Editor's key points

- This article pursues an understanding of collaborative care as it is practised in the North End Community Health Centre through a relationship-based care model. Collaborative care at the North End Community Health Centre operates through authentic, honest, meaningful relationships between providers and patients, providers and providers, and providers and the community. Staff members believe this mechanism promotes radical, effective health care.
- Key lessons on collaborative practice include the need for provider "buy-in"; the constraining effects of traditional medical hierarchies on collaborative care; supporting both providers and patients through reflexive practice; supporting a collaborative care model through relationship-based care; and the need for long-term stable funding mechanisms to be central to government planning.
- Collaborative care might be the future of health care but requires further definition, clarification, and thoughtful evaluation; consideration of a patient perspective from this setting would be beneficial.

North End Community Health Centre in Halifax, NS

Relationship-based care goes beyond collaborative care to address patient needs

Allison Hudson MD Andre Daniel Boudreau MD CCFP(EM) Janice Graham PhD

Abstract

Objective To identify and describe features of relationship-based care that contribute to a successful collaborative model of primary care delivery.

Design Focused institutional ethnography using a critical medical anthropology approach.

Setting The North End Community Health Centre (NECHC) in downtown Halifax, NS.

Participants Twenty health care providers employed or previously employed at the NECHC.

Methods Qualitative data collection included participant observation, recorded and transcribed semistructured interviews, informal discussions, and policy document analysis. Data collection continued until saturation was reached, between December 2014 and October 2016. Data were member checked, coded, and triangulated with evidence from policy documents and informal conversations to establish credibility.

Main findings The NECHC offers high-quality care to the community, welcoming marginalized, vulnerable populations. The NECHC's recognized success is grounded in unique relationships among providers, patients, and the community. Four key themes contributing to relationship-based care in the clinic's operation emerged: an activist provider identity, cultural safety, provider-patient relationships, and provider-provider relationships. Inadequate provincial funding mechanisms limit the work and development of the clinic.

Conclusion Collaborative care is advanced by health authorities to improve quality of care and reduce health care costs. This model is still poorly understood in Nova Scotia. The findings, which draw on focused ethnographic fieldwork and analysis of the NECHC, suggest that the NECHC is a pragmatic real-world model of collaborative health care. The success of its approach relies on a deliberative democratic realization of reflexive practice through relationship-based care.

Centre de santé communautaire North End à Halifax, N.-É.

Les soins axés sur la relation vont au-delà des soins collaboratifs pour répondre aux besoins des patients

Allison Hudson MD Andre Daniel Boudreau MD CCFP(EM) Janice Graham PhD

Résumé

Objectif Cerner et décrire les caractéristiques des soins axés sur la relation qui contribuent à la réussite d'un modèle collaboratif de prestation des soins primaires.

Type d'étude Ethnographie institutionnelle ciblée au moyen d'une approche anthropologique médicale critique.

Contexte Le Centre de santé communautaire North End (NECHC), au centre-ville d'Halifax (N.-É.).

Participants Vingt professionnels de la santé actuellement ou antérieurement employés au NECHC.

Méthodes La collecte des données qualitatives comportait l'observation des participants, des entrevues semi-structurées enregistrées et transcrites, des discussions informelles et l'analyse de documents stratégiques. La collecte des données s'est poursuivie jusqu'à l'atteinte d'une saturation, entre décembre 2014 et octobre 2016. Les données ont été vérifiées, codées et triangulées par les membres, et les données probantes tirées des documents stratégiques, de même que les conversations informelles, ont servi à établir leur crédibilité.

Principales constatations Le NECHC offre des soins de grande qualité à la communauté, et accueille des populations marginalisées et vulnérables. La réussite reconnue du NECHC repose sur des relations uniques entre les professionnels, les patients et la communauté. Les 4 principaux thèmes cernés comme des facteurs qui contribuent aux soins axés sur la relation dans le fonctionnement de la clinique sont les suivants : l'activisme reconnu des professionnels, la sécurité culturelle, les relations professionnels-patients et les relations entre professionnels. Les mécanismes de financement provinciaux inadéquats limitent le travail et le développement de la clinique.

Conclusion Les autorités de la santé maintiennent que les soins collaboratifs améliorent la qualité des soins et réduisent les coûts des soins de santé. Ce modèle est encore mal connu en Nouvelle-Écosse. Les constatations, qui reposent sur des travaux ethnographiques ciblés sur le terrain et sur une analyse du NECHC, font valoir que le NECHC est un modèle pragmatique et réaliste des soins de santé collaboratifs. La réussite de cette approche dépend d'une concrétisation démocratique délibérative de la pratique réflexive grâce à des soins axés sur la relation.

Points de repère du rédacteur

- Dans cet article, on cherche à mieux comprendre les soins collaboratifs tels qu'ils sont prodigués au Centre de santé communautaire North End, notamment selon un modèle de soins axés sur la relation. Les soins collaboratifs y fonctionnent selon le principe des relations authentiques, honnêtes et significatives entre les professionnels et les patients, entre professionnels, et entre les professionnels et la communauté. Les membres du personnel estiment que cette façon de procéder favorise des soins de santé efficaces et consciencieux.
- Au nombre des leçons apprises sur la pratique collaborative figurent la nécessité d'obtenir « l'adhésion » du professionnel; les effets contraignants des hiérarchies médicales traditionnelles sur les soins collaboratifs; le soutien à apporter aux professionnels et aux patients au moyen de la pratique réflexive; l'appui à donner au modèle des soins collaboratifs grâce à des soins axés sur la relation; et la nécessité que des mécanismes de financement stables et à long terme soient prioritaires dans la planification gouvernementale.
- Les soins collaboratifs pourraient représenter l'avenir des soins de santé, mais il faudrait une meilleure définition, plus de clarification et une évaluation plus consciencieuse. Il serait aussi bénéfique de prendre en considération les points de vue des patients de cet établissement.

[The North End Community Health Centre is] one big family. We all just grow up together.

What does collaborative care mean for primary care providers? Provincial and federal governments propose that collaborative care will lower costs and improve the quality of primary health care.[1,2] To date, there is sparse supporting evidence for these assumptions.[3-5]

Collaborative care encompasses a range of team-based interdisciplinary care models. One example is the community health centre (CHC). In this article we pursue an understanding of collaborative care as it is practised in the North End Community Health Centre (NECHC) in Halifax, NS, through a relationship-based care model. Family practice is grounded in a unique social contract between patients and providers.[6] This relationship has been shown to influence patient outcomes,[7-18] particularly in marginalized populations.[11,18] So too do relationships between health care providers in collaborative teams influence patient outcomes.[19,20] Yet, to date, there is limited literature on collaborative and relational care from the perspective of health care providers and health care teams that includes administrative and support staff.[5,7,21-26]

Beginning in Canada in 1926 with the Mount Carmel Clinic in Winnipeg, Man, CHCs approached primary care through a framework encompassing community-centred, interprofessional, wellness, social justice, and equity lenses.[27,28] The expansion of CHCs was driven in part by the necessity of addressing the needs of vulnerable populations, low-income and street-involved individuals, newcomers to Canada, and ethnic minorities.[29] These groups are often underserved by mainstream health care and also have complex health care needs.[30] Canadian CHCs have demonstrated improved patient outcomes and health system savings when compared with fee-for-service models,[31,32] and specific benefit when working with street-involved populations.[33]

The NECHC began as a community initiative to improve access to health care services in a Halifax neighbourhood in 1971. The community, comprising a large African Canadian population displaced after their segregated community, Africville, was demolished, felt disrespected and poorly treated in existing health care institutions. Many residents avoided seeking health care unless in crisis.[34] Community members lobbied to have a health care clinic that would be located within the neighbourhood that would prioritize community needs. Today the North End community has expanded and includes a large number of low-income and street-involved individuals, First Nations individuals, and newcomers to Canada.

From its creation the centre has faced financial challenges resulting from fluctuating government support. In 1976 a formal association was established with the Halifax Infirmary to alleviate this pressure. This agreement was severed in 1982, as centralized control and restrictive policies were believed to fundamentally affect delivery of the clinic's mandate. In the 1990s clinic staff negotiated a transition from fee-for-service to a CHC model with salaried funding.

> When I first arrived we were all fee-for-service; there were very few physicians who were paid anything other than fee-for-service. Because of the nature of the work we do and the complexity of the cases we saw, we went to the government and said, "Please, can you put us on salaries as opposed to fee-for-service? It just makes more sense and liberates us to spend the time that we need." What fee-for-service does is encourages quick turnaround; salary supports taking the time that we need. We were successful in negotiating that. There was some negotiating with that; there were some rocky years because Doctors NS [Nova Scotia] is our bargaining unit, and when you are bargaining 99% fee-for-service and 1% alternate funding you don't attract much attention. So there were a number of years—and they always linked it to the master unit value, which was the unit of change, so they would always—if the master of unit value went up it would take 3 months to go up for us. So there were a number of years where it was difficult and we had to fight tooth and nail for everything we did. But alternate funding has taken on more of a viability and so, for example, a lot of the specialty groups are on alternate funding, which has led to being a bigger part of Doctors NS. Family doctors still do not command a lot of attention and they got dinged in the recent contract. (Provider 7)

The NECHC now receives stable provincial funding but remains in a precarious financial situation owing to a funding freeze from the early 2000s.

> The centre has had a number of years of increased operational spending, so every year they are trying to find ways to continue to maintain current clinical service levels [without an increase in funding] .... Budget restraints have always been there, so they have made cuts in other areas [administrative support]. They have also made a number of cuts within this 2016-2017 budget cycle where finance was one part of it, admin support for executive director and primary care manager was reduced from a [full-time equivalent] to part-time 0.5. The health promotion program is not continuing because the funding ran out. We had to cut back on our backfilling for nursing coverage by about 50% and cut back on support staff by about 50%, eliminate a permanent position 0.5 for ADM [advanced document management] that involved scanning in all the chart information; so that was eliminated as well, which is very unfortunate because

> right now, they have about two-thirds of the providers doing ADM, and we should be going the other way .... [This] will put more pressure on the front staff .... I think this year is kind of the tipping point ... I think this was the year that, where at some point there is going to be an impact [on patient care]. (Provider 19)

Despite limited resources, the NECHC has been recognized locally and nationally for its success in serving many marginalized communities.[35,36] The centre has been praised for its interdisciplinary collaboration style[37] and is valued by Dalhousie University in Halifax as a training site for health care professionals. Internally generated patient satisfaction surveys have demonstrated a high degree of patient satisfaction with the care received at the centre,[38] which is described as the heart of the North End community.[39,40]

In this focused institutional ethnography, we contribute a systems-level analysis of collaborative care. We explore and evaluate the perspectives of the health care workers in the context of a CHC. Staff describe collaboration at the NECHC as a dynamic family relationship. We describe their work building relationships in the everyday life, professional practice, and policies of the clinic, providing a constructive example to further develop effective collaborative care strategies.

Background

The NECHC is the largest CHC in Nova Scotia, with more than 45 staff members (physicians, nurses, nurse practitioners, occupational therapists, dietitians, social workers, mental health support, and administrative staff). All patients are assigned a family physician but might be primarily followed by a nurse practitioner. The centre comprises a permanent clinic, a community space, and the Mobile Outreach Street Health (MOSH) program van service.

Unlike other clinics in the Halifax Regional Municipality, the NECHC does not cap patient numbers. Services are provided to individuals who live within the catchment area. Exceptions are made for past clinic patients and individuals with specific needs (eg, they were released from prison, they are vulnerably housed, they have complex addictions). Patient demographic characteristics are not formally documented but are subjectively described as "diverse"; despite encroaching gentrification in the neighbourhood, most patients belong to low-income households.

The NECHC maintains autonomy despite being under the jurisdiction of the Nova Scotia Health Authority (NSHA). The centre is managed by a community board of directors and an appointed executive director. Lump sum "global funding" is provided through the provincial Medical Services Insurance (MSI) program and the NSHA in return for provision of a set number of clinical hours. All staff members receive a salary and all services are free to patients. Specific programs are funded through individual grants and fundraising. The permanent clinic operates from 9:00 AM to 5:00 PM Monday to Friday, with an evening drop-in clinic. The MOSH program has funding for 12 hours per day, 6 days per week, operating on a flexible schedule.

Communication between interdisciplinary team members operates through formal and informal mechanisms. Interdisciplinary and MOSH rounds are held weekly. Most clinical staff members communicate casually in person daily via an "open-door policy" or through the electronic medical record messaging system. The executive director communicates primarily through e-mail.

Methods

This research is approached conceptually and methodologically through a critical medical anthropology–focused institutional ethnography. Critical medical anthropology examines health systems and social practices, unpacking ideological assumptions, looking beyond biomedical explanations to the political, sociocultural, and economic matrix that influences the delivery, treatment, and perception of disease.[41-45] Focused ethnography allows concentration on a distinct issue (eg, relationship building) and shared experiences in a particular setting.[46] Institutional ethnography connects the sites and situations of day-to-day activities, professional practices, and policies.[21,47,48]

Ethics approval for the study was granted by the NSHA. Further approval was provided by an internal ethics review committee through the NECHC. Informed consent was obtained from all participants; this process was conducted by the lead researcher (A.H.).

Data collection, transcription, and analysis was completed by the lead researcher, an undergraduate medical student at the time, with support from the research team. A combination of qualitative methods was employed in this study, including participant observation, document analysis, semistructured interviews, and informal discussion between December 2014 and October 2016. In-depth interviews were conducted with 20 providers and staff previously and currently employed at the NECHC. Participants were selected to encompass the breadth of disciplines operating within the NECHC to allow for a systems-level understanding of the centre. Daily field notes were used to record observations and informal conversations. These were indexed, transcribed, coded, and analyzed using a constant comparative and concept development approach.[49-51] Document analysis included NECHC social media accounts, promotional materials, and internal clinic reports.

The data were analyzed to understand patterns of social relations within the day-to-day reality of the NECHC. Data were reviewed manually and patterns were identified, clustered, and sorted until distinct and comprehensive themes were generated. Data were

member checked and triangulated using interview data, observational data, document analysis, and perspectives of other participants to validate developing themes. New information emerging throughout the study was applied reflexively to clarify and inform subsequent lines of inquiry. The resulting themes were then evaluated to identify potential strengths, weaknesses, and opportunities to improve health care delivery.

Findings

Relationship-based care, where relationships are recognized as often more important than medical interventions to health care, is a core philosophy of the NECHC. Although not all providers use the term *relationship-based care,* it has been described in NECHC educational documents:

> The who and how of health care (ie, the relationship) is often more important than the what (ie, the intervention) in impacting health. Sometimes this means going against common practices of having many people (eg, assistants too) see a client for small pieces of a puzzle in order to build trust, at least until positive momentum is established and trust can be transferred to a few more providers.[52]

Additionally, this approach was ubiquitously valued for efficacy, especially among vulnerable patients.

> Relationship-based care … is based on trust, on taking time to build trust, on trying to … continue the relationship when folks don't necessarily need you when there is not an immediate crisis …. Just constantly checking in … you know, how are things going? …. And accepting … them where they are, without judgment and with respect … no finger pointing … staying with someone in a direction that they are heading that can feel uncomfortable sometimes, like you are not quite doing your job, but being brave enough to stay in contact and have open conversations with them, even though they are doing some pretty unhealthy things …. You need to disagree in a nonjudgmental way so that folks feel that you care and are willing to respect their decisions … staying with the relationship …. Relationship-based care is based on honesty; it's based on a little looser boundary than the professional boundary that we had in-hospital; it's about keeping the relationship going even when there isn't a defined need. It's based on introspection and being willing to learn and examine yourself. (Provider 5)

> To put it crassly you score big points when you go up to someone and say, "You know, man, I know this is a really hard time for you" …. Yeah, that's just the key to unlock someone's burdens a little bit. I've always been someone who is easy to talk to, a good listener, but there is just a history that one can develop, that you can bring in; you can bring in humour, authenticity, on a deeper level that mostly enhances the relationships. Sometimes there are relationships that should be short term. And we can get a little crusty with folks, when perhaps I should be backing off and recognizing my biases. But overall, 98% of the time, [it is important to know] the history, the knowledge of the client's families, and interactions and community plus the collaboration with other disciplines, not just with the facts but with their philosophies and perspectives. (Provider 5)

> To me it [relationship-based care] comes back to just having a trusting relationship, [which] is the foundation for successful relationships; in order to have that trust there needs to be the commonality of "I understand you; you understand me," and when you have that people allow you into parts of their lives that they wouldn't allow you otherwise. To me, it's the foundation of why this clinic is successful. It's about finding out where people are at, accepting where they are at, and still being present and not being judgmental. (Provider 2)

Our study identified 4 central themes that characterize elements that NECHC providers build on to practise relationship-based care: an activist provider identity, cultural safety, provider-patient relationships, and provider-provider relationships.

Activist provider identity

The NECHC providers share a strong identity politic centred on community activism and advocacy.

> Not that I've done anything super useful but … I can't keep working like this, to be a pawn of the system that creates poverty and sickness. If that was the end goal that would be super disheartening. The possibility of making a change by knowing how or what is what drives me. (Provider 1)

> I have a role consulting with staff and health care providers within the system, like community services or hospital based, to help interpret or translate people's experiences, expectations, [and] recommendations that other providers are trying to make happen, or help with advocacy pieces, help to allow people to speak for themselves. I am aware that I carry more privilege and authority [as an educated health care provider] than the people that I work with. If that must be the case, I try to leverage that as much as possible. (Provider 1)

Staff members identified themselves as "odd" or "different from mainstream health care [providers]," established by a "self-selection" process.

> We have always maintained independence from the health authority, which is crucial. In fact, someone from the health authority said to me years ago, "You know, if you had come under our control that clinic wouldn't still be operating." It's the sense of personal investment we had in it, the sense that we all had an impact, and I don't think that would have existed if we had been under the control of the health authority. (Provider 18)

> I think I create a genuine relationship with patients. Not to be critical of traditional professional relationships, but I don't really establish the same degree or rigidity of professional boundary that you might come to be told to do when you are in school. There are for sure the aspects that need to be there for the safety of both parties around, like, confidentiality and, like, respect of each other's expertise, and some aspects of that which do remain. (Provider 1)

The NECHC recruits and attracts those comfortable on the fringes of health care and willing to work in active collaborative patient- and community-focused advocacy.

> Really, we were the odd people—we were considered very odd; they would be saying to themselves, "Thank goodness those people [NECHC physicians] were up there [at the NECHC] doing whatever." Keeping people out of the hospital, but it's only been in the last 8 years that there has been an increasing recognition of the work that is being done here and the importance of it. (Provider 7)

> It has been my view, my learning, that they [people who don't share the clinic philosophy of care] don't stay as long. I believe that in this kind of setting, it has to be a heart thing, that we are all working towards the best interest of the patient, the client. (Provider 11)

> I think one of our hiring practices is with regards to feeling comfortable in a culturally diverse environment and not just comfortable but actively support[ing] that. And have a philosophy and attitude of respect for everybody. That's a very powerful thing, most people in an interview, the answer is "Oh, you're not supposed to discriminate"; of course, you're not supposed to say that. But in terms of people's attitudes and how they truly function, that's what is valued here. And there have been times here where someone has been hired and it didn't work out very well and eventually they left. To me I haven't seen another place that focuses on human values and what you want as a part of a key for success in our team. So I think that's a main thing. (Provider 12)

> There is a bit of a self-selection for folks who come to the NECHC; you know, people are looking for a philosophy of collaboration and community. There have been people who have come and didn't feel that and, you know, they ended up not staying because they were unsatisfied. (Provider 6)

These qualities are considered in hiring practices. For example, MOSH includes street-involved community members in hiring decisions. These values are exemplified in a long-serving core clinic team identified as the "heart of the clinic." Staff members who "don't fit" turn over quickly. A unified NECHC identity is reinforced through a perceived independence from the health authority. Staff members have freedom to innovate, reflexively problem solve, and push boundaries (eg, entering homes with bedbugs, giving therapeutic hugs), which would be difficult to practise within the health authority. This staff identity upholds the NECHC mission: to support North End Halifax to be a healthy community by offering leadership in primary health care through health services, education, community development, outreach, and advocacy.

Culturally safe care

The NECHC was created to provide culturally safe care for African Nova Scotians living in Halifax's North End.

> I feel like we are pretty well regarded in the community both by providers and clients and the general population. But of course there are folks who, like ... it won't be possible that everyone would say and speak well of us or feel comfortable coming to us. (Provider 15)

> Well, in the beginning, in 1971, very humble beginnings of the NECHC, the reason why this place exists today, is because people from the community went to the tertiary care centre and felt that they didn't receive the care that they needed, and were not respected, [were] disrespected, or were discriminated against, so they got together and said, "Let's get something in our own community." That was the beginning. That frame of thinking still exists with many people. I hear it from many clients: "I'm not going to emergency; I'm not going to the hospital. If I go there I'm made to feel like I'm worthless or a second-class citizen, or because I have addictions issues they will look down on me. Because I don't have a place to live, because I don't have an MSI card." [This was said by] someone I spoke to a couple of weeks ago because they didn't have an MSI card and so that was stress to them. The person needed care, they finally figured out that we could treat this person even without an MSI card, but by then this person was frustrated and took off. I think that the idea that it's not safe in other centres in the hospital environment or community, [in] larger tertiary care centres, they're not a safe space, and they are coming here because it is in

> the community. There are people that they know, there are people of African descent and different cultures that makes people feel comfortable, safe; it's almost like *Cheers*—you like to go where everybody knows your name. Where people know you, even when it's a new client, we like to let them know that we respect everyone; you respect us and we respect you and you are important to us and we won't judge you. And I think that makes people feel safe and feel like this is a place where they can come and be in the space and they will be OK. (Provider 11)

Today that role has expanded to include individuals who are members of the LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning, and other gender identities) community, Mi'kmaq, street involved, substance users, and newcomers to Canada. Providers consider this role fundamental to the mission of the centre. Mechanisms employed to actively contribute to culturally safe care at the NECHC are provider diversity, an ongoing consent process, and adaptive use of space.

Staff diversity is viewed as essential to facilitating cultural safety. The NECHC recruits for diversity with the belief that patients will feel more comfortable being treated by staff members who share their ancestry or identity: "It does help that you can have people you identify with culturally, racially." (Provider 2)

Additionally, the NECHC prioritizes hiring community members to further support community bonds. This institutional value is challenged at times, when placements of students from affluent white backgrounds cause unease and tension with both patients and staff members. Most staff members choose to engage with this tension as a means of teaching students around culturally safe care.

Patient consent for medical procedures and health discussions are seen as deliberative, dialogical patient-provider relational processes.

> I have learned about how those [dynamics] actually have an impact on people. It's a willingness to be educated ourselves. Like we are professionals and I have expertise, but so does everybody else. It's not just a 1-way street, it's a 2-way street. Seeing things with immigrant populations that come here, we've seen a number of different waves from Vietnamese boat people to now with the Syrians, they come from a culturally different background, so if you don't understand that or know that, you aren't going to do a very good job for them. I can remember an example, and to today I feel horrified. It was about 25 years ago and I was a young new grad, this was a young Vietnamese woman, and I did a vaginal exam and I basically broke her virginity or that was her perception. Because of her culture, I asked for her permission and she gave it, but I didn't understand that she didn't have the option to say no to me because I am an influential person. So that's to me what is different on a day-to-day basis. Some of it you can learn, and some of it has to be part of who you are. If you are willing to accept change and openness and be open to learning things you will do well, and if you are kind of not that way you won't do well here. And that is not to say that you are [a] bad person or whatever, but it's not for everybody. (Provider 15)

Approval is not assumed, especially in outreach; providers respect that their involvement might not be wanted. Explicitly asking, "Is it okay if we talk about …" or "Can I check in with you next week to talk about …" establishes active participation, builds respect, recognizes autonomy, and encourages trust. Reflexively negotiating consent also reminds health providers that they are still outsiders to the community they are serving.

> In the clinic, I might have, if someone said their chest was bothering them I would reach for my stethoscope; I wouldn't think to ask, or [point] it out. In this situation someone might have a scar that they don't want to show us, so you can't just automatically go in there. So sometimes you just have to ask a few more questions, "Are you okay if I continue to ask you questions about this?" (Provider 5)

The use of space also functions to break down provider-patient tensions. The mobile outreach team and home visits allow for patients to be contextually situated in spaces where they feel comfortable. The formality of a clinic structure serves to reinforce the hierarchy of the provider-patient relationship; by removing this barrier patients are provided with a greater sense of autonomy and control.

> I feel like since I have been more involved in the community programs I have had a better sense of building relationships. It's just seeing people outside of the clinical setting allows people to see you differently. They see you differently and you see them differently and interact differently. I think that has been for the better … increasing the relationship, so now I like how I can start walking down the street and know people by name, and they say hello to me, I say hello to them, and we can stop and chat. It's the little things like that. (Provider 4)

> Most men I've made a connection with outside of a shelter setting, you can make connections with men in shelters, they just have more time to view you and learn you outside of a shelter; most of the connections I have made with men have been through their female partners who have said, "Smarten up, arsehole, he's right here, come on." (Provider 5)

Some staff suggested that the relaxed "dinginess" of the clinic contributed to patients feeling less intimidated during interactions.

Provider-patient relationships

The delivery of relationship-based care is grounded in feminist standpoint epistemology where knowledge and power are seen to be socially situated.[53] Providers use intentional strategies to address relationships between political and social power and knowledge to support connection with patients. Both clinical and administrative staff members identified relationship building as a central feature of the clinic and why they appreciate working there.

> Going above and beyond … trying to understand … where they are coming from … sometimes that really rude patient is just, like … so frustrated …. There [are] a lot of reasons why. That really appeals to me, sort of thinking bigger than just what's right in front of you. (Provider 8)

Features of relationship building highlighted from our findings include boundaries, language, time, harm reduction, and community involvement.

Strict professional boundaries and behaviour protect patients from inappropriate influence and legally protect providers. The NECHC staff leverage their relative bureaucratic freedom to build relationships through informal communication styles and more relaxed boundaries. Staff focus on authenticity in coproducing relationships with patients—countering authoritarian, rule-driven professionalism traditionally demanded by health care professions.

> I speak their language … ask if they [understand] … sometimes I state it 3 times in different vernacular. I can come up with colourful examples. So you know, safety discussion: "Do you engage in anal sex; do you bum fuck; do you fuck up the ass?" "You know, sometimes the penis can get yeast infections also; yes, your dick can get a jock itch kind of thing, on your dick too …." It's about getting comfortable. Paying attention to reading people a little more … just straight up asking about language, and making sure I understand too, because it goes both ways … getting to know what a stem is, a crack tube, a safe-use crack kit, getting to know what people mean by fixing rather than IV [intravenous]-drug use. And being comfortable: "Do you bang? Do you IV-drug use?" "Yeah, I've had an IV at the hospital." "No, do you bang; do you hit?" (Provider 5)

Examples ranged from casual style of dress, language choices, using therapeutic hugs, and active engagement in the community outside of work. This process empowers patients with a higher degree of cultural capital where they know things their provider does not and serves to dismantle the elevation of health care providers in the provider-patient relationship.

A relaxed concept of time facilitates relationship building: "[The] sense of time is different in the health centre compared to the hospital; it's more fluid here." (Provider 1)

Staff members prioritize patient care over schedules. Providers work through breaks and extend appointments. Staff generally believed these conditions are best supported by a salaried funding model. Outreach programs largely operate without formal scheduling. This philosophy of time leads to some tensions, with underfunding and staff shortages resulting in increased wait times and irritated patients.

Harm reduction is a central tenet of relationship-based care at the NECHC. Providers believe in "meeting folks where they are at." Harm reduction recognizes that pragmatic patient action outweighs imposing an unrealistic ideal treatment. This strategy was often employed when poverty or addictions contributed to patients' health. Providers engage with creative problem solving and must accept when patients make choices that counter medical best practices.

> It's about seeing people and accepting them where they are in their life no matter where that is. And not judging them for whatever choices they [are] making, but being open to listening to what they need and being with them in that place. And still maintaining professional context. It doesn't mean you have no boundaries and give people whatever they want. But I have a professional expertise, and if you ask my opinion I am going to give my opinion, but you can still make whatever decisions that you want. Particularly it becomes extreme in the MOSH clientele because these are people, many of whom have been injured and traumatized by health care professionals and many other people in their lives. They are struggling with mental health and addictions, poverty, and their armour is up, so to be able to work well with them, and they have a good radar, they know when you have a fake smile and are not fully present. So that is the piece and it's kind of hard to describe exactly what it is. It is an attitude and an approach of being with someone that either encourages someone to continue or run in the other direction. (Provider 15)

> Some community members have really bad pet peeves or bad experiences. Those are really tough personalities and often people with mental health [issues]. It's hard to really gauge that sort of thought. But yeah, in general it is well respected and lots of people feel very fortunate to have that sort of health care. (Provider 10)

Community participation is considered the foundation of the NECHC's success in building meaningful relationships

with members of this community. Providers identified that many of their patients maintained their trust and confidence in the NECHC because of its position and role within the community. The centre is an interwoven component of a changing neighbourhood. Its residents maintain a sense of ownership over the centre, a legacy from its origins. Still, the governance system intended to support ongoing involvement and representation of community members has struggled to maintain diversity (ie, lower-income, Indigenous, or African Nova Scotian individuals) in its executive board of directors. Community participation has declined in prenatal care, and participation in new group initiatives fluctuates.

> You have to have specific programs targeted to specific populations ... would MOSH clients feel comfortable coming to a seniors' program or a health talk? We are trying to increase our reach. We are trying to work with ISANS [Immigrant Services Association of Nova Scotia] to bring in some of the new immigrants to our reading group. (Provider 3)

Provider-provider relationships

Collaboration as practised at the NECHC expands traditional workplace dynamics to form an interconnected family ("Our work family, we [NECHC staff] call it" [provider 15]), extending relationship-based care to engaged co-workers.

> Relationship [-based] care involves [the] relationship of the collaborators ... I have to demonstrate my assessment skills and I have to earn their trust as such. I was able to show my skills and apprentice, pick up some tips. Hierarchy is different here ... a little more merit based than title based ... the easy manner with which we are able to converse and consult and challenge each other and review things together without feeling that we are interfering with a process. And with concerted efforts made at meetings for everyone to be heard. And with the ability for all members within the NECHC to be on committees, with the regular staff meetings and regular rounds. The staff meetings are informative with an agenda, but there is much more encouragement of feedback and conversation around issues. Part of this is accomplished simply because we are smaller, that when teams become larger they are unable to pull this off. But it is beyond size ... there is a philosophy that encourages people, the comfort that most people have at the clinic and the mostly positive reinforcement that people will get for speaking up that makes it feel less hierarchical. (Provider 5)

This approach is seen as countering tertiary care buzzwords like *collaborative care,* which is viewed as "wishful thinking" in the absence of tangible funding.

> Multidisciplinary teams in the hospital worked like a "Tag, you're 'it,' high-five, over to you." Whereas here, there is just more time for information; it's beyond information sharing—what is the difference—perspective sharing as well ... and that has its biases also but in rounds here, you have 10 years of someone that you know, and someone is able to remember it's 10 years ... since their husband died and this ... derailment might be related to [that]. So little things like that that really fill out the picture and develop the relationship-based care, to use that term. (Provider 5)

> What hasn't changed, which is disappointing [regarding funding], we have all these buzzwords like *health centre;* the IWK calls itself a health centre. They are a tertiary care centre; there is nothing healthy about them. I'm being a little bit facetious, but they are a tertiary acute care hospital; but there is all this terminology, like *collaborative practice,* all these terms that get tossed around, but the administration still operates from an acute care point-of-view hierarch, and from a tertiary care perspective. When you come from an anthropology background or a social background you know that's not what makes healthy societies ... we should be investing the other way around; so that's disappointing that despite all the buzzwords we haven't seen a real significant shift in funding toward social determinants to making our population healthy. (Provider 3)

Three key areas of this dynamic were revealed in our findings: hierarchy, provider trust, and conflict. The NECHC reframes the traditional medical hierarchy.

> [What] we appreciate is that we are flat lined. We are not hierarchical. We are flat line. So that's like—you know, this is what we are. A physician really doesn't have any more authority per se, you know, as an employee at the health centre than I do. My opinions, you know, matter, and are just as valuable as the executive director's, you know. So we are flat line, not hierarchical; so we are flat line. That's one of the good things about this place. (Provider 13)

Nonphysician team leads and perspectives are valued and prioritized. The MOSH team is run almost exclusively by nurses and an occupational therapist; physicians serve as team support. Nonphysician staff members felt validated and respected at the NECHC compared with jobs they had held in other health care settings.

Trust between providers facilitates provider autonomy. This aspect of the NECHC's health care service helps nurse practitioners fulfilling their scope of practice, whereas they described feeling micromanaged in other clinical settings. The MOSH team relies on trusting relationships between providers, as urgent management decisions might need to be made through telephone consultations. Relaxed

communication within the clinic supports this flexibility and fluidity, as providers know they can rely on their colleagues when they feel outside of their depth.

The NECHC maintains a culture of addressing the negative. Providers intentionally engage with errors, problems, and challenges of the job in regular and candid debriefing sessions.

> It's a really challenging environment … it brings up a lot of emotions … and in your own personal life things are happening too. We are trained to come as a professional and keep those totally separate, but it's ridiculous, you can't; you don't want to bring your burden to the relationship and have an impact on the patient. So we as a team actively talk about what a struggle we have. So it's closed doors, no one else is allowed in, there are lots of tears, but it's wonderful, you know. And we have, actually, a facilitator who comes in and helps us. He was recently—he's joined the group … I'm coming because I've never seen this level of relationship building as I've seen in this group. You really feel like people have your back and you could come to that group and say anything and they would support you. (Provider 15)

> That is one of the amazing things about MOSH and that that there is a very personal connection. Nobody struggles to talk about successes. There are very few work environments where you feel safe to share your vulnerabilities, the things that challenge you, and to put it out there. Because that is not easy to do. It's not easy to do at any time. It's a necessary part. We struggle all the time. It's important to put it out there and realize that it's not just me that struggles with that. You're my mentor, the one who I've always looked up to, and it's really reassuring to know that you struggle sometimes too, and it's not just me, so it really is a unique [group]. And it takes a healthy group, we're really fortunate to have a really good team and keep it real and [it] helps us all to work. (Provider 1)

In an era of glorified success stories, this honesty creates a deep bond among providers that encourages mental well-being and a dynamically critical reflexive practice.

The CHC model and relationship-based care approach were suggested to be an ideal manifestation of primary care: "Our target group is becoming dispersed over the entire city and we can't deal with it all. It would be nice to see some more community health centres, which is the right model for dealing with these kinds of things [low-income populations]." (Provider 3)

Discussion

Collaborative care at the NECHC operates through authentic, honest, meaningful relationships between providers and patients, providers and providers, and providers and the community. Collaboration in this sense is not simply an institutional structure—it is a philosophy of caring.[54] Staff members believe this mechanism (relationship-based care) promotes radical, effective health care. A patient satisfaction survey showed similar opinions were held by patients.[38]

This ethnographic study of the NECHC offers insights for future collaborative community practices in Nova Scotia. Key lessons on collaborative practice include the following:

- Provider "buy-in" is essential.
- Traditional medical hierarchies constrain collaborative care.
- Reflexive practice supports both providers and patients.
- Relationship-based care supports a collaborative care model.
- Long-term stable funding mechanisms need to be central to government planning.

Provider buy-in is essential to collaborative care. A social justice identity politic encourages camaraderie across health professions, active team engagement, and informal reflexive communication practices capable of challenging established practices.

A growing literature identifies the limitations of physician-centred models of care.[55,56] The NECHC prioritizes deliberative, democratic collaborative engagement encompassing a range of health providers and patients.[57] This approach requires intentional work and restructuring of traditional provider roles. The result is respect, provider satisfaction, and holistic decision making.

Marginalized and racialized communities require a style of care that promotes safety.[58] Providers at the NECHC individually and collectively reflect on and challenge their personal biases, negative emotions, and experiences to accomplish culturally safe care. This reflexive practice serves to support provider needs in a complex challenging environment.

The term *relationship-based care* is not new.[59-62] The literature recognizes that patient experience, including patients' relationships with health care providers, affects health. The NECHC experience expands this understanding. Relationships are seen to encompass community values and interdisciplinary relationships, in addition to the traditional provider-patient dynamic. In these relationships, trust, respect, and authenticity are valued over professionalism or policy.

Precarious financial constraints endanger the NECHC's relationship-based collaborative care, creating a culture of stress among the providers. As patient numbers continue to increase, a funding crunch attacks the heart of the NECHC's patient-centred care. Grant restrictions impose programs that are not community centred. Staff shortages result in clinicians completing clerical work instead of seeing patients. External funding calls go unanswered owing to staff reductions. Wait-time

pressures encourage policies enforcing clinic schedules and reducing collaborative meeting time. There is a renewed interest in a stronger partnership with the health authority. Some participants expressed concern that this might affect the centre's ability to provide relationship-based care as it is currently practised.

Limitations

This study presents a cross-sectional description of the NECHC during the period in which this research was conducted. Data were collected only from health care providers. Further characterization of the clinic from a patient perspective would add depth to our understanding of clinic function.

Conclusion

Collaborative care might be the future of health care but requires further definition, clarification, and thoughtful evaluation; consideration of a patient perspective from this setting would be beneficial. We propose that the NECHC is an exemplary illustration of the value of relationship-based collaboration, reliant on provider buy-in with clinic and community values, the deconstruction of medical hierarchy, and reflexive practice. Inadequate funding, provider burnout, wait times, and administrative stress threaten to disrupt the unique functioning of this centre. Funding bodies need to provide secure and sufficient support, financially and structurally, to promote healthy development of community-tailored collaborative clinics.

Dr Hudson is a psychiatry resident at the University of British Columbia in Vancouver. **Dr Boudreau** is Assistant Professor of Emergency Medicine and Co-Faculty Lead for the Service Learning Program of the Global Health Office at Dalhousie University in Halifax, NS. **Dr Graham** is a medical anthropologist, Professor of Pediatrics (Infectious Diseases), and Director of the Technoscience and Regulation Research Unit at Dalhousie University.

Contributors

Dr Hudson was responsible for the initial project design, ethics approval, data collection, analysis, and preparation of the manuscript. **Drs Graham** and **Boudreau** were involved in refining the project design and methodology, analysis, and editing and approval of the manuscript.

Competing interests

None declared

Correspondence

Dr Allison Hudson; e-mail **allison.hudson@dal.ca**

References

1. Government of Canada. *Primary Health Care Transition Fund*. Ottawa, ON: Government of Canada; 2007. Available from: **www.canada.ca/en/health-canada/services/primary-health-care/primary-health-care-transition-fund.html**. Accessed 2019 Jun 25.
2. Health Professions Strategy and Practice. *Collaborative practice*. Calgary, AB: Alberta Health Services; 2015. Available from: **www.albertahealthservices.ca/assets/careers/ahs-careers-stu-supporting-interprofessional-placements.pdf**. Accessed 2019 Jun 25.
3. Strumpf E, Ammi M, Diop M, Fiset-Laniel J, Tousignant P. The impact of team-based primary care on health care services utilization and costs: Quebec's family medicine groups. *J Health Econ* 2017;55:76-94. Epub 2017 Jul 1.
4. Dunkley-Hickin C. *Effects of primary care reform in Quebec on access to primary health care services* [doctoral dissertation]. Montreal, QC: McGill University; 2013.
5. Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: an integrative literature review. *Int J Nurs Stud* 2015;52(7):1217-30. Epub 2015 Mar 19.
6. McWhinney IR. The importance of being different. Part 1: the marginal status of family medicine. *Can Fam Physician* 1997;43:193-5 (Eng), 203-5 (Fr).
7. Bresalier M, Gillis L, McClure C, McCoy L, Mykhalovskiy E, Taylor D, et al. *Making care visible. Antiretroviral therapy and the health work of people living with HIV/AIDS*. Toronto, ON: Making Care Visible Working Group; 2002.
8. Flores G. Culture and the patient-physician relationship: achieving cultural competency in health care. *J Pediatr* 2000;136(1):14-23.
9. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care* 1989;27(3 Suppl):S110-27. Erratum in: *Med Care* 1989;27(7):679.
10. Mallinson RK, Rajabiun S, Coleman S. The provider role in client engagement in HIV care. *AIDS Patient Care STDS* 2007;21(Suppl 1):S77-84.
11. McCoy L. HIV-positive patients and the doctor-patient relationship: perspectives from the margins. *Qual Health Res* 2005;15(6):791-806.
12. Mykhalovskiy E. Beyond decision making: class, community organizations, and the healthwork of people living with HIV/AIDS. Contributions from institutional ethnographic research. *Med Anthropol* 2008;27(2):136-63.
13. Owens A, Randhawa G. 'It's different from my culture; they're very different': providing community-based, 'culturally competent' palliative care for South Asian people in the UK. *Health Soc Care Community* 2004;12(5):414-21.
14. Rajabiun S, Mallinson RK, McCoy K, Coleman S, Drainoni ML, Rebholz C, et al. "Getting me back on track": the role of outreach interventions in engaging and retaining people living with HIV/AIDS in medical care. *AIDS Patient Care STDS* 2007;21(Suppl 1):S20-9.
15. Salmon P, Young B. Dependence and caring in clinical communication: the relevance of attachment and other theories. *Patient Educ Couns* 2009;74(3):331-8. Epub 2009 Jan 20.
16. Stewart MA, McWhinney IR, Buck CW. The doctor/patient relationship and its effect upon outcome. *J R Coll Gen Pract* 1979;29(199):77-82.
17. Varga C, Brookes H. Factors influencing teen mothers' enrollment and participation in prevention of mother-to-child HIV transmission services in Limpopo Province, South Africa. *Qual Health Res* 2008;18(6):786-802.
18. Schoenthaler A, Chaplin WF, Allegrante JP, Fernandez S, Diaz-Gloster M, Tobin JN, et al. Provider communication effects medication adherence in hypertensive African Americans. *Patient Educ Couns* 2009;75(2):185-91. Epub 2008 Nov 14.
19. Wu FM, Rubenstein LV, Yoon J. Team functioning as a predictor of patient outcomes in early medical home implementation. *Health Care Manage Rev* 2018;43(3):238-48.
20. Strasser DC, Falconer JA, Herrin JS, Bowen SE, Stevens AB, Uomoto J. Team functioning and patient outcomes in stroke rehabilitation. *Arch Phys Med Rehabil* 2005;86(3):403-9.
21. Campbell H, Hotchkiss R, Bradshaw N, Porteous M. Integrated care pathways. *BMJ* 1998;316(7125):133-7.
22. Mykhalovskiy E, Smith G. *Getting 'hooked up': a report on the barriers people living with HIV/AIDS face accessing social services*. Toronto, ON: Ontario Institution for Studies in Education; 1994.
23. Bruner P, Davey MP, Waite R. Culturally sensitive collaborative care models: exploration of a community-based health center. *Fam Syst Health* 2011;29(3):155-70.
24. McPherson CM, McGibbon EA. Rural interprofessional primary health care team development and sustainability: establishing a research agenda. *Prim Health Care Res Dev* 2010;11(4):301-14.
25. Belanger E, Rodríguez C. More than the sum of its parts? A qualitative research synthesis on multi-disciplinary primary care teams. *J Interprof Care* 2008;22(6):587-97.
26. Schepman S, Hansen J, de Putter ID, Batenburg RS, de Bakker DH. The common characteristics and outcomes of multidisciplinary collaboration in primary health care: a systematic literature review. *Int J Integr Care* 2015;15:e027.
27. Canadian Association of Community Health Centres [website]. *About community health centres*. Toronto, ON: Canadian Association of Community Health Centres. Available from: **www.cachc.ca/about-chcs**. Accessed 2019 Jun 25.
28. Association of Ontario Health Centres. *The CHC model of care. Information and resources for community-based primary health care training*. Toronto, ON: Association of Ontario Health Centres; 2009.
29. Guenter D, Oudshoorn A, Mancini J. Models of primary care delivery for under-served populations in inner-city settings. In: Arya AN, Piggott T, editors. *Under-served. Health determinants of Indigenous, inner-city, and migrant populations in Canada*. Toronto, ON: Canadian Scholars; 2018. p. 185-96.
30. Hay D, Varga-Toth J, Hines E. *Frontline health care in Canada: innovations in delivering services to vulnerable populations*. Ottawa, ON: Canadian Policy Research Networks; 2006.
31. Glazier RH, Zagorski BM, Rayner J. *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10*. Toronto, ON: ICES; 2012.
32. Russell G, Dahrouge S, Tuna M, Hogg W, Geneau R, Gebremichael G. Getting it all done. Organizational factors linked with comprehensive primary care. *Fam Pract* 2010;27(5):535-41. Epub 2010 Jun 9.
33. Muldoon L, Dahrouge S, Hogg W, Geneau R, Russell G, Shortt M. Community orientation in primary care practices. Results from the Comparison of Models of Primary Health Care in Ontario Study. *Can Fam Physician* 2010;56:676-83.
34. Halifax Infirmary. *Report on the North End Clinic*. Halifax, NS: Halifax Infirmary; 1971.
35. McGibbon E. Health and health care: a human rights perspective. In: Raphael D, editor. *Social determinants of health: Canadian perspectives*. 2nd ed. Toronto, ON: Canadian Scholars' Press; 2009. p. 318-35.
36. Health Council of Canada. *Getting it right: case studies of effective management of chronic disease using primary health care teams*. Toronto, ON: Health Council of Canada; 2009.
37. Lovett T. *Exploring the structures and processes needed to support the development of collaboration amongst public health nurses, family practice nurses, and nurse practitioners who work in breastfeeding support and promotion* [master's thesis]. Halifax, NS: Dalhousie University; 2011.
38. *North End Community Health Centre strategic plan 2015-2019*. Halifax, NS: North End Community Health Centre; 2015.
39. Roth N, Grant JL. The story of a commercial street: growth, decline, and gentrification on Gottingen Street, Halifax. *Urban Hist Rev* 2015;43(2):38-53.
40. Barnard DR. *Envisioning pathways to community health through the eyes of North End Haligonians* [doctoral thesis]. Halifax, NS: Dalhousie University; 2010.
41. Baer HA, Singer M, Johnsen JH. Toward a critical medical anthropology. *Soc Sci Med* 1986;23(2):95-8.

42. Singer M. Developing a critical perspective in medical anthropology. *Med Anthropol Q* 1986;17(5):128-9.
43. Pfeiffer J, Nichter M. What can critical medical anthropology contribute to global health? A health systems perspective. *Med Anthropol Q* 2008;22(4):410-5.
44. Lock M, Scheper-Hughes N. A critical-interpretive approach in medical anthropology: rituals and routines of discipline and dissent. In: Johnson TM, Sargent CF, editors. *Medical anthropology: contemporary theory and methods.* New York, NY: Praeger Books; 1990. p. 47-72.
45. Corin E. The social and cultural matrix of health and disease. In: Evans RG, Barer ML, Marmor TR, editors. *Why are some people healthy and others not? The determinants of health populations.* New York, NY: Taylor and Francis; 1994. p. 93-132.
46. Knoblauch H. Focused ethnography. *Forum Qual Soc Res* 2005;6(3):Art 44.
47. Smith GW. Political activist as ethnographer. *Soc Probl* 1990;37(4):629-48.
48. Devault ML. Introduction: what is institutional ethnography? *Soc Probl* 2006;53(3):294-8.
49. Baker AC, Giles AR. Cultural safety: a framework for interactions between Aboriginal patients and Canadian family medicine practitioners. *J Aborig Health* 2012;9(1):15-22.
50. Richards L. *Handling qualitative data: a practical guide.* 2nd ed. Thousand Oaks, CA: Sage Publications; 2009.
51. Strauss AL, Corbin J. *Basics of qualitative research. Techniques and procedures for developing grounded theory.* 2nd ed. Thousand Oaks, CA: Sage Publications; 1998. p. 312.
52. Hill N, Marval B. *Helpful considerations for health professionals working outside the box 2016. Fact sheet.* Halifax, NS: North End Community Health Centre; 2016.
53. Harding S, editor. *The feminist standpoint theory reader. Intellectual and political controversies.* New York, NY: Routledge; 2004.
54. Graham JE, Bassett R. Reciprocal relations: the recognition and co-construction of caring with Alzheimer's disease. *J Aging Stud* 2006;20(4):335-49.
55. Bourgeault IL, Mulvale G. Collaborative health care teams in Canada and the USA: confronting the structural embeddedness of medical dominance. *Health Sociol Rev* 2006;15(5):481-95. Epub 2014 Dec 17.
56. Newhouse RP, Spring B. Interdisciplinary evidence-based practice: moving from silos to synergy. *Nurs Outlook* 2010;58(6):309-17.
57. Safaei J. Deliberative democracy in health care: current challenges and future prospects. *J Healthc Leadersh* 2015;7:123-36.
58. Beck BJ, Gordon C. An approach to collaborative care and consultation: interviewing, cultural competence, and enhancing rapport and adherence. *Med Clin North Am* 2010;94(6):1075-88.
59. Clavelle JT. Relationship-based care as a pathway to excellence in care and service: the St Luke's story. In: Glembocki MM, Fitzpatrick JJ, editors. *Advancing professional nursing practice. Relationship-based care and the ANA standards of professional nursing practice.* Minneapolis, MN: Creative Health Care Management; 2013. p. 415-26.
60. Cropley S. The relationship-based care model: evaluation of the impact on patient satisfaction, length of stay, and readmission rates. *J Nurs Adm* 2012;42(6):333-9.
61. Koloroutis M, editor. *Relationship-based care. A model for transforming practice.* Minneapolis, MN: Creative Health Care Management; 2004.
62. Winsett RP, Hauck S. Implementing relationship-based care. *J Nurs Adm* 2011;41(6):285-90.

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2019;65:e344-55