| **Article details: 2015-0128** | |
|---|---|
| Title | Processes of patient-centred care in Family Health Teams: access, continuity, and coordination: a grounded theory study |
| Authors | Judith Brown, Bridget Ryan, Cathy Thorpe |
| **Reviewer 1** | Elena Neiterman |
| Institution | University of Waterloo, School of Public Health and Health Systems |
| General comments (author response in bold) | Significance:<br>1. I think that the paper would improve if the authors would provide more explanations about the significance of this topic. The "SO WHAT?" question remains somewhat unanswered. Admittedly, the authors do discuss the importance of this topic in the interpretation section, but I think it would be more beneficial to stress the importance early on, so that the readers would be more engaged with the manuscript. For instance, at the end of page 1, the authors state: "While much is known about individual processes of care (access; continuity; coordination of care; and patient-centred care) [11-17], less is understood about if, and how, these processes are related." It would help if the authors could provide a very brief description of the individual processes of care – I am not entirely sure that we can assume that all the readers of the journal know much about the individual processes of care. This could also lead to a rationale of why it is important to understand if/how these processes are related. This would provide the much needed reference to significance early on in the manuscript.<br>**This is a helpful comment. We have addressed it in two ways. First, we have provided definitions of the processes in the Introduction as suggested. Second, we have clarified the purpose of the study. The inter-connectedness of the processes was a result of the constant comparison analysis. We apologize that this sentence may have caused confusion (pages 1 and 2).**<br><br>Methods:<br>2. In the methods section, the authors mention the mixed methods and the grounded theory study. A bit more details on the decision to use grounded theory would help. Specifically, the study design that is described by the authors does not really resemble the grounded theory approach: while the coding does follow the methods outlined by the grounded theory scholars, the processes of data collection and analysis seem to be consistent with a regular qualitative study (and not grounded theory) – the sites/participants were chosen a-priori, there is no mentioning of constant comparative analysis, no clear description of what categories were generated, etc. So, I am wondering if the authors can elaborate on their use of grounded theory or rethink the title/method altogether.<br>**The reference to the mixed methods study has been removed (page 2) as it is unnecessary and confusing to the reader. Although this study was part of a larger mixed methods study, referencing the larger study adds nothing to the understanding of this paper. Additional detail has been added to the analysis section including the constant comparison analysis (page 3). As well, a sentence has been added to the Findings describing that the interwoven nature of the processes emerged from the data and was not an a-priori theme (page 4).**<br><br>Findings:<br>3. I would reconsider presentation of findings. I think the most important finding that the authors want the readers to take home is that the four processes that they described were interrelated and that patient-centered care is the central organizing context for the participants to discuss their experiences of working in the FHTs. Therefore, I would start with that and then show other processes and/or HOW they were interrelated. My other concern about the findings is that each section ends somewhat abruptly. Including 1-2 sentences in the end of each section about the significance/importance of this finding (or providing a link to the overall theme) would go a long way to keep the presentation more coherent.<br>**The authors appreciate this suggestion and have placed the patient-centred findings at the beginning of the Findings. We agree that this tells the story in a more compelling way. As well, linking sentences have been added between the findings on each process. We have also reordered the listing of the processes in the Introduction to be consistent throughout the paper.**<br><br>Interpretation:<br>4. In the limitation section, the authors talk about the sample size and the challenges pertaining to transferability of the findings. They also talk about saturation as related to the number of interviews conducted. I think that the authors would agree with me that in a qualitative study the number of interviews is not related to saturation. Instead, the qualitative researchers focus on the quality of data and are concerned with theoretical saturation. I also do not necessarily see it as a problem that only 20 out of 200 sites were under study – the number of participants is large, and this is a qualitative study, so the numbers are not significant. An obvious limitation of the study is the lack of reference to gender/power within the teams. I would think that the status within the team (and one's profession) could have played a role in how the participants responded to questions/saw their FHTs. Did, for instance, physicians, nurses and social workers see access and coordination (or patient-centered care) in a same manner? Were there any differences pertaining to the position of the health care professionals and his/her interaction with patients? It is somewhat surprising that the authors do not really engage in intersectional analysis and I see it as a limitation of their study that is |

| | |
|---|---|
| | warranted to be acknowledged. I would also think about the potential of exploring the views/experiences of patients/recipients of care who could provide a different view of FHTs.<br>**Regarding sample size, the authors agree and have removed reference to sample size as a limitation (pages 13 and 14). However, we have added in the Limitations that our findings cannot necessarily be transferred to other primary care models outside of the FHTs: "Another limitation of the study is that only FHTs in Ontario were examined and this limits the transferability of the findings to other primary care models" (page 14).**<br>**The reference to saturation has been changed to better reflect the theoretical saturation that was achieved for this portion of the study. It is true that the sites were identified a priori but the authors believe that despite this, theoretical saturation was reached. By the 110th interview, no new themes or issues arose that suggested the need to conduct more theoretical sampling (page 3).**<br>**The authors acknowledge under the Limitations that any power differential experienced by members of different professions was not examined in this study. We have not acknowledged within the text any discussion around gender and power. The majority of the participants were female because this reflects the composition of Family Health Teams, where as an example, 50% of the family physicians are female (page 14).**<br>**A sentence has been added to the Conclusion indicating that future research needs to examine these processes of care from the perspective of patients: "Future research also needs to include patients' perceptions and experiences regarding these processes of care as they may differ from those of health care providers." (page 14)** |
| **Reviewer 2** | Saad Shakeel |
| Institution | McMaster University, Surgery |
| General comments (author response in bold) | Minor Revisions<br><br>1) Introduction:<br>- It may be helpful to provide definitions of key processes, in specific patient-centered care. It becomes evident in interpretation section that these measures were defined differently by individual participants. Based on the review of literature, it appears that a unified approach to defining these measures is absent.<br>**o The way we define key processes has implications on evaluating performance of FHT's. Lack of proper definition induces subjectivity, which may point towards a need to standardize these important frameworks of care quality.**<br><br>**o An acknowledgement of the fact that there exist no unanimous definitions for these measures may be adequate. If the authors do choose a definition, it may be pertinent to comment (in discussion section) on whether the interviewees perceived these concepts differently than the chosen definitions. It could represent a need for attitude change/training.**<br><br>**We appreciate and agree with the reviewer's comments and reflections on the important role of definitions. We did not offer our participants' definitions of these processes of care as we felt it would be too prescriptive and not in line with grounded theory methodology. The descriptions of the processes of care emerged from the data. That being said, at the reviewers' request we have added definitions in the Introduction that are commonly used in the context of primary health care (page 1 and 2).**<br><br>2) Methodology:<br>- It is unclear why the Ontario College of Family Physicians (OCFP) chose FHT practice sites? It could be helpful to provide an explanation of how this might have impacted or potentially biased the results. The authors do mention that the goal of site selection was to ensure diversity of participants but it would be valuable to describe the process in a bit more detail.<br>**We have clarified in the Participant Recruitment that the recruiting of the FHTs was done with administrative assistance from the Ontario College of Family Physicians. Additionally, the parameters around maximum variation for the sites was described in the text (page 2).**<br><br>**o Address the limitations associated with sampling technique e.g. executive director or office manager may be more likely to choose participants that can present an 'idealist' version of the practice.**<br><br>**While the authors acknowledge the conceptual reality of this limitation, the candor of the participants assured the authors that this indeed was not the case. Participants mentioned areas of concern such as long wait lists for mental health access and challenges in managing transitions of care noted, for example, in the coordination section of the paper.**<br><br>- Consider providing a list of questions asked in semi-structured interviews. Do we know that leading questions were not asked that may sway findings in a particular direction?<br>**o For instance, instead of asking 'describe how your team provides timely access?', would it make any difference to the findings if the question was, 'Do you believe your organization provides timely access? If yes, describe the process".**<br>**We have added an appendix with the semi-structured interview guide.** |

| | |
|---|---|
| | 3) Discussion:<br>- It could be added in the limitations section that the interviews provide one-dimensional view of how the care is delivered. It seems obvious that provider(s) will regard their quality of provided care to be 'excellent' since funding bodies were involved in the study.<br>**We do not believe that this was a limitation because the participants openly discussed their challenges and sub-optimal care such as the concerns expressed around difficulties in transitions of care.**<br><br>- For future research, may be point towards a need to conduct patient's interviews at these sites to gain their perspective on FHT's and insights into any recommended improvements in care processes and outcome.<br>**The need to gain the patient perspective on these processes of care is acknowledged in the Conclusion of the paper (page 14).** |