NL

Family Care Teams were introduced to NL in 2023. As outlined in the FCT Health Policy Framework, with the aim to:

> "…improve access and continuity of primary health care (PHC) for individuals and families in their community. They represent a significant shift from solo-based community practice and program-based models of service delivery to an inter-disciplinary team-based model. Family Care Teams offer seamless access to multiple health care professionals that focus on meeting the health and social needs of individuals and families (Policy Framework Gov NL, 2023)."

Composition and Function of Family Care Teams in NL

Teams are planned using a needs-based approach and an individualized approach to care so that the health and social needs of individuals and families are met. According to the FCT Policy Framework, FCTs include:

- Family Physicians
- Nurse Practitioners
- Clinical and Social Navigators
- Nurses (Registered Nurses, Licensed Practical Nurses),
- Manager and Clinical Director (physician)
- Practice Improvement Leaders/Practice Facilitation Coaches
- Administrative/Clerical Support

Based on needs and available resources, FCTs will also have the following providers:

- Allied Health Professionals (Physiotherapy, Occupational Therapy, Speech Language Pathology)
- Pharmacists
- Social Workers
- Public Health Nurses
- Psychologists
- Community Health Nurses
- Others including Learners

A Family Care Team will have clear pathways to connect and/or integrate with:

- Community-based practices (physicians, allied health, pharmacists, etc.)
- Community para-medicine
- 23 Health Centres
- Indigenous Governments and Organizations

A Family Care Team will have linkages to:

- Academic Institutions

- Social and Health Networks
- Schools, municipalities, community organizations/groups
- Provincial Health Authority programs (Policy Framework Gov NL, 2023).

A patient is considered connected to a Family Care Team when he/she/they have been assigned to that FCT clinic or included on its patient panel. Patients are considered attached when they have a designated most responsible provider within the team—a primary care provider who oversees their care and serves as their main point of contact (NLHS Correspondence, 2025).

List of available information/resources on FCT in NL & virtual primary care options

Resource	Description	LINK
Gov NL: FCTs A Health Policy Framework for Newfoundland and Labrador, 2023	• Document is intended for those involved in the planning, implementation, ongoing service delivery, performance monitoring and evaluation of FCTs in NL. • Sets out the key provincial policy directions and expectations for FCTs as a cornerstone component of a transformed primary health care (PHC) system for NL.	LINK
Gov NL & NLHS: FCT, Page for the Public, Patients, and Families	Webpage with information on FCTs for the Public, Patients and Families, as well as for Health Care providers and Staff. Covers: • What is a Family Care Team? • What Services are included in a Family Care Team? • How do I find a Family Care Team? • How do I Provide Feedback?	LINK
Family Care Team Resource Hub	• A platform designed to support inter-professional team members that work in FCTs and enhance inter-professional collaboration. Intended for Health Care Providers and Staff. • Created from a partnership between Quality of Care NL, the Office of Professional & Educational Development in the Faculty of Medicine at MUN, and the Department of Health & Community Services with advisory input from NLHS and other stakeholders	LINK
	• Resource page includes Webinars, Family Care Team Shorts, QOC NL Healthy Discussions, Collaboration Links, Navigation Links, Toolkits and Dashboards, Podcasts, e-Learning, Chronic Disease, All web links, All video resources	LINK
Gov NL Health Care Action Updates: FCT webpage	• Provides a summary of the latest published numbers on FCTs in the province • Addresses the questions: ○ What is a Family Care Team? ○ How does a Family Care Team support me? ○ How do I find a Family Care Team?	LINK
NLHS Family Care Teams webpage	• Webpage includes information related to: ○ FCT locations ○ Access to primary health care ○ How to get connected to a family care team ○ Patient & provider video testimonials on FCT ○ Community partnerships	LINK

Resource	Description	LINK
	○ Health-care system improvement	
Patient Connect NL	• Provincial registry of individuals who have identified as being without a Primary Care Provider (Family Doctor or Nurse Practitioner) in Newfoundland and Labrador (NL). • Provides a registration form on the webpage for those who are without a primary care provider or will be without a provider in the next 3 months.	LINK
NLHS Primary Care Options Webpage	• Webpage lists Primary Care Service Options in NL including: ○ FCTs ○ Patient Connect NL ○ Care options (Walk in Clinics, Finding a Family Doctor, Healthline 811, Virtual care: Teladoc, Virtual Care: RVCC Western, Pharmacies) ○ Mental Health and Addictions ○ Complex Pain ○ Preventive Care ○ Additional services ○ What level of care do I need? Symptom checker	LINK
NLMA Affiliation of Community-based Physician Offices with Family Care Teams	• NLMA webpage published several documents in 2024 related to the affiliation of Community-based Physician Offices with FCTs including: ○ Memo from Darla King, VP Transformation-Well-being, NL Health Services (NLHS), and Gertie Mai Muise, Executive Director, Newfoundland and Labrador Medical Association (NLMA) regarding the Affiliation of Community-based Physicians Offices with FCTs ○ NLHS Affiliation Agreement Letter of Offer Template ○ Governance and Policies Guide for Affiliating Community Family Practices ○ Affiliation Agreement FAQ	LINK
NL Virtual Primary Care Program Website (Teladoc Health Canada)	• Website with information on virtual primary care for Newfoundlanders and Labradorians without a Family Doctor or Nurse Practitioner. Includes information on: ○ Who is eligible? ○ FAQs	LINK
Medicuro – Virtual Healthcare	• Newfoundland-based virtual healthcare provider • Offers virtual healthcare appointments to residents across the province — including in rural and remote areas — with primary services being at no cost to anyone with a valid MCP card. • Medicuro's goal is to make it easier for people to access timely medical care without needing to travel or wait for a clinic appointment especially in areas with little or no access to health care.	LINK
Strategic Health Network for Primary Care	• A key pillar of the Health Transformation Framework is the establishment of Strategic Health Networks (SHNs). A SHN is a provincially mandated group of experts responsible for setting care standards and driving system-level optimization, particularly for high-priority services. SHNs function as decision-making bodies and include leadership resources within their structure. These inter-professional groups have a provincial mandate to drive targeted, measurable, and	LINK

Resource	Description	LINK
	sustainable improvements in health outcomes and service delivery. NL Health Services plan to establish 12 SHNs by March 31, 2026. **What did we do during 2024-25?** • Continued implementation work to formally establish three SHNs1 which include the Surgical Services, **Primary Health Care**, and the Health of the Older Adult SHNs. • Implemented targeted strategies through the SHN structure to support transformation objectives that address current needs and priorities. For example, **Family Care Teams (FCTs)** and Ophthalmology Central Intake.	

Early Insights into Family Care Team Implementation in NL: Insights from NLHS

In the fall of 2025, we reached out to our partners at the Newfoundland and Labrador Health System (NLHS) and Memorial University to get insight into how Family Care Teams are being implemented, studied and experienced in Newfoundland and Labrador (NL). Below we will share a few questions and responses that may be of particular interest to readers of our report.

*Please note that priorities may evolve following the rollout of CorCare, given that future plans and processes are still taking shape.

Question: Since implementation, how have Family Care Teams been functioning in practice? Are there any notable successes or challenges?

Response from our partners at NLHS:

- "Since implementation of FCT, several notable successes have emerged. One of the most significant has been improved access to primary care providers and enhanced continuity of care- something many patients have been without for a long time. This improvement has enabled individuals to stay within their community rather than relocating to access primary care services. FCTs have also helped ensure patients are able to see the right provider, at the right time, and in the right place, leading to more coordinated and patient-centered care overall.

  One of the main challenges FCTs are facing is the pressure to begin attaching patients before they have reached a level of readiness or maturity to sustain that capacity. Many teams are also contending with staff shortages and have been unable to secure the full complement of team members they need. In addition, there has been some role ambiguity, as teams bring together professionals from diverse backgrounds, who may not have a clear understanding of each other's roles, responsibilities, and scope of practice. Building this shared understanding takes time but is essential for effective collaboration and quality patient care.

To address these challenges, quality improvement teams are working closely with FCT on the ground, offering hands-on support, guidance and coaching as teams establish and refine their operations."

Question: Have any significant changes or lessons emerged since the rollout began?

Response from our partners at NLHS:

- "One of the biggest lessons that have emerged since the rollout of FCTs is the recognition that each team is unique. FCTs differ in their composition, community context and readiness, which means they will develop and mature at different rates. Each team brings its own strengths and faces distinct challenges, and it is not realistic to expect uniformity across the province. Instead, the focus should be on supporting each team's growth in a way that reflects the needs of the patients and communities they serve."

Question: Has patient feedback been collected from those accessing Family Care Teams? If not, are there plans to gather input (e.g., through surveys or interviews)?

Response from our partners at NLHS:

- "We have partnered with the Research and Innovation Department to pilot patient experience surveys in a Family Care Team in the Western Zone using Txt Squad. Patients will receive a survey link through Txt Squad following their appointment with the Family Care Team. The intent is to expand the survey to all Family Care Teams. Insights from this pilot will guide quick, continuous quality improvement and support future rollout across all Family Care Teams."

Question: Are there any other initiatives or projects related to Family Care Teams (either planned, in-progress, or upcoming) that would be valuable to include in the 'Newfoundland & Labrador Context' section of our report?

In particular, is there anything that might be helpful for patients or the public to know?

Response from our partners at NLHS:

- "An Evidence to Practice Project Team has been established to estimate the number of NL residents attached to a primary care provider, assess the complexity of patients connected to FCTs, and explore the accessibility of nursing and allied health services available to FCT patients.

  Planning is underway to identify how many FCTs are needed and where they should be located to ensure everyone in the province has access to primary care. We continue to collaborate with community physicians to strengthen partnerships with FCTs and ensure patients and communities have meaningful opportunities to contribute to their development. We're also taking steps to raise public awareness about FCTs."

Family Care Team Projects at Memorial University

Several researchers at Memorial are conducting or engaged in initiatives around FCT in NL. Some relevant projects are listed in the table below:

Project/Initiative	Description	LINK
Primary Care Research Implementation Improvement and Evaluation (PRIIME) Network	• NL component of the Canadian Primary Care Research Network (CPCRN) • Support research, implementation initiatives, quality improvement activities, and system driven evaluation • Provide additional support services for our special priority topic areas	LINK
	• Research project inventory of primary care projects in the province	LINK
Understanding the complexities of implementing team-based primary care, Family Care Teams Project	• Project in progress, examines the integration of Family Care Teams, emphasizing collaborative care that includes diverse healthcare professionals working together to improve patient outcomes.	LINK
Principles into Practice: Evaluating the Patient Centeredness of Family Care Teams in Newfoundland and Labrador Through the Lens of the Picker Principles	• Qualitative case study (data collection phase) • To assess how patient-centred care (PCC) is experienced in NL's new FCTs.	LINK
Interprofessional Collaboration in Newfoundland and Labrador's Family Care Teams: A Qualitative Case Study of Determinants, Processes, and Outcomes	• Qualitative study (data collection/analysis phase) • Will explain how structural conditions (workforce, co-/near-location, shared EMR, governance, payment) activate collaboration mechanisms and improve outcomes (access, continuity, experience, equity). Findings will map context–mechanism–outcome pathways and deliver actionable recommendations for provincial policy and QI.	LINK
Evaluating a complex, team-based primary care intervention in rural Newfoundland and Labrador: Advancing implementation science	• **Goal:** to inform the implementation, evaluation, and scale/spread of a team-based model of primary care (FCTs) in NL. • **Approach**: considers contextual factors, stakeholder input to articulate key components and mechanisms of the intervention; use that information to build evidence-based strategies to support implementation and a comprehensive evaluation framework; work with stakeholder to move the strategies and the evaluation framework into practice.	LINK
Maximizing the Potential of Primary Care:	• **Aim**: to inform the implementation, evaluation, and spread/scale of FCTs in NL and advance implementation	LINK

Project/Initiative	Description	LINK
Implementing and Evaluating Team-Based Primary Care in Newfoundland and Labrador	science for a team-based model of primary care; understand how FCTs affect outcomes, identifying both causal variables (mediators) and factors that influence the strength or direction of their effects (moderators).	
Umbrella Review and Multiple Case Study: Strengthening Team-Based Care: Optimizing the Scope of Practice of Primary Care Nurses ("SCOPE PC-N")	• **Aim**: to strengthen team-based primary care and PC-Ns' intra-professional collaboration by delineating professional scopes of practice of each PC-N provider. • The project consists of two linked studies: 1) umbrella review and 2) multiple case study. The Umbrella Review will consolidate international scoping and systematic review evidence on PC-N roles into a single comprehensive report.	LINK
Dissemination of a National Set of Family Practice Nursing Competencies to Support the Integration of Family Practice Nurses within Primary Care	**Objectives** • (1) To support knowledge translation and dissemination of family practice nursing competencies to patients/public citizens, primary care providers, health administrators, educators, decision-makers, and relevant associations nationally and internationally, and • (2) To facilitate the use of family practice nursing competencies by key stakeholders in activities focused on the integration of family practice nurses in primary care.	LINK
Understanding the Transition to Practice Experiences of Nurses and Their Contributions within Family Care Teams in Newfoundland and Labrador	• Completed; Manuscript submitted for publication: September 2025 • **Citation**: Lukewich, J., Devey-Burry, R. (Co-Principal Applicants); Asghari, S., Poitras, M-E., Etchegary, C., Mathews, M. (Received: December 2023). Understanding the Transition to Practice Experiences of Nurses and Their Contributions within Family Care Teams in NL. Memorial University Faculty of Nursing.	
PaRIS Survey Results [PaRIS is the Organisation for Economic Co-operation and Development (OECD)]	• Completed • Patient-Reported Indicator Surveys initiative where countries work together to develop, standardize, and implement a new generation of indicators that measure the outcomes and experiences of health care that matter most to people. • **Aim**: to gather patient data on how they view their health and experience of care	LINK LINK
Quality of Care NL, Practice Points LINK	Volume 12: December 2025 • Update on FCT Progress in Newfoundland and Labrador • Supporting Interprofessional Collaborative Practice in FCTs in Newfoundland and Labrador	LINK LINK
	Volume 11: July 2024 • FCT Progress in NL • Supporting Inter-Professional Collaboration in FCTs in NL ○ Demonstrate the operational capacity of FCTs in NL as of Nov 2023	LINK LINK

Project/Initiative	Description	LINK
	Volume 10 May 2023 • Collaborative Community Teams in NL (now known as FCTs) • describes the implementation status of Collaborative Community Teams in NL as of 2023	LINK

Other

- The Canadian Primary Care Research Network, in partnership with Alberta Health Services, the Government of NL, Health Canada, and CIHR, hosted a Best Brains Exchange (BBE) in early 2025. This session identified core outcomes and domains for evaluating team-based primary care implementation in Canada, with strong consensus on prioritizing patient- and provider-reported experiences and outcomes. A peer-reviewed publication is planned to present the finalized evaluation framework developed through this BBE (LINK).

Appendix C: Grey Literature

As a part of this Rapid Evidence Report, our Patient Co-Lead and Patient Partner conducted a targeted grey literature search to identify reports that would not typically appear in standard health science research databases. CHRSP researchers provided a list of relevant websites, organizations, and keywords to guide this process. The project's established inclusion and exclusion criteria were applied to determine which reports were relevant to include.

Our Patient Co-Lead and Patient Partner identified three reports and one additional resource through a brief search for grey literature. While screening the research literature, CHRSP researchers also found two additional reports, which we reviewed as a team and chose to include alongside the other grey literature resources. In total, five reports and one checklist were included as grey literature.

A list of all sources and their characteristics can be found below:

List of Grey Literature

Reports

1. Booker et al. **Clinical and cost-effectiveness of paramedics working in general practice: a mixed-methods realist evaluation.** Health Soc Care Deliv Res. 2025 Feb;13(6):1-137. (LINK) [Click on download and print under "Toolkit" to read the full PDF (LINK) (Found in the primary literature search)
2. Healthwatch England. **Strengthening Primary and Community Care Services- The Foundation for Most Care and Treatment** [Internet]. UK; 2022 Apr. (LINK) (Identified by Rosemary Lester)
3. McDermott et al. **Scale, scope and impact of skill mix change in primary care in England: a mixed-methods study**. Health Soc Care Deliv Res 2022;10(9). (LINK) (Found in the primary literature search)
4. National Voices. **A Shift to Multidisciplinary Teams in General Practice: What this means For People Experiencing Health Inequalities and frequent users of primary care**. [Internet]. UK; 2023 Jun. (LINK) (Identified by Rosemary Lester)
5. UBC Innovation Support Unit. **Patient Comms Learning Cycle: Key learnings report** [Internet]. UBC; 2023 Oct. (LINK) (Identified by Cris Carter)

Other Sources

1. UBC Innovation Support Unit. **TBC Communication-to-Patient Checklist** [Internet]. (LINK) (Identified by Cris Carter)

Grey Literature Characteristics

Of the reports, two are comprehensive mixed-method studies that include dedicated sections on patient experience, and both examine workforce changes within UK general practice.

- **McDermott (2022)** examines "skill mix changes" in primary health care, which involve employing practitioners from a wide range of health care disciplines to address unsustainable GP workload pressures. Study authors explore overall patterns of practitioner employment in general practice, the reasons driving skill mix changes, provider and patient experiences, and the impact on system-level outcomes and costs.
- **Booker (2025)** also assesses workforce changes in general practice but concentrates on the specific role of paramedics. The report evaluates how paramedic-delivered care compares with non-paramedic care in terms of clinical effectiveness and cost.

Both reports contain sections that examine patient perspectives. McDermott (2022) through focus groups and a patient survey, and Booker (2025) through interviews and patient questionnaires.

The remaining three reports were published by organizations aiming to represent patient voices, including:

- A report from Healthwatch England published in 2022 provides a briefing of patient stories and experiences about access to GP Teams in primary and community services (Healthwatch England, 2022);
- A report from National Voices published in 2023 includes findings from a focus group of those that experience health inequities and/or frequent users of primary care regarding their experiences with multidisciplinary teams (National Voices, 2023); and
- A Key Learnings Report from the UBC Innovative Support Unit published in 2023 includes the results of interviews with members of the Primary Care Patient Voices Network on Team-Based Care in BC, focused on the communication of team-based care from the patient perspective (Innovation Support Unit, 2023).
    - The Innovation Support Unit also provides a Communication to Patient checklist suggested to enhance communication related to Team-Based Care (UBC Innovation Support Unit, Checklist).

Of the grey literature sources identified, our Patient Co-Lead and Patient Partner noted that both the Healthwatch England report and McDermott (2022) offered some valuable recommendations. However, they felt that the National Voices report was the most relevant from the patient partner point of view. An additional observation from the grey literature search was that patient partners consistently found these sources more accessible and easier to read than academically oriented publications.