Specialists **Team Care** Collaborative

Final Evaluation Report

Elayne McIvor (MPH, CE),
Catalyst Consulting

April 2024

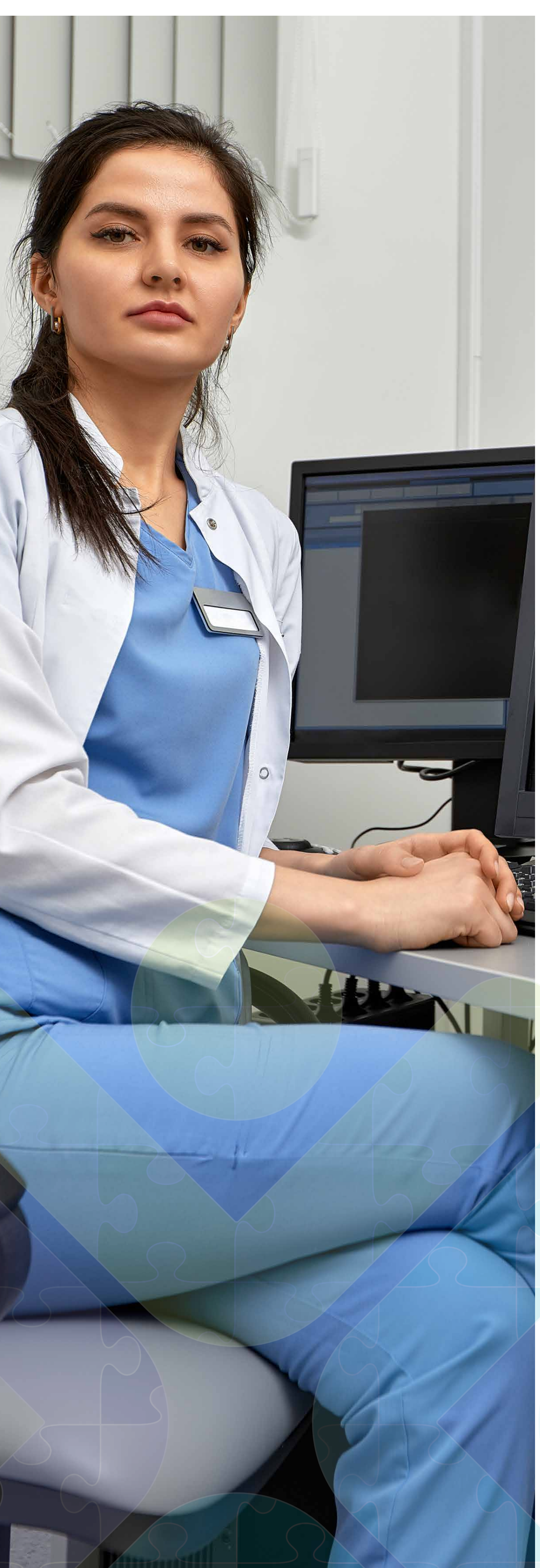


Table of Contents

ACKNOWLEDGEMENTS 3

EXECUTIVE SUMMARY 4

BACKGROUND 4

METHODS 4

KEY FINDINGS 5

CONCLUSION & RECOMMENDATIONS 6

INTRODUCTION 7

STCC OVERVIEW 7

EVALUATION METHODS 7

KEY FINDINGS 8

1. GOAL PROGRESS 8

2. TEAM FORMATION 9

3. CLINICAL CAPACITY 13

4. IHI QUADRUPLE AIM 14

5. COLLABORATIVE FEEDBACK FROM SPECIALISTS 25

6. SUSTAINABILITY 31

CONCLUSION 32

RECOMMENDATIONS 32

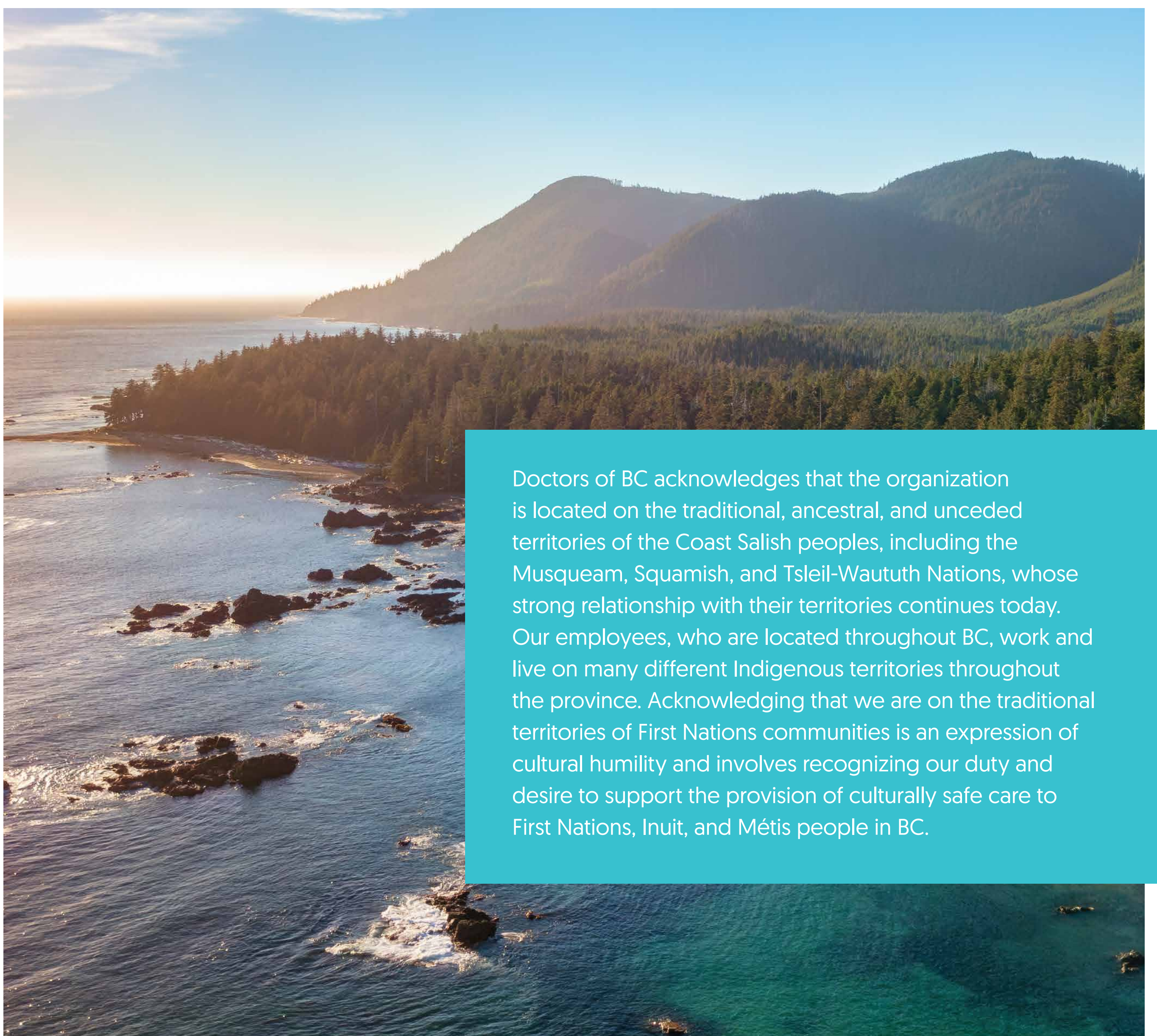
LIMITATIONS 33

APPENDICES 34

APPENDIX A. PROVIDER EXPERIENCE SURVEY TOOL 34

Acknowledgements

LAND ACKNOWLEDGEMENT



Doctors of BC acknowledges that the organization is located on the traditional, ancestral, and unceded territories of the Coast Salish peoples, including the Musqueam, Squamish, and Tsleil-Waututh Nations, whose strong relationship with their territories continues today. Our employees, who are located throughout BC, work and live on many different Indigenous territories throughout the province. Acknowledging that we are on the traditional territories of First Nations communities is an expression of cultural humility and involves recognizing our duty and desire to support the provision of culturally safe care to First Nations, Inuit, and Métis people in BC.

EVALUATION CONTRIBUTORS

Sincere appreciation is extended to the STCC Working Group members and the Collaborative patient advocate who provided guidance throughout the evaluation process and reviewed this report. Their valuable feedback and comments strengthened the quality of this evaluation as a whole. Special thanks to Doctors of BC staff who closely supported the data collection and analysis process, including Garth Vatkin, Eric Young, and Alison Foulds.

EXECUTIVE SUMMARY

BACKGROUND

The SSC developed the Specialists Team Care Collaborative (STCC) to support specialist-led teams to implement team care models in their outpatient community practices to improve the provider and patient experience. In January 2023, the STCC launched its first cohort of 11 specialist-led teams, representing 9 different specialties and communities across British Columbia.

The SSC commissioned Catalyst Consulting to complete a process and outcome evaluation of the collaborative to examine its successes, areas for improvement, and potential impacts on patients, health care providers, and health care resource utilization. The following report presents an overview of key findings from the final evaluation.

METHODS

Data was collected and analyzed from the following sources for the final evaluation. Where possible and appropriate, validated tools were employed to assess the constructs of interest.

- SSC Project Reporting Tool & Measurement Tool
- Collaborative activity evaluation form (N=110)
- Collaborative event evaluation form (N=132)
- Team function survey (N=37)
- Provider experience survey (N=96), collected pre- (N=35); mid- (N=34); and post-Collaborative (N=27)
- Patient experience surveys at initial consult (N=495), and 3-month follow-up (N=133)
- Specialist site-lead interviews (N=21)
- Focus group with allied health professionals and nurses (N=10)
- Focus group with medical office assistants (MOAs) and office managers (N=11)

KEY FINDINGS

1. Goal Progress

Final evaluation results show that the STCC was successful in achieving each of its intended goals, as follows.

	Midterm Results	Final Results	Target	Status
Goal 1: 90% of patients will indicate that they had an improved experience as a result of team care.	93%	95%	90%	Target met
Goal 2: 90% of care providers will report improved job satisfaction due to the implementation of team care at their site.	80%	93%	90%	Target met
Goal 3: Specialist clinical capacity will increase by 50%.	34%	53%	50%	Target met
Goal 4: Utilization of health care resources outside of the specialists' team will decrease by 25%.	Unavailable at time of reporting	26%	25%	Target met

2. Team Formation

All but one of the STCC sites established team care models and average results demonstrate that they have established high-functioning teams. The majority of specialists and team members agreed that they have successfully fostered key principles of effective team care models, such as teamwork and mutual trust. Various factors facilitated their success in forming teams, while others posed as barriers.

3. Clinical Capacity

Across all participating sites, clinical capacity increased by an average of 53% after establishing their team care models. This increase in patient volume surpassed the STCC target of a 50% improvement in throughput overall. All participating clinics consistently demonstrated improvements in their clinical capacities after participation in the Collaborative, with variability in the extent of increases from site to site.

4. Quadruple Aim

- Provider experience: When examining average results for specialists and their team members, we observe improvements in the majority of dimensions of provider experience measured after they transitioned to team care models. Greatest improvements were observed in: time spent on the EMR at home; time for documentation; and control over workload. Ninety-three percent provided positive ratings for their overall job satisfaction at the end of the Collaborative, surpassing the STCC goal of a 90% increase for this outcome.
- Patient experience: Final evaluation results show that patients had highly positive experiences with the sites' team care models. On average across the clinics, over 95% of the patients surveyed provided positive ratings of: being treated with courtesy and respect; having confidence in the clinical teams; satisfaction with how clinical teams listened; and the clinic teams working well together. Ninety-five percent of patients agreed or strongly agreed that they were satisfied with their care overall, surpassing the 90% target for this outcome.

- Reduced per capita cost: On average, there was a 26% reduction in patients' self-reported use of acute care services after receiving care from sites' team care models, surpassing the STCC target of a 25% decrease. Patients also reported decreased use of services from their family doctors and walk-in clinics.

5. Collaborative Feedback

Overall, the STCC was reported to be a valuable use of time for all participants. The majority agreed that the Collaborative supported them to implement change processes that supported their transitions to team care models. The top 3 most useful supports provided were the: (i) financial support to offset the costs of hiring staff; (ii) specialist stipend to participate; and (iii) site visits. The sites also particularly benefited from the specialist mentorship offered through the Collaborative, as well as the site-to-site learning opportunities. Participants identified opportunities to refine such initiatives in the future.

6. Sustainability

The majority of participating specialists reported that their team care models were financially sustainable, while the minority were somewhat financially precarious. Following the completion of the STCC, specialists explained that it would be beneficial to have ongoing peer learning and mentorship opportunities.

Conclusion & Recommendations

Overall, findings from this evaluation demonstrate that the STCC has been a successful initiative. The Collaborative's processes and supports enabled 10 specialists to establish effective team care models that collectively achieved the STCC's goals related to patient experience, provider experience, clinical capacity, and utilization of health care resources. Findings from this evaluation support the SSC's decision to offer future cohorts of the Collaborative given the positive outcomes documented in this report. Based on the results presented, a series of recommendations have been put forward for consideration by the STCC and SSC to: build upon Collaborative successes and address challenges; improve the QI and evaluation strategies in future iterations of this work; and support spread of the initiative in the future.

INTRODUCTION

The Specialist Services Committee (SSC) aims to improve patient care by engaging specialist physicians to collaborate, lead quality improvement activities, and deliver services with supports and incentives. In alignment with this goal, the SSC developed the Specialists Team Care Collaborative (STCC) to support specialist-led teams to implement team care models in their outpatient community practices. The Collaborative strives to achieve the following aim and goals by March 2024.

AIM	GOALS
90% of Collaborative sites will implement a team model of care to improve the provider and patient experience.	1. 90% of patients will indicate that they had an improved experience as a result of team care. 2. 90% of care providers will report improved job satisfaction due to the implementation of team care at their site. 3. Specialist clinical capacity will increase by 50%. 4. Utilization of health care resources outside of the specialist's team will decrease by 25%.

In 2022/23, the SSC commissioned Catalyst Consulting to complete a process and outcome evaluation of the Collaborative to examine its successes, areas for improvement, and potential impacts on patients, health care providers, and health care resource utilization. The following report presents an overview of the findings from the final evaluation using the Collaborative's evaluation questions and Institute for Healthcare Improvement (IHI) Quadruple Aim as frameworks for assessment. A midterm evaluation report was completed in September 2023.

STCC Overview

In January 2023, the STCC launched its first cohort of 11 specialist-led teams, representing 9 different specialties and communities across British Columbia. From October to December 2022, a pilot of the collaborative took place with 3 specialist-led teams, who continued their participation with the remainder of the first cohort. The collaborative uses the IHI Breakthrough Series to guide its activities and supports. Various supports are provided to the teams by the SSC, such as mentorship opportunities, communities of practice, learning sessions, and financial support to offset the cost of hiring team members. A Toolkit was developed to support participating specialists and their teams to successfully transition to team care models.

Evaluation Methods

The STCC evaluation is guided by the following questions:

1. To what extent is the Collaborative successful in reaching its goals?
2. How successful are the sites in implementing team care models?
3. How does the clinical capacity of participating sites change after implementing team care models, if at all?
4. What are the impacts of implementing team based care models on the Quadruple Aim?

5. How useful is the STCC collaborative model in supporting teams to implement team based care models?

6. What supports do sites require to sustain their team care models in the future?

Data was collected and analyzed from the following sources for the final evaluation report. Where possible and appropriate, validated tools were employed to assess the constructs of interest.

- SSC Project Reporting Tool & Measurement Tool
- Collaborative activity evaluation form (N=110)
- Collaborative event evaluation form (N=132)
- Team function survey (N=37)
- Provider experience survey (N=96), collected pre- (N=35); mid- (N=34); and post-Collaborative (N=27)
- Patient experience surveys at initial consult (N=495), and 3-month follow-up (N=133)
- Specialist site-lead interviews (N=21)
- Focus group with allied health professionals and nurses (N=10)
- Focus group with medical office assistants (MOAs) and office managers (N=11)

KEY FINDINGS

1. GOAL PROGRESS

To what extent is the collaborative successful in reaching its goals?

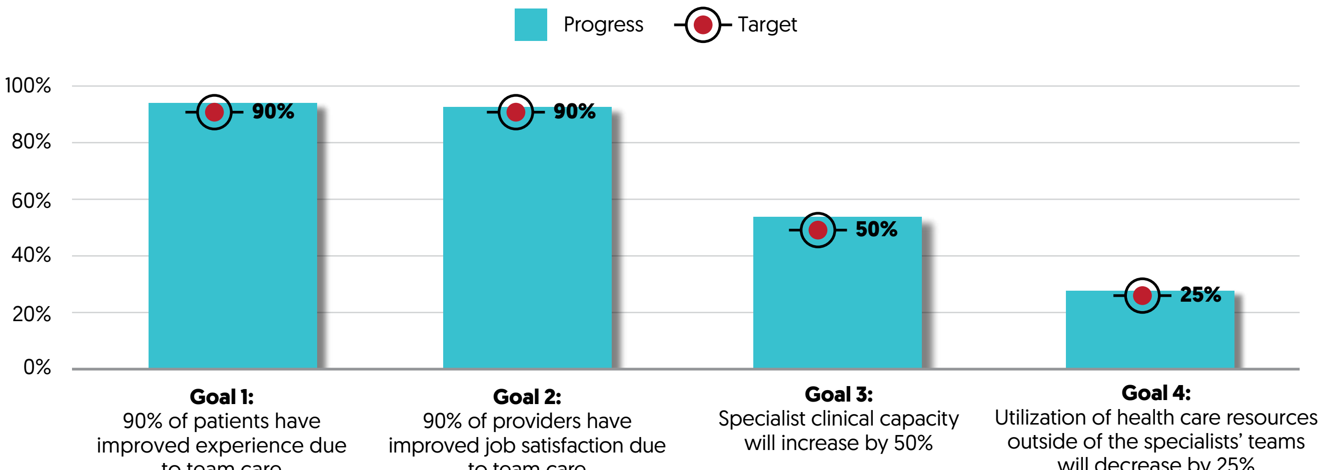
Final evaluation results show that the STCC was successful in achieving each of its goals.

At the start of the Collaborative, the STCC Working Group set four goals they aspired to achieve by the initiative's completion. Findings from the evaluation demonstrate that the key targets for each of the goals were met as of March 2024, as follows (Figure 1).

- 95% of patients surveyed reported being satisfied with their care in the sites' team care models (90% target).
- 93% of participating specialists and their team members said they were satisfied with their jobs in their new teams (90% target).
- Across all sites, transitioning to team care models increased sites' clinical capacities by an average of 53% (50% target).
- Once engaged in care with the sites, patients reduced their use of acute care resources by an average of 26% (target 25%).

More detailed results summarizing progress towards goals are provided throughout the body of this report.

Figure 1. Progress towards STCC goals compared to performance targets



Goal 1: 90% of patients have improved experience due to team care

Goal 2: 90% of providers have improved job satisfaction due to team care

Goal 3: Specialist clinical capacity will increase by 50%

Goal 4: Utilization of health care resources outside of the specialists' teams will decrease by 25%

2. TEAM FORMATION

How successful are the sites in implementing team care models?

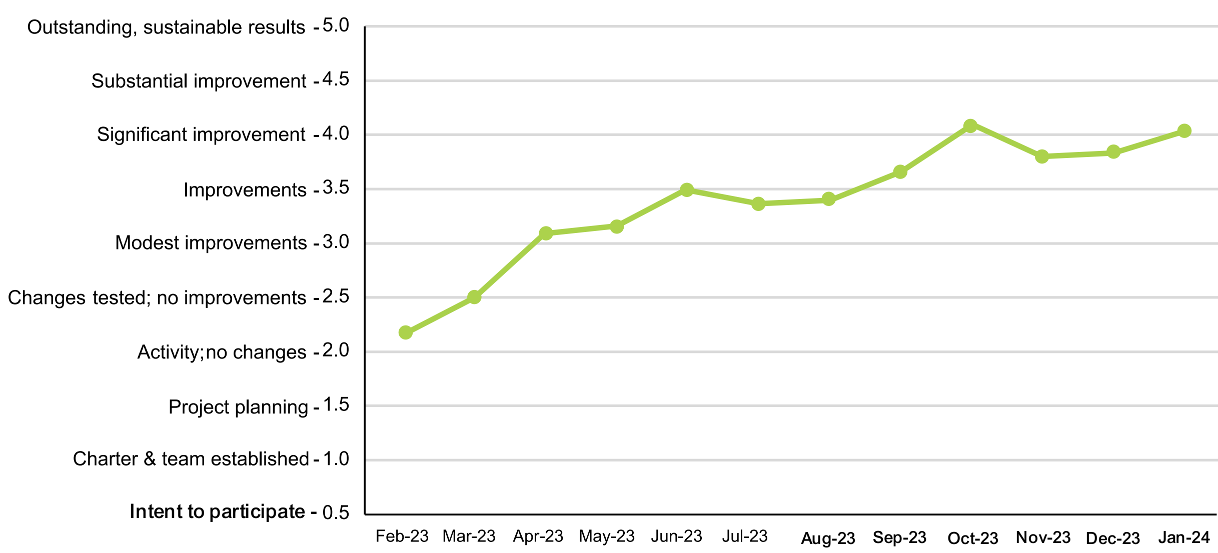
All but one of the STCC sites established team care models and average results demonstrate that they have established high-functioning teams. Various factors facilitated their success in transitioning to new models, while others posed as barriers.

Of the 11 specialist-led teams in the first cohort, 10 hired team members and transitioned to team care models. Mid-way through the Collaborative, one site withdrew because they did not find the team care model to be a good fit with their pre-existing practice design.

A team self-assessment scale was used to monitor site progress in meeting improvement goals and implementing changes on a monthly basis.[1] Gradually over the lifespan of the Collaborative, average findings show that teams have positively progressed through the improvement project. All teams implemented change ideas and observed improvements in site- and collaborative-level outcome measures (Figure 2).[2]

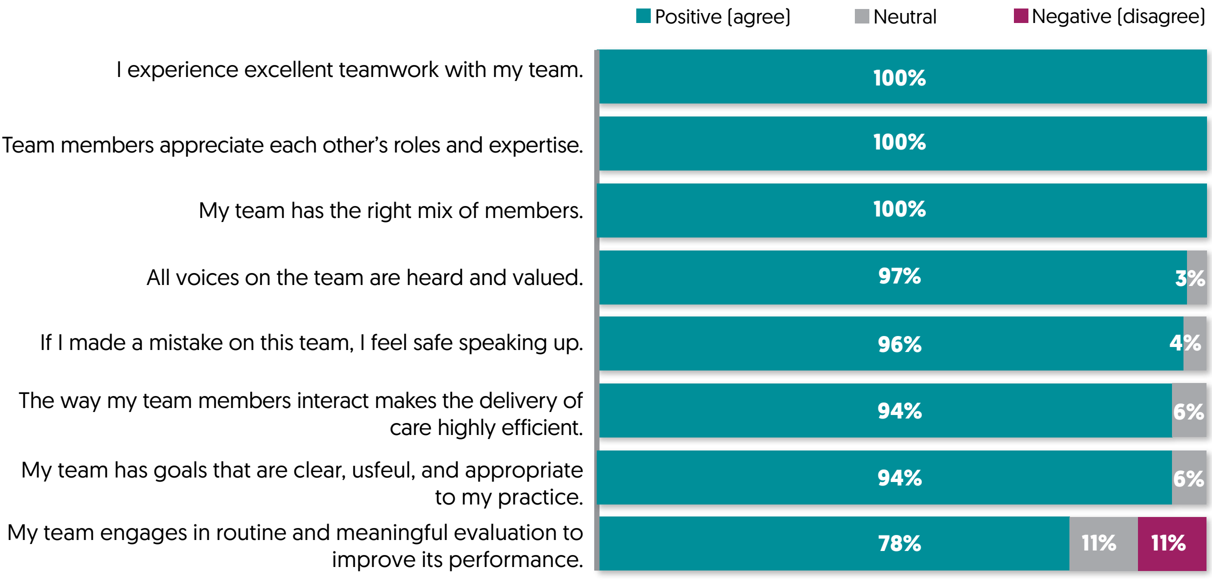
1 A modified version of the Assessment Scale for Collaboratives was employed (IHI, 2023).
2 Team self-assessment ratings were validated by the STCC Improvement Advisor on a monthly basis.

Figure 2. Average team ratings of progress towards implementing change ideas and meeting improvement goals by month



The Collaborative evaluation also assessed team function, or the extent of "teamness" within each of the participating sites.[3] Average results show that the sites have highly adopted key principles of team-based care (Figure 3). All teams agreed or strongly agreed that: they experience excellent teamwork, team members appreciate each other's roles and expertise, and they have the right mix of members. More than 90% also agreed that their teams embody several other principles of team-based care, such as having appropriate team composition, psychological safety, mutual trust, efficient care, and appropriate goals. While a slightly smaller proportion of sites agreed that their teams engage in routine and meaningful evaluation (77%), the majority still agreed with this statement.

Figure 3. Specialist and team members' agreement with statements assessing team function



3 The team function survey was informed by the following validated tools: ACE-15 Tool (Tilden, et al., 2016) and the Primary Care Team Dynamics Survey (Song, et al., 2015).

Table 1 summarizes various factors that supported the sites to establish successful team care models, according to specialist site leads and their team members.

Table 1. Factors that supported teams to establish team care models, as reported by participating specialists and their team members

Group	Factors that supported the establishment of team care models
Specialists	• The STCC framework and supports to guide teams through the process • Site-to-site learning opportunities facilitated information exchange, collaborative problem-solving, and a sense of support while undergoing change processes • Mentorship provided by co-chairs offered teams customized guidance based on real-world experiences, as well as encouragement to experiment with different practice change ideas • Adopting a 'trial and error' mindset when experimenting with change ideas • Having the understanding that the transition is iterative and will take time • Being clear about your 'why' for making change • Financial support from SSC to offset the cost of bringing on new team members • Hiring team members who are a good fit for the teams • Holding all-team staff meetings and team building opportunities to encourage connection and team building • Having proper and sufficient physical space for all team members to do their work • Quality improvement training for all team members
Allied Health Professionals and Nurses	• Frequent communication about what is working well, and what is not • Becoming comfortable with change
MOAs and Office Managers	• Willingness to make mistakes and experiment with new ideas • Team building opportunities and the formation of stronger relationships • Understanding team members' roles and goals • Specialist respect for team members, listening to them, and valuing their opinion

"It has to be the right fit of personalities. If that isn't there, it wouldn't work out. Anytime we deal with human interaction, there can be clashes or interpersonal dynamics. So selecting the right people is crucial. Your staff are an extension of yourself, so you have to be on the same page and have the same work ethic." - Specialist

"Frequent team meetings to gauge what is going well and ways that we can improve moving forward were key."
- Allied Health Professional/Nurse

"Our success has to do with the approach the specialist has taken. He listens to me, appreciates my input, and is open to trying new ideas."
- MOA/Office Manager

Participating sites also reported that they experienced, or are continuing to face various barriers to transitioning to team-based care models (Table 2).

Table 2. Barriers to transitioning to team care models, as reported by specialists and their team members

Group	Barriers
Specialists	• Time required to implement team care models, as well as the complexity of the process • Increased workload on specialists to train staff and check-in with them, alongside having more patients to manage • Limited pool of administrative staff willing to take on work involved with team care models • Human resources sustainability and turnover in team members, particularly given the time and costs involved with training new hires and building team cohesiveness • Coordinating schedules of part time staff • Cultural shift for specialists from working independently to operating as a team • Specialists letting go of control and respecting the training/expertise of other team members • The current MSP billing structure requires specialists to physically see patients to bill a reasonable amount for the visit, which poses as a particular challenge for surgical specialists • Ensuring sufficient patient demand once clinic efficiencies are in place • Team care not being the right fit for all specialists given the shift in focus of specialists' tasks away from spending time with patients
Allied Health Professionals and Nurses	• Finding time to meet with specialists to receive training, guidance, and ask questions • Not having strong relationships and/or the right match in personalities amongst teams
MOAs and Office Managers	• Increased workload for administrative staff

"There is only one me, and you have to find time in the day to train, check-in, and all these other things. So while you have these efficiency gains on one side, there is also this hidden burden of work on the specialist."
- Specialist

"Trying to find time to have our specialist train us can be challenging since he has a busy schedule. He was having to put a lot of hours in during his off-time to train us."
- Allied Health Professional/Nurse

"Transitioning to team care has over doubled the workload for the MOAs."
- MOA/Office Manager

Roughly half of the participating sites experienced some staff attrition during the lifespan of the STCC, particularly among MOAs. When asked why such turnover took place, specialists pointed to a variety of reasons, including: parental leaves; the perception that administrative staff were not sufficiently qualified or the 'right fit' for team care models (e.g., uncomfortable with ambiguity and change); the heavy workload for MOAs to support team care models; personality mismatch amongst team members; and the general competitiveness of the job market.

"The team care model requires more IQ. It requires more complicated scheduling systems and the one MOA we had wasn't a good fit."
- Specialist

"If I hire an MOA at $22/hour, and the asks from this project were high. All of the sudden that job should be paid at $30, and if it isn't then they might leave."
- Specialist

3. CLINICAL CAPACITY

How does the clinical capacity of the sites change after implementing team models, if at all?

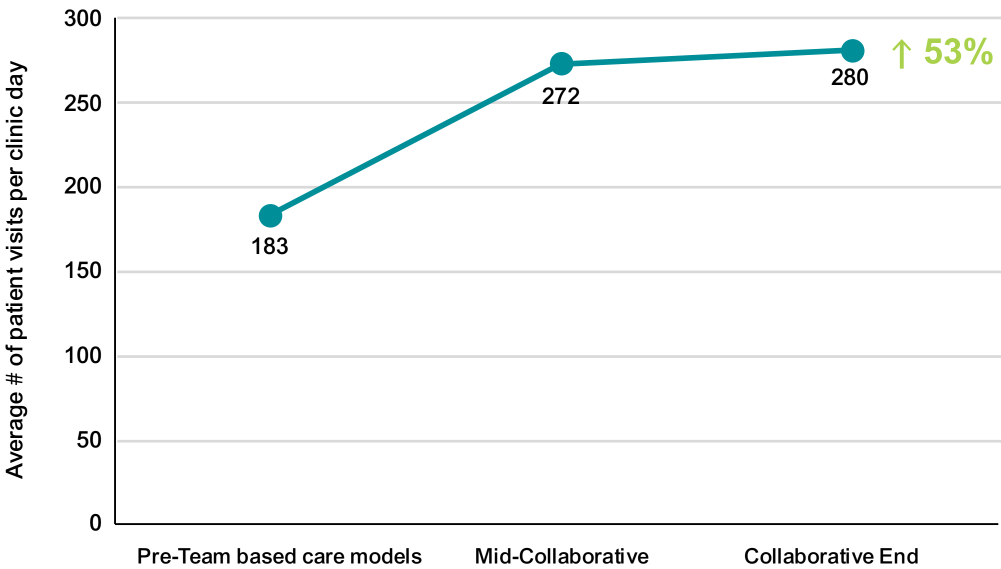
Across all participating sites clinical capacity increased by an average of 53% by the end of the Collaborative, surpassing the STCC target of a 50% improvement overall.

The STCC defined clinical capacity as the average number of patient visits that the sites completed per clinic day.[4] When comparing the total number of visits completed by all sites before implementing team based care models and after the Collaborative, the results show a 53% increase in volume, from an average of 183 to 280 average visits per clinic day. As shown in Figure 4, clinical capacity gradually increased over the lifespan of the

4 Visits included: (i) all patients seen and cared for by the clinic, including in-person and virtual visits; (ii) new and existing patients; (iii) visits that took place on clinical days with the team members. To account for fluctuations in patient visits month-to-month, 2-month averages were calculated for each of the sites at pre-, mid- and post-Collaborative, where possible. Pre-Collaborative dates ranged from May 2022 to April 2023, depending on start dates and when baseline data was submitted. Mid-Collaborative dates were from June to July 2023. Post-implementation dates ranged from November 2023 to February 2024, with the most recent data used in the calculation. The Collaborative-level average percent change in clinical capacity was calculated by treating all of the sites as a whole.

Collaborative. All participating clinics consistently demonstrated improvements in their patient volumes after transitioning to team care models, with variability in the extent of increases from site-to-site.

Figure 4. Change in clinical capacity for STCC sites as a whole pre-team based care models, mid-Collaborative, and at the Collaborative end



4. IHI QUADRUPLE AIM

What are the impacts of implementing team based care models on the Quadruple Aim?

Provider experience: When examining results for all STCC participants as a group, provider experience improved for the majority of dimensions assessed after sites established team-based care models. Ninety-three percent provided positive ratings for their overall job satisfaction at the end of the Collaborative, which met STCC goal of a 90% increase.

Specialists and their team members were asked to rate various dimensions of the provider experience working within their new team care models at pre-, mid-, and post-Collaborative (see Appendix A for the survey questions used).[5] Changes in the proportion of the desirable responses provided for each dimension of provider experience assessed are outlined in Tables 3, 4, 6 and 7 below.[6]

When examining average results for all participants (i.e. specialists and their team members), we see improvements for the majority of the dimensions of provider experience measured when comparing pre- and post-Collaborative ratings (Table 3). Ninety-three percent provided positive ratings for their overall job satisfaction at the end of the Collaborative, surpassing the STCC goal of a 90% increase for this outcome. Greatest improvements were observed in: work atmosphere; time spent on the EMR at home; and work-life integration. There was no change observed in how efficiently the teams worked together, however all survey responses were positive before and after the formation of the team care models.

5 Physician experience survey questions were informed by the validated "Mini Z" tool (Institute for Professional Worklife, 2020), as well as questions from the CMA National Physician Health Survey (CMA, 2021).

6 'Desirable responses' were defined as the positive response options in the Likert questions asked, as defined by the scoring methodology for the Mini Z tool (Institute for Professional Worklife, 2020).

Table 3. Results for all roles: Percent of desirable responses for dimensions of provider experience examined, at pre-, mid-, and post-Collaborative

Dimensions measured (desirable responses)	Pre-	Mid-	Post-	Difference in % (pre to post)
Satisfied with current job (agree, strongly agree)	80%	85%	93%	↑13%
Feeling a great deal of stress (disagree, strongly disagree)	43%	32%	48%	↑5%
Burnout symptoms (no symptoms, not feeling burned out)	83%	82%	85%	↑2%
Control over workload (satisfactory to optimal)	83%	85%	93%	↑10%
Sufficient time for documentation (satisfactory to optimal)	71%	79%	78%	↑7%
Work atmosphere (calm to busy but reasonable)	74%	79%	93%	↑18%
Team works efficiently together (satisfactory to optimal)	100%	100%	100%	0%
Time spent on EMR at home (satisfactory to minimal/none)	75%	81%	92%	↑17%
Work-life integration (satisfied, very satisfied)	63%	68%	78%	↑15%

When analyzing the provider experience data for specialists only, the findings similarly show improvements in all dimensions assessed, with the exception of job-related stress which worsened by 87% from the start to the end of the Collaborative and team efficiency which remained consistently positive (Table 4). Greatest improvements were observed in specialists': time for documentation; time spent on the EMR at home; and work-life integration.

Table 4. Results for specialists: Percent of desirable responses for dimensions of provider experience examined, at pre-, mid-, and post-Collaborative

Dimensions measured (desirable responses)	Pre-	Mid-	Post-	Difference in % (pre to post)
Satisfied with current job (agree, strongly agree)	80%	80%	88%	↑8%
Feeling a great deal of stress (disagree, strongly disagree)	100%	70%	13%	↓87%
Burnout symptoms (no symptoms, not feeling burned out)	50%	60%	75%	↑25%
Control over workload (satisfactory to optimal)	70%	70%	100%	↑30%
Sufficient time for documentation (satisfactory to optimal)	20%	50%	75%	↑55%
Work atmosphere (calm to busy but reasonable)	60%	70%	88%	↑28%
Team works efficiently together (satisfactory to optimal)	100%	100%	100%	0%
Time spent on EMR at home (satisfactory to minimal/none)	30%	70%	75%	↑45%
Work-life integration (satisfied, very satisfied)	10%	40%	50%	↑40%

Qualitative results corroborated the aforementioned data trends in provider experience for specialists. Table 5 summarizes key changes specialists noticed in their provider experience after transitioning to team-care models. Establishing team care models has been transformative for some specialists, as it positively impacted their quality of life and experience of burnout, amongst other improvements. With regards to job-related stress, while some specialists reported that their stress decreased, others said that it stayed the same or increased due to a variety of factors, such as the pressure of having more patient volume and team-based care requiring them to focus on aspects of their practices that are less rewarding or interesting to them personally.

Table 5. Specialists' self-report of changes in their provider experience after transitioning to team-care models

Dimensions of provider experience assessed	Sample quotations
Job satisfaction • Increased satisfaction and enjoyment at work • Improved quality of life • Ability to focus on tasks that provide specialists with more personal and professional enjoyment	*"This has been the greatest change in my career and quality of life since I started medicine for the better. I would never go back to doing it the old way."* *"I am able to do more focused work in areas that provide me with satisfaction, and spend less time on things that take away from that."*
Job-related stress • Reduced stress about patient waitlists, heavy workloads, and not providing patients with adequate appointment times • Relief knowing they have a team to rely on, rather than being solely responsible • Increased stress due to higher volume of patients to see and manage • Added stress from the focus on tasks they enjoy less than spending time with patients	*"I had this anxiety about our waitlist. But now I know we are getting to people sooner and that feels good. That used to really weigh on me."* *"Seeing more patients can add stress too. You are needing to followup with more people."* *"I would say my stress has all come out in a wash. For me, the goal isn't to run my clinic faster and see more patients. It doesn't fit with what I enjoy. It ended up equal, but different at the end."*
Burnout • Increased well-being; decreased exhaustion • Burnout for some was due to work outside of the team-based care clinics	*"When I exit a day in the office now, I feel energized, positive. I used to be drained and exhausted with lots of work left to do."* *"My office is not the source of my burnout. It comes from provincial things I am working on. I am probably just as burnt out, but my office and team are just a place I can go and enjoy my job."*
Control over workload • Improved control given delegation of tasks to team members • Some experienced increased workloads due to work and/or commitments outside of team care	*"I definitely feel like hiring staff has given me more control over my workload. They can now do all of the follow-ups I used to be responsible for, which makes my days less full and more predictable."* *"To be honest, there have been a lot of stressors that don't have anything to do with STC. There is an increased workload right now. I am working more now."*

Dimensions of provider experience assessed	Sample quotations
Time for documentation • Documentation tasks were often delegated to team members, and therefore specialists had a less involvement with this activity	*"Yes, I would say we have plenty of time to complete documentation now. My team members are on top of this, so that it no longer weighs on me."*
Work atmosphere • Improved work atmosphere given opportunity to collaborate with team members that specialists enjoy working with • Reduced sense of isolation managing cases alone and strengthened ability to problem-solve challenging patient scenarios as a group	*"I get to work with a really awesome team and we really enjoy working together. That really helps our whole satisfaction in our work."* *"I enjoy having another person to talk to about the medical care of my patients. If I am working in isolation, it can be more challenging."*
Team efficiency • Practice changes were implemented that increased efficiencies, such as delegation of tasks to staff that specialists previously completed (e.g., history taking, follow-ups, answering patient questions, group education). Specialist time is reserved for tasks that require their expertise, reducing burden on them.	*"My nurse will see all the new patients, then present the information to me, and I go in and see the patient myself. They do a lot of the data gathering, and teasing out symptoms. So that saves me the time of doing that background work. Now I can focus on diagnosis and management of the problem."* *"Having someone to help me offloads a lot of the burden off my shoulders, so I can share that burden with my nurse."*
Time spent on EMR at home • Reduced time spent on EMR at home since charting is being completed by team supports during the work day	*"At the end of the day you can go home and not worry about anything. I used to do a lot of work after hours."* *"I never have to do work on the EMR at the end of the day anymore."*
Work-life integration • Improved balance between work and personal obligations/interests	*"I have a family, hobbies and things I want to get to. Anything I can do to get my work done in a timely fashion within normal work hours is key. And that is happening now."*

For the sites' allied health professionals/nurses and administrative staff, most dimensions of provider experience improved over the course of the Collaborative, with the largest improvement observed in both group's job-related stress (Table 6 and 7). No change was observed for either group's report of team efficiency, or allied health/nurse report of time spent on the EMR at home. For allied health professionals and nurses, a slight decrease was observed in them having sufficient time for documentation. On average, the results for administrative staff showed worsening burnout, as well as decreased control over their workloads and sufficient time for documentation.

Table 6. Results for allied health professionals and nurses: Percent of positive responses for dimensions of provider experience examined, at pre-, mid-, and post-Collaborative

Dimensions measured (desirable responses)	Pre-	Mid-	Post-	Difference in % (pre to post)
Satisfied with current job (agree, strongly agree)	85%	92%	100%	↑15%
Feeling a great deal of stress (disagree, strongly disagree)	15%	8%	80%	↑65%
Burnout symptoms (no symptoms, not feeling burned out)	92%	100%	100%	↑8%
Control over workload (satisfactory to optimal)	85%	85%	100%	↑15%
Sufficient time for documentation (satisfactory to optimal)	92%	92%	80%	↓12%
Work atmosphere (calm to busy but reasonable)	85%	92%	100%	↑15%
Team works efficiently together (satisfactory to optimal)	100%	100%	100%	0%
Time spent on EMR at home (satisfactory to minimal/none)	100%	77%	100%	0%
Work-life integration (satisfied, very satisfied)	92%	85%	100%	↑8%

Table 7. Results for administrative staff (MOAs and office managers): Percent of positive responses for dimensions of provider experience examined, at pre-, mid-, and post-Collaborative

Dimensions measures (desirable responses)	Pre-	Mid-	Post-	Difference in % (pre to post)
Satisfied with current job (agree, strongly agree)	75%	82%	89%	↑14%
Feeling a great deal of stress (disagree, strongly disagree)	25%	27%	44%	↑19%
Burnout symptoms (no symptoms, not feeling burned out)	100%	82%	78%	↓22%
Control over workload (satisfactory to optimal)	92%	100%	78%	↓14%
Sufficient time for documentation (satisfactory to optimal)	92%	90%	78%	↓14%
Work atmosphere (calm to busy but reasonable)	75%	73%	89%	↑14%
Team works efficiently together (satisfactory to optimal)	100%	100%	100%	0%
Time spent on EMR at home (satisfactory to minimal/none)	91%	100%	100%	↑9%
Work-life integration (satisfied, very satisfied)	75%	73%	78%	↑3%

Qualitative data collected from team members further shed light on their provider experience within team care models (Table 8).[7] These results largely triangulated survey findings and reinforced that team members' provider experience improved for most of the constructs we examined. In terms of job satisfaction, team members described their enjoyment at work, particularly given their positive work atmospheres, ability to make changes quickly, and focus on improving patient care. The MOAs and office managers explained that their increased burnout was related to the heavy administrative workload associated with running team-based care models, which also contributed to their feelings of stress.

Table 8. Team members' self-report of changes in their provider experience after transitioning to team-care models

Dimensions of provider experience assessed	Sample quotations
Job satisfaction • General increase in job satisfaction and enjoyment at work • Satisfaction being involved with models where there is opportunity to learn, changes can be made quickly, and patient care is improved upon	*"My job satisfaction is higher than I could have ever imagined."* *"The physician I am working with has taught me so much, and is open to answering any of my questions. She has taken a lot of her time to teach me."* *"It has been nice to be part of a project that is trying to improve patient care. We have been able to make a lot of changes quickly in the clinic, which is a nice change from the hospital setting."*
Job-related stress • Sense of being able to share stress/concerns amongst team members, rather than in isolation • Added stress for some allied health/nurses since they are conscious about the financial health of the clinic (e.g., patient no-shows) • Increased stress for some MOAs/office managers given the additional burden of administrative work associated with team care models	*"It feels like sharing the stress amongst people rather than just holding it on your own."* *"It is new for me to kind of have this feeling of stress if a patient doesn't show up for an appointment with me because that is a financial loss. I didn't feel that working in other settings before."* *"I think this project has added a lot of additional stress for our administrative team. Perhaps it will just take some more time."*
Burnout • Reduced burnout for allied health/nurses, when comparing work atmosphere in previous hospital-based positions • Some administrative staff reported feeling burnt out given additional load of work associated with team care	*"In team care, I feel like I matter as a person. The staff care about me as a person, which prevents burnout. This is really different than working at the hospital where I just couldn't see myself continuing to sustain that work. I was just an employee number."*

7 Note that qualitative findings from both allied health/nurses and the administrative staff have been presented together given consistency in themes. Any differences in their feedback have been noted accordingly.

Dimensions of provider experience assessed	Sample quotations
Control over workload • Allied health/nurses explained that their workload is manageable, but heavy on clinic days • Administrative staff said their workload is much higher working in team-based care, some explaining that this is manageable and others finding it overwhelming	*"In terms of workload, it is definitely heavy on clinic days. But given the specialist is a surgeon, there are only a couple of those per week. So it isn't too much to have a few heavy days."* *"In terms of the workload, transitioning to team care has over doubled the workload for the MOAs. This has added some extra stress for us and can be overwhelming."*
Time for documentation • Allied health/nurses reported having sufficient time for documentation, while administrative staff reported having not enough	*"The documentation load on the MOA is huge and hasn't been lifted by adding in the allied health professional, if anything it has made it worse. That is causing more work for our office administration. We have more staff, but the same amount of admin help."*
Work atmosphere • Improved both for allied health/nurses and administrative staff given opportunity to work as a team and collaboratively resolve challenges	*"For us, this change has created a more positive and enjoyable atmosphere. I think we have enjoyed working together and we have lots of fun."* *"We have a really good team here and love working together. It makes me excited to come to work instead of dreading it. I feel very blessed to be part of this team."*
Team efficiency • Increased due to practice changes (e.g., reduced duplication of the same tasks, taking tasks off the specialists' plate, etc.)	*"We are way more efficient. Delegating certain tasks so they are not being repeated by multiple people who were all getting the same result."*
Time spent on EMR at home • Reduced for all team members	*"We really strive to complete all EMR work during clinic time so we don't take work home with us. This was more of a burden on the specialist in the past."*
Work-life integration • Work-life balance remained stable for team members	*"I wouldn't say there has been any change in balancing work and home life."*

Patient experience: Final evaluation results show that patients had highly positive experiences with the sites' team care models. Ninety-five percent of patients agreed or strongly agreed that they were satisfied with their care overall, surpassing the 90% target for this outcome.

The large majority of patients reported positive experiences receiving care within the sites' team care models (Figure 5). On average across the clinics, 95% or more of the patients surveyed provided positive ratings of: being treated with courtesy and respect; having confidence in the clinical teams; satisfaction with how clinical teams listened; the clinic teams working well together; and satisfaction with their care overall.[8]

8 'Positive responses' were defined as the top 2 positive response options in the Likert scales, while negative ratings were the bottom 2.

Figure 5. Patient experience ratings after visits within sites' team-based care models

	Positive responses	Neutral or not sure	Negative responses
Treated with courtesy and respect	99%	1%	
Confidence in the clinical team	98%	1%	1%
Satisfaction with how the clinical team listened	96%	1%	3%
Clinic team worked well together	96%	2%	2%
Overall satisfaction with care	95%	2%	3%

Patients were also asked to qualitatively comment on their experiences receiving care in the sites' team care models. The majority of comments were positive in nature and illustrated that patients are generally satisfied with the specialists' new models of care. Key themes from their positive comments included the following:

- General positive feedback about team members (e.g., kind, helpful, caring, professional, approachable)
- Questions were answered and patients understood what was discussed by health care providers
- Patients felt seen, heard, and reassured
- Health care needs were responded to, and issues were often resolved or greatly improved
- New models offered more holistic, wrap around care to patients given connections to allied health professionals (e.g., counsellors) and nurses with specialization in areas of need (e.g., nutrition)
- Specialists and their team members work well together (e.g., efficient, complimentary, good internal communication, collaborative, etc.)

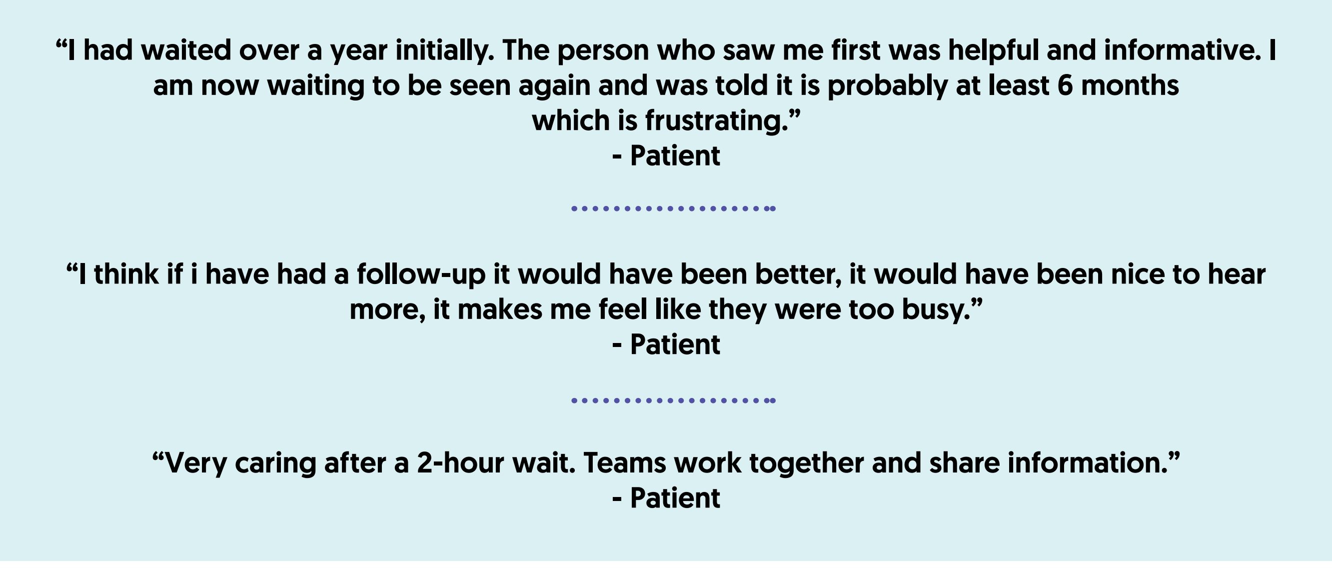
"I really enjoyed the atmosphere. Though it was very welcoming. All 3 people I had experience with, the receptionist, the physiotherapist, and the doctor were very welcoming and approachable. Very good communication and assisted with my understanding. Love the team based approach." - Patient

"The team-based model is excellent. In particular, I appreciated the Nurse Specialist. She was very thorough in her history taking and answered all my questions." - Patient

"I participated in a zoom focus group meeting. The staff did an excellent job presenting a plan for COPD management. What they are doing is phenomenal." - Patient

"I thought it was fantastic, it was so nice to be able to see the Dr., nurse and dietician all at one appointment. We are really happy with the great care we receive."- Patient

When describing their experience with the clinics, a small number of patients provided negative feedback. Key themes from their comments were related to: long wait times to schedule appointments, long wait times in-office, feeling rushed during appointments, delayed follow-up appointments, and difficulty communicating with the teams regarding questions.



Evaluation findings speaking to the positive patient experience were corroborated by specialists and their team members. They have observed that patients tend to be quite satisfied receiving care in the team care model, and often seem more satisfied than the standard of care that was provided in the past. Specialists and their team members also highlighted ways in which they believe their patients' quality of care has improved, as follows.

- Patients have more time to share their concerns (e.g., 30-minutes with allied health and 10-minutes with specialists), allowing them to feel more seen and heard.
- More longitudinal care for patients, as provided by the allied health providers and nurses.
- Improved access to multidisciplinary care resources at no cost to patients (e.g., counselling)
- Improved access to educational information to prevent future health issues and better manage current concerns.
- Patient questions are answered in a more timely fashion since non-specialist team members are typically capable of fielding them.

The STCC sites all said that they implemented various changes to improve the efficiency of their practices, such as having non-specialist providers take patient histories, offer group education sessions, answer patient questions, and complete patient follow-ups. The majority of specialists and their team members explained that such practice efficiencies improved access to care for patients by:

- Reducing waitlists and wait times;
- Having increased capacity to see non-urgent patients, which was reported to often improve patients' quality of life since their unaddressed health issues were altering their day-to-day life; and
- Being able to complete more timely follow-up with patients since this is often being managed by non-specialist providers.

"We are way more efficient now because tasks the specialist used to do have been offloaded to us. We can see double the number of patients because the specialist can focus on the things only he can do." - Allied Health Professional/Nurse

"For our clinic, the wait times decreased drastically. Our patients often had issues that were substantially impacting their quality of life and required attention, but wait times were over 18-months. Now we have reduced it to about 6 in just about over a year." - MOA/Office Manager

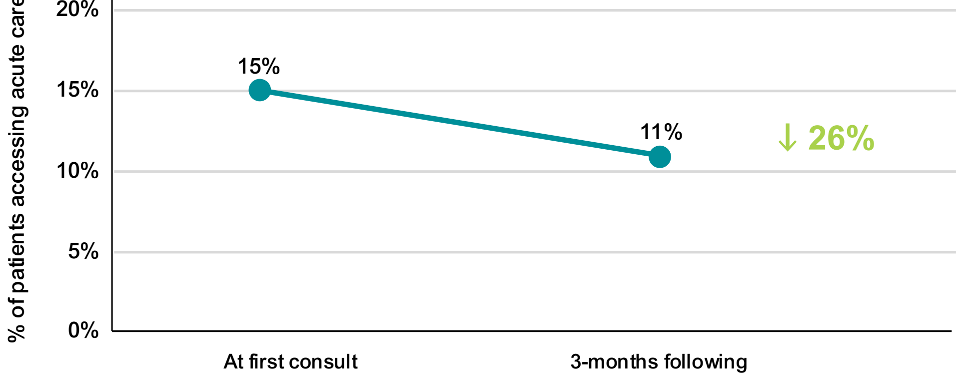
"It allows a lot of patients sitting at home with their non-urgent issues to be seen sooner and receive longitudinal care for those issues. This is huge for patients – before being able to see them, many have become quite isolated dealing with life-changing problems that are not urgent." - Specialist

Reduced per capita cost: On average, there was a 26% reduction in patients' self-reported use of acute care services after receiving care from sites' team care models, surpassing the STCC target of a 25% decrease. Patients also reported decreased use of services from family doctors and walk-in clinics.

As a proxy measure of assessing whether the team based care models reduced health care costs, the evaluation explored patients' self-reported use of health care resources outside of the specialists' teams before and after receiving care within the new models. Findings show an average 26% reduction in patients' self-reported use of acute care services, with 15% reporting use of such services at first their consultation with the specialists' teams and 11% indicating use of such services 3-months following (Figure 6).[9]

At the time of the follow-up survey, half of the patients accessed acute care resources for conditions/concerns unrelated to issues being seen by the specialists' teams (50%), while 30% of the visits were regarding related conditions/concerns, and 20% were unsure. Patients explained that they continued to use acute care resources after receiving care from specialists' teams for the following reasons: there were no other options (N=5); being unsure of their health condition was an emergency or not (N=4); being told by a health care provider to go to emergency (N=2); it was clearly an emergency (N=2); and not knowing where else to go (N=1).

Figure 6. Proportion of patients reporting use of acute care services at first consult and at 3-months following



9 This data examined patient survey results comparing self-reported use of acute care services from the initial consultation with the participating clinics to 3-months following the initial consult. Use of acute care resources was defined by whether patients accessed the emergency department, urgent care centres, and/or admissions to hospital in the past 3-months.

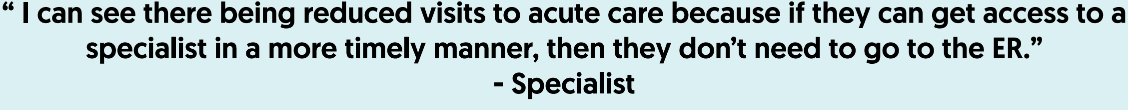
In addition to decreased use of acute care services, patients also self-reported reduced use of services from family physicians and walk-in clinics after receiving care from participating sites (Table 9). Patients reported a 57% reduction in use of services from their family doctors and a 60% decrease from walk-in clinics.

Table 9. Proportion of patients reporting use of different health care resources outside of the specialists' teams, pre-Collaborative and 3-months following

Type of health care services accessed	Pre-Collaborative	3-month follow-up	% change
Acute care	15%	11%	↓26%
Family doctor	46%	20%	↓57%
Walk-in clinic	5%	2%	↓60%
Any care outside specialist teams	60%	33%	↓45%

Specialists and their team members were also asked to speculate on whether their team care models reduced costs to the health care system. Overall, both groups hypothesized that their models are likely decreasing the use of health care resources outside of clinics, and are therefore decreasing costs to the system. They explained that their team care models prevent the use of health care services from other sources by providing patients with:

- Reduced wait times to receive care
- Opportunity to have their questions answered in a timely manner
- Educational information and tools to prevent future health issues/complications from arising (e.g., educational sessions, teaching exercises, action plans for care)



" I can see there being reduced visits to acute care because if they can get access to a specialist in a more timely manner, then they don't need to go to the ER."
- Specialist

"We provide certain appointments that are all about preventative maintenance and care. So yes, I can see how there would be reduced costs."
- Allied Health Professionals/Nurse

"We get lots of questions from patients about aftercare and post-surgical things. And they don't know the signs to look for in terms of an infection. Rather than them typically just going to emerg, we can often provide them with the reassurance they need to avoid that visit."
- MOA/Office Manager

On the other hand, a handful of sites expressed concern that patients are attempting to receive care from their clinics for concerns that would be more appropriate for family physicians to address. They explained that the decline of family physicians in the province contributes to this situation, as well as patients being able to gain access to care faster through their clinics. These findings were corroborated by the decline in family physician visits reported by patients 3-months after receiving care from specialists' sites.

"A lot of patients don't have a primary care provider and we are providing care that would be more appropriate for family physicians at times."
- Specialist

"I think this is more draining on specialists because of the lack of GPs that are available for patients right now. We are often getting patients coming to us for what they would regularly go to the GP for because they don't have a GP and don't want to wait at a walk-in clinic."
- Allied Health Professional/Nurse

"Patients are starting to say that they can see us faster than they can see their own family doctor, so it's almost a double edged sword."
- MOA/Office Manager

5. COLLABORATIVE FEEDBACK FROM SPECIALISTS

How useful is the collaborative model in supporting teams to implement team based care models?

Overall, the STCC has been a valuable use of time for all participants. The majority agreed that the Collaborative supported them to implement change processes that supported their transitions to team care models. The top 3 most useful supports provided by the STCC were the: (i) financial support to offset the costs of hiring staff; (ii) specialist stipend to participate; and (iii) site visits.

Results demonstrate that participating sites were satisfied participating in the Collaborative. All participants agreed or strongly agreed that the valuable use of their time overall. Similarly, the majority (62%) agreed or strongly agreed that STCC activities have been a valuable use of their time, such as the kick-off meeting, STCC Bootcamp, site visits, all-site webinars, and individual team check-ins. Ninety-six percent also agreed or strongly agreed that the Learning Sessions and Outcomes Congress were a valuable use of their time.

"It was a very good project. I am very happy with my involvement. Time well spent figuring out how to implement this."
- Specialist

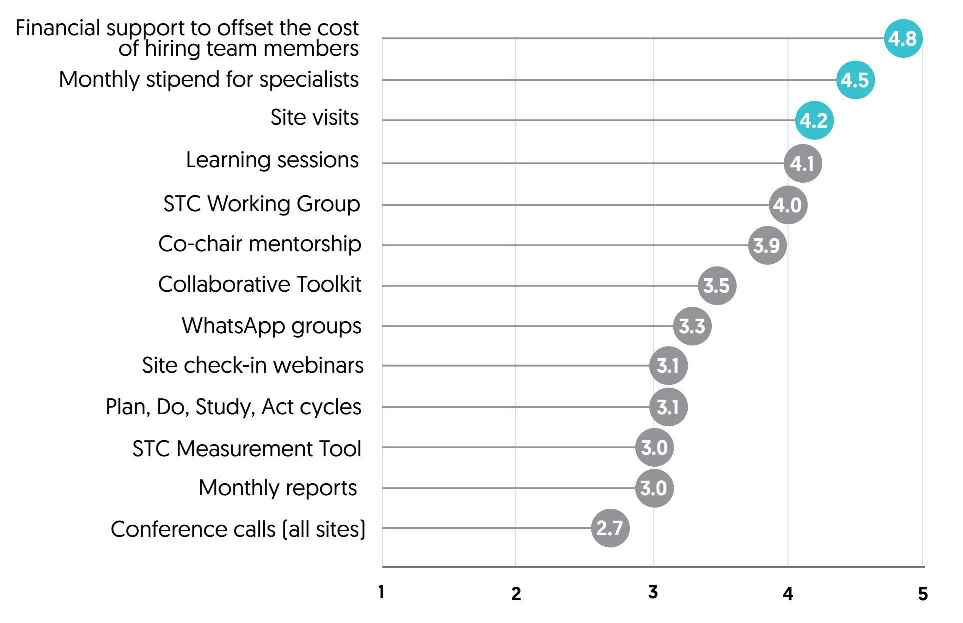
Eighty-five percent of Collaborative participants agreed or strongly agreed (85%) that the STCC supported them to implement change processes that enabled them to transition to team-based care models, while 17% disagreed or strongly disagreed. They attributed this sense of support to the formal structure of the Collaborative, as well as the various tools and resources provided along the way.

"A lot of this Collaborative came down to moral support. I would have never done this without having the STC to provide that. It was a nice impetus and motivation to try a new idea."
- Specialist

> **"You always think about doing something, but would never take that risk without a guiding hand. The STC was essential to supporting us to take the leap and make it to the other side."**
> **- Specialist**

The usefulness of the different supports provided by the STCC were rated by specialists and their team members (Figure 7).[10] The top 3 most useful supports provided were the: (i) financial support to offset the cost of hiring team members; (ii) monthly stipend for specialists; and (iii) the site visits completed by co-chairs.

Figure 7. Sites' ranking of the usefulness of different supports provided by the STCC



> **"The defining feature of the collaborative was that it financially supported you through this risk. It lowered the fear threshold to take this on. I can tell you that I would have never done this if that wasn't there."**
> **- Specialist**
>
> **"There was a really steep learning curve in the beginning, so it was great that there was financial support for us to take our time to learn at the start. That slow ramp up was helpful."**
> **- Allied Health Professional/Nurses**

10 Usefulness ratings have been illustrated collectively across participants' roles given that results from specialists, allied health professionals/nurses, and MOAs/office managers were largely consistent.

"By far, the most valuable part of this was listening and learning from other physicians who were mentors in this project. Even though they weren't in the same area of work as me, it is still valuable to hear about the successes and challenges they have faced."
- Specialist

"The site visits were particularly beneficial and should continue in the future. The [Co-Chair] came in and observed how we worked, how the clinic ran, and they gave helpful tips on how it could be improved. That observation of how we ran our team was the most helpful thing the Collaborative offered."
- Specialist

Specialists and their team members also provided qualitative feedback about the pros and cons of each STCC support offered (Table 10).

Table 10. Pros and cons of the different supports provided by the STCC

Support provided	Pros	Cons
Financial support to offset the cost of hiring team members	• Took the pressure off for sites while staff were being on-boarded and trained • Reduced the financial risk for specialists	• 25% of specialists felt the financial support was 'too low', while the remaining 75% thought it was 'just right'
Monthly stipend for specialists to participate	• Specialists felt appreciated for the time they invested in Collaborative-oriented matters	• 42% of specialists said the stipend was 'too low', when the remainder found it to be 'just right' • Some specialists did not believe the stipend reflected the time they invested
Site visits	• Provided tailored advice and guidance to sites, which translated to practice improvements • Helpful to actually show changes practices are trying to make	• Could have been more site visits offered
Learning Sessions	• Opportunity for learning and connection, both within and between teams • Business leadership content	• In-person, day-long events meant sites had to cancel clinic days to attend • Some did not find the content particularly valuable • Substantial cost to run the in-person sessions • Some did not resonate with 'health leadership' content

Support provided	Pros	Cons
STCC Working Group	• Helpful team members • Prompt communication and reminders about deadlines	• High volume of communication at times
Co-Chair mentorship	• Credibility - Mentors had real-world experience successfully implementing team-based care • Coaching was tailored to sites' needs • Mentors were highly accessible • Offered connections to various resources (e.g., business contacts) • Provided encouragement to try experiment with new ways of working • Helpful for troubleshooting	• Mentors' recommendations often did not apply for sites given the disconnect between their respective specialty areas (e.g., surgical vs. non-surgical clinics) • Some surgical specialists felt like they had to invent how to do team-based care for specialists who spend time outside the clinic (e.g., how to make financials work given limited number of clinic days)
Collaborative Toolkit	• Useful information and tools to support practice changes and overcome challenges	• Long document • Not comprehensively reviewed by some specialists, or reviewed once and not revisited
WhatsApp groups	• Helpful for troubleshooting and problem solving with peers, particularly in the early days of the Collaborative	• Difficulty searching for information shared • Activity in chat groups tapered off over time • More helpful for allied health professionals than other groups
Individual check-in webinars	• Helpful for sites that were less established	• Less useful for sites that were further ahead in transitions to team care • Reduced frequency of meetings mid-way through the Collaborative and beyond
Plan, Do, Study, Act Cycles	• Helped sites deliver improvements through a structured experiential approach	• Some were unclear about what this referred to

Support provided	Pros	Cons
STCC Measurement Tool, Support & Approach	• Helpful to reflect on progress sites were making towards Collaborative goals over time • Validated specialists' speculations about shifts in their patient throughput	• Unclear expectations at start of project • Burdensome and complex process to provide data • Focused on indicators of interest to the Collaborative, as opposed to measures that sites would have prioritized (e.g., strong focus on clinical capacity over patient and provider experience) • Indicators could be more tailored to sites' practices and their respective goals • Lack of clear, simple process for pulling and submitting baseline data • Competitive nature when reviewing outcomes; individual site data being compared • Pressure to be successful and show positive results • Interpersonal dynamics among Co-Chairs and STCC Working Group related to clinical capacity data
Monthly reports	• Opportunity to reflect and check-in on progress	• Time consuming • Frequency of submission too frequent
Conference calls (all sites)	• Useful for learning and problem solving, particularly towards the start of the Collaboration and for less established sites	• Meetings agendas were too broad at times; require more structure • Meetings were too frequent • Topics covered were too novice for some sites • Viewed as a 'chore' to participate once team-based care models were up and running

Specialist site leads also emphasized the value of learning from other STCC teams given the opportunity to learn from others' successes and failures, consider different solutions to problems, and reduce the sense of isolation while undergoing complex changes.

"Learning from other physicians and their teams was so key. So things like hearing from them about what they were doing to improve their efficiency. It was really collaborative."
- Specialist

"It was really helpful seeing what everyone else was doing. And incorporating ideas into our practice, rather than reinventing the wheel."
- MOA/Office Manager

In addition to the feedback provided on the usefulness of Collaborative supports above, specialists and their team members also identified some important aspects of the STCC that could be improved in the future, as follows.

- Specialists and their team members frequently explained that the duration of the Collaborative and its supports could have been shortened given that teams were often up-and-running with their team care models mid-way through the project. Towards the end of the Collaborative, the required STCC meetings and sessions turned into an obligation for participants, as opposed to useful learning opportunities.
- Participants sites were all at different levels of progress in establishing their team care models. Future consideration could be given to tailoring supports closer to what each site needs, rather than attempting to provide useful content or training for all clinics at once.
- Allied health providers/nurses and MOAs/office managers suggested that more opportunities could have been created for them to learn from one another throughout the Collaborative. They further noted that it would be particularly helpful if they could be matched with peers of similar specialties, given similarities in practice realities.

"Towards the end of the project, the frequent check-ins and webinars felt like too much at least for us. It was time consuming and felt like a chore by the end. At the beginning, it was helpful to get that framework and foundation. But then we got into our groove and the clinic really ran with it and took it in our own direction, so there was less of a need for support."
- Allied Health Professional/Nurse

"In the future, it would be helpful to create peer learning opportunities that are more specific to our specialties. Because I found that a lot of the things one speciality would talk about didn't really relate to our practice and how things are done."
- MOA/Office Manager

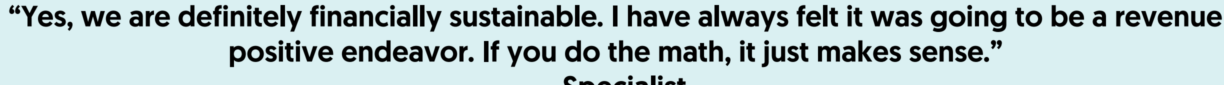
The large majority of specialist site leads from the first cohort expressed interest in supporting future SSC-led team care cohorts in some capacity (e.g., as mentors, help inform program design). Some noted that they would only be able to participate in such work if they were remunerated for their time. A small number of specialists said that they were unsure about supporting future team care cohorts, as they would need to learn more about the role and expectations for involvement before committing.

6. SUSTAINABILITY

What supports do sites require to sustain their team care models in the future?

The majority of participating specialists reported that their team care models were financially sustainable, while the minority were somewhat financially precarious. Following the completion of the STCC, specialists explained that it would be beneficial to have ongoing peer learning and mentorship opportunities.

At the end of the Collaborative, participating specialists were asked whether they considered their team care models to be financially sustainable, or not. The majority said that their models are financially sustainable, while some even explained that their team-based care models are generating more revenue than their clinics had in the past. The remaining minority of specialists indicated that their team care models were financially precarious, as they continued to worry about paying their allied health providers and the potential costs associated with inevitable staff turnover. In addition, some specialists explained that providing team-based care generates less revenue for them than the traditional or standard model of care.



"Yes, we are definitely financially sustainable. I have always felt it was going to be a revenue positive endeavor. If you do the math, it just makes sense."
- Specialist

"It is sustainable as far as I can tell, but I would be billing more if I went back to providing the bare minimum level of care. I take home less money to provide better quality of care."
- Specialist

Specialist site leads were asked to identify any future support they needed to sustain their team care models after the STCC. Many suggested that while they are self-sustaining, it would be beneficial to have periodic check-ins with the co-chairs and other teams to foster ongoing learning opportunities and support. A handful of specialists also expressed interest in having access to occasional consultant support moving forward in some specific areas, such as human resources, finances, and optimization of electronic medical records systems. One specialist suggested that it would be valuable to have standard on-boarding or orientation materials to share with new hires in the future to help orient them to the team-based care model.

CONCLUSION

Overall, findings from this evaluation demonstrate that the STCC has been a successful initiative. The Collaborative's processes and supports enabled 10 specialists to establish effective team care models that collectively achieved the STCC's goals related to patient experience, provider experience, clinical capacity, and utilization of health care resources. Findings from this evaluation support the SSC's decision to offer future cohorts of the Collaborative given the positive outcomes documented in this report.

Recommendations

Based on findings from the final evaluation, the following key recommendations have been put forward for consideration by the STCC and SSC.

Considerations for spread and scaling team based care for specialists

i. Consider exploring mechanisms to document key practice solutions and workflow ideas implemented by the first cohort to avoid future teams from reinventing the wheel.

ii. Continue with the intention to involve specialist participants from the STCC in future iterations of this work, as mentors or to inform future program design. The STCC should remunerate them for the time to act as mentors or leaders of such work.

iii. Continue to provide specialist teams with initial financial support to offset the cost of hiring team members considering how critical this funding was for specialists to assume the risks of trying out team based care.

Build upon successes & address challenges

i. To enhance the success of future team care cohorts, the SSC should aim to build upon factors that supported STCC clinics to transition their models of care, such as the importance of adopting a 'trial and error' mindset and being clear about the 'why' for making change. Potential strategies to minimize barriers teams faced in establishing their team care models should also be explored, such as the heavy workload for administrative staff and billing limitations of the current MSP fee structure system.

ii. Maintain Collaborative supports that were found to be most useful to participating sites, such as the financial support to offset the cost of hiring team members, the stipend for specialists to participate, site visits, specialist mentorship, and site-to-site learning opportunities.

iii. Consider implementing changes to address suggestions for improvement identified by participating specialists and their team members, such as more closely matching the specialties of the mentors and the sites, offering more tailored support to sites (e.g., more site visits, fewer all-site meetings), and reducing the length of time supports are offered given the most STCC sites' models were well established mid-way through the STCC. Other suggestions for improvement have been outlined in the 'Collaborative Feedback' section of this report.

Improve the QI/evaluation strategy in future iterations of this work

i. Explore strategies to capture data on both the Collaborative-level outcomes and indicators of most interest to the participating sites. For instance, a set of 'core' indicators could be mandated for sites to collect and submit data on, while an 'optional' list of measures could be created where teams could pick or choose what matters most to them. To further tailor indicators to sites' interests, one-on-one QI/evaluation support could be provided to help the teams determine team-specific measures.

ii. Be clearer with sites about the evaluation expectations from the start of future cohorts. More concrete and detailed instructions should also be provided to teams regarding processes for pulling baseline data.

iii. Continue with the intention to provide one-on-one support to the teams on evaluation-related matters to ensure they are supported.

iv. Avoid site-to-site comparison of data to lessen competitiveness and ensure the focus is maintained on supporting each team regardless of where they are at in their team-based care journeys.

v. Explore ways to reduce the burden on teams to participate in QI/evaluation activities, including data submission.

Limitations

The following methodological limitations should be kept in mind when interpreting the results presented in this report.

i. To measure reduced costs to the health care system, the proxy measure of patients' self-reported, pre/post use of health care resources outside of the sites' teams was employed. Limitations of this approach are that the data is subject to biases of self-report data, such as social desirability bias and recall bias. In addition, a convenience sample of patients was used (i.e. non-randomized), pre/post data was not matched/paired, there were variable response rates across participating sites, and the sample size was somewhat low for the patient follow-up survey (N=133). These factors further limits the validity of these results. With this said, adopting the proxy measure and making the aforementioned methodological decisions was determined to be most appropriate for this evaluation given the complexity of completing longitudinal analyses and following patients over time.

ii. To assess the provider experience in the Collaborative, one of the survey questions used to measure 'job-related stress' was negatively worded, while the remainder of the questions were positively worded. It is possible that STCC participants did not read the response options carefully and incorrectly selected responses based on the pattern observed in other questions' Likert scales. Strategies should be implemented to address this potential issue in the future, such as reminding respondents to pay close attention to question wording and/or shifting all questions to be positively worded.

APPENDICES

Appendix A. Provider Experience Survey Tool

Provider Experience Survey

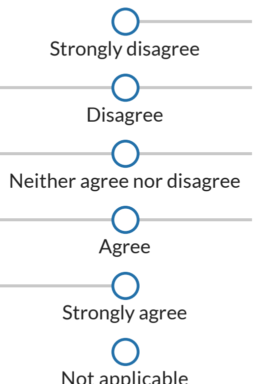
The Provider Experience Survey is for specialists and their clinic staff participating in the Specialists Team Care Collaborative to provide their input and experience being part of this initiative. We ask participants to complete this at the start and end of the collaborative. Results will be anonymous and only the aggregate results will be reported. If you have any questions, please contact admin@unstck.ca.
This survey is expected to take five to ten minutes.

* **Role**

- Specialist Physician
- Nursing
- Allied Health Professional
- Medical Office Assistant
- Other:

Job Satisfaction

* **Overall, I am satisfied with my current job.**



* **Overall, I am satisfied with my current job.**

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
- Not applicable

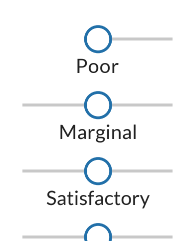
* **I feel a great deal of stress because of my job.**

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
- Not applicable

* **Using your own definition of "burnout", please choose one of the answers below:**

- I feel completely burned out. I am at the point where I may need to seek help.
- The symptoms of burnout that I'm experiencing won't go away. I think about work frustrations a lot.
- I am definitely burning out and have one or more symptoms of burnout, e.g. emotional exhaustion.
- I am under stress, and don't always have as much energy as I did, but I don't feel burned out.
- I enjoy my work. I have no symptoms of burnout.
- Not applicable

* **My control over my workload is:**

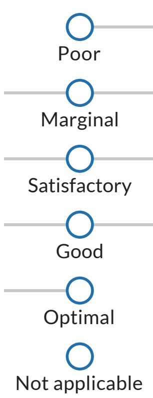


Optimal

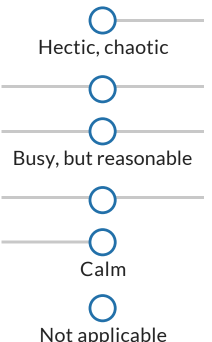
Not applicable

* **Sufficiency of time for documentation is:**

This includes clinical and/or administrative documentation.

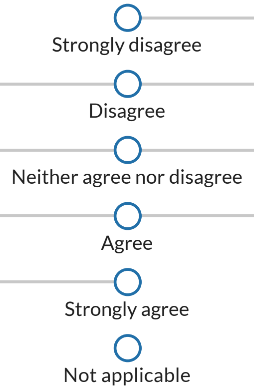


* **What best describes the atmosphere in your primary work area?**

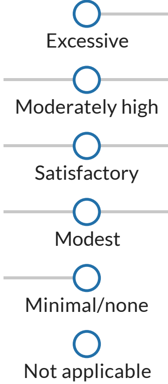


* **The degree to which my care team works efficiently together is:**

* **If I made a mistake on this team, I would feel safe speaking up.**



* **The amount of time I spend on the electronic medical record (EMR) at home is:**



* **Please rate your satisfaction with work-life integration (i.e. meeting personal and professional obligations).**

- Very dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very satisfied
- Not applicable

Thank you for taking the survey.