Team-based care Evaluation and Adoption Model
The TEAM Framework
Abridged Version

V3-00

Purpose

This document provides an abridged description of the ISU's Team-based care Evaluation and Adoption Model (TEAM) Framework. This document is meant for partners and collaborators who are working with the ISU to review the constructs of the TEAM Framework without being overwhelmed by the considerable detail we have developed.

TEAM Framework Goals

The goals for the ISU TEAM Framework are:

1. To be relevant and applicable to team-based care (TBC) projects in British Columbia (BC);
2. To cover the key dimensions of TBC;
3. To be a framework that provides provincial consistency and allows for local adaptability;
4. To support both formative evaluation within projects and summative evaluation over time in order to support decision making in a timely manner.

The proposed framework provides an approach that will help the ISU work with TBC projects (e.g. Patient Medical Home (PMH) or Primary Care Network (PCN)) to select appropriate qualitative and quantitative measurement and assessment tools. The framework will support consideration of metrics that span the dimensions of TBC identified by the ISU and can be adapted to meet the needs of individual practice sites looking to implement, develop, and/or evaluate TBC.

TEAM Framework

The TEAM Framework is derived from the literature and evidence on team-based primary and community care (TBPCC) and evaluation and was developed through an iterative process. It is comprised of an Evaluation Model and an Adoption Model.

The Evaluation Model is positioned on the backdrop of the WHO Social Accountability Pentagon Model[1] to acknowledge that there are a range of stakeholders that are involved in TBC projects. In the context of each project's evaluation plan, these stakeholders should be considered. The model consists of 10 dimensions: Relationship Centred Care, Patient Experience, Provider Experience, Team Function, Quality of Care Process, Capacity & Access, TBPCC Foundations, Governance & Accountability, Health of the Population, and Healthcare Costs (Figure 1).

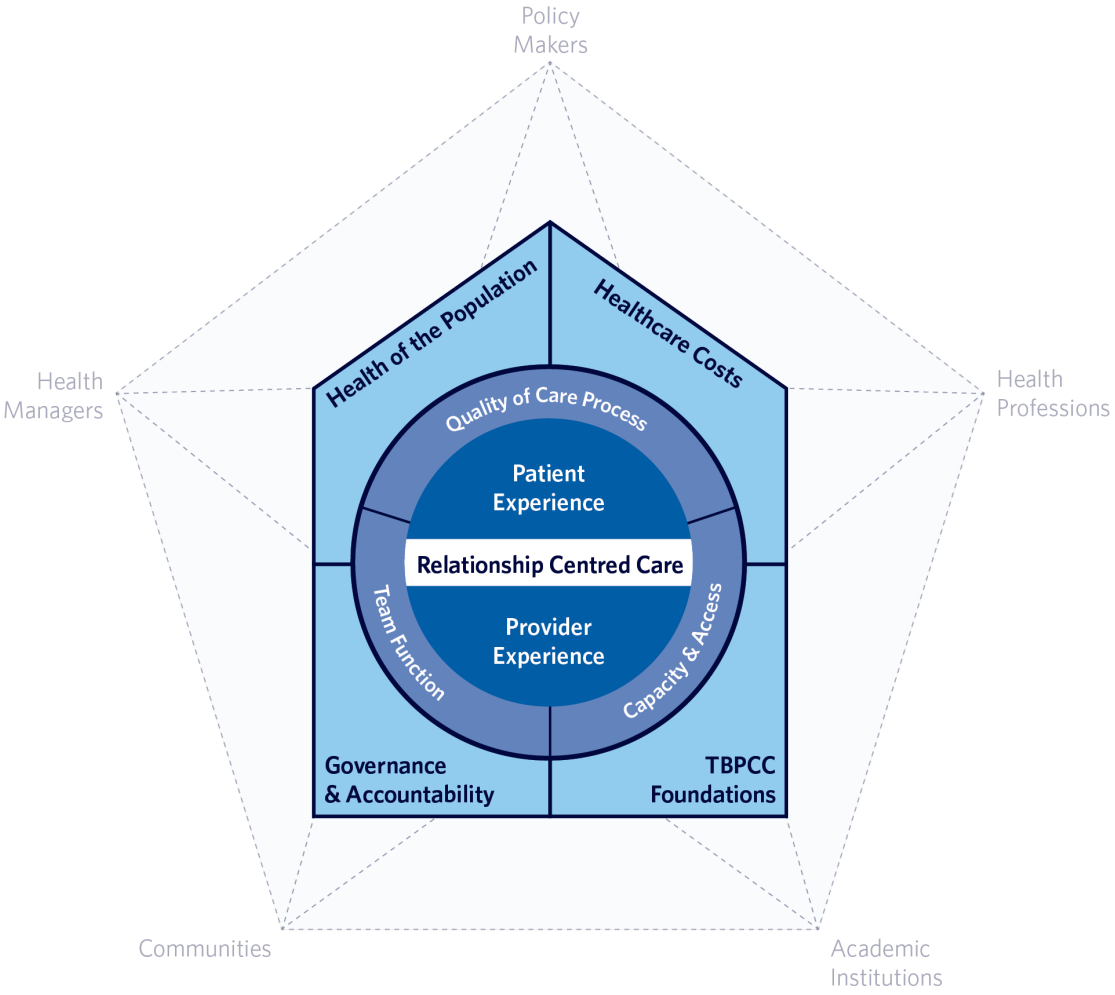

Figure 1: Evaluation Model

Each dimension contains a number of aspects and each of these aspects, in turn, have specific indicators, or measures (Figure 2). We have started mapping existing published and validated tools to the dimensions and plan to develop a list of recommended tools to support flexible evaluation planning that will meet the needs of specific communities as well as broader reporting requirements.

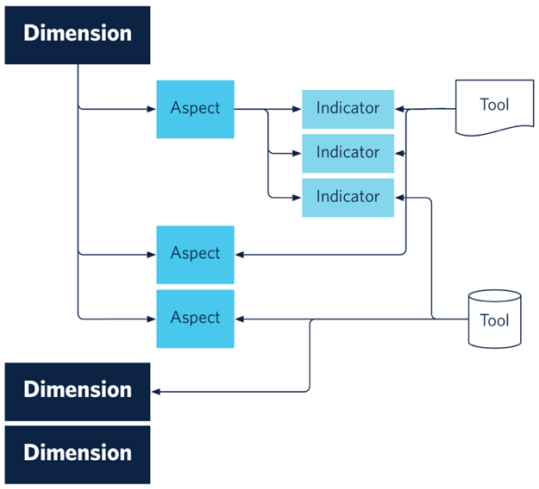

Figure 2: TEAM Framework - Dimensions, Aspects, Indicators and Tools

The dimensions of the Evaluation Model are designed to guide an evaluation plan alongside the Adoption Model (Figure 3), to ensure comprehensive formative and summative evaluation across the dimensions. The Adoption Model illustrates how to consider the evolution of indicators over time across the dimensions of the Evaluation Model; from measuring baseline and early intention to change, through to observable behaviour and, finally, long-term outcomes. Timing for different indicators is important and we should not be looking for long-term outcomes in the first weeks following implementation. The Adoption Model also incorporates the EPIS (Exploration, Preparation, Implementation and Sustainment) implementation framework[2] to highlight the importance of considering at what stage of adoption a team is at when planning and implementing evaluation and quality improvement efforts.

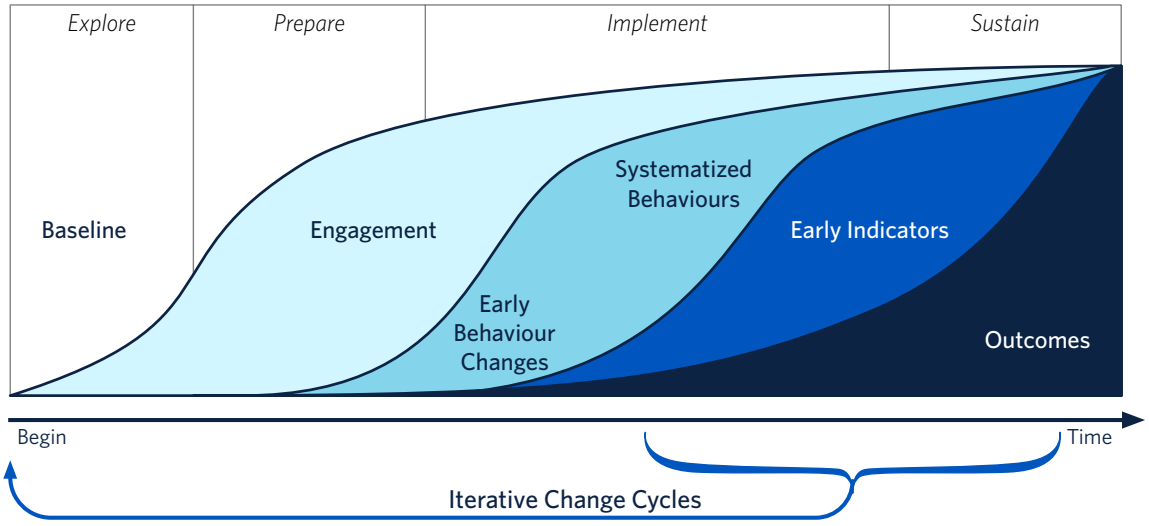

Figure 3. Adoption Model

The definitions and aspects of each dimension are outlined in the following section.

Definitions and Aspects

Relationship Centred Care

Central to the framework and assesses the quality and continuity of a therapeutic relationship between healthcare providers and patients. It focuses on person- and family-centredness,[3] and on providing culturally safe,[4] whole-person care over the short and long-term.[5–11] Numerous studies have shown associations between relationship-centred care and improved patient outcomes.[12–15]

Relationship Centred Care Aspects:

- Continuity
- Cultural Safety
- Patient, Family and Relationship Centredness

Patient Experience

The patient and family's subjective experience of the care they receive. This encompasses experiences with the care team and clinic facilities. It includes aspects such as patient perception of access to care, relationships and trust in healthcare providers, respect and dignity, as well as patient empowerment and activation.[3,6,7,9,12,16] In a systematic review Doyle et al. (2013) found a strong correlation between patient experience of care and clinical safety and effectiveness.[17]

Patient Experience Aspects:

- Patient Empowerment and Activation
- Patient Perception of Care

Provider Experience

The subjective experiences of individual providers in the team about their work. This includes the delivery of care to patients, interactions with their work environment, their individual role within the team and their work/life balance, which may be reflected in career satisfaction and professional morale.[7,11,16]

Provider Experience Aspects:

- Provider Experience of Work and Care

Team Function

The structure and operation of a team, the interactions of team members, and the additional supports required, including practice facilitation, information systems, team training and leadership.[3,6–8,18] The Team Function dimension is broadly focused on communication and relationships within the team and includes team behaviours that can be observed and measured.[5,19]

Team Function Aspects:

- Communication
- Information Systems
- Team Training

Quality of Care Process

The assessment of primary care services that are actively provided by teams to patients in communities. This dimension focuses on continuous quality improvement in primary care teams and the provision of safe, quality care for the management and control of disease.[3,8–10,18]

Quality of Care Process Aspects:

- Care Effectiveness
- Care Safety
- Quality Improvement Activities

Capacity & Access

Includes geographical access, organizational access and responsiveness, where all people in a community have equitable access to quality care.[5,8–11] Capacity & Access focuses on the accessibility and capacity of primary care teams[8] and the ability of a practice to provide comprehensive and coordinated care.[6,8,9] It incorporates the ideals of advanced and timely access, including the provision of extended hours and same day access to urgent care, as well as virtual access to care when needed.[3,5–7,9,18]

Capacity & Access Aspects:

- Comprehensive Services
- Equitable Access
- Service Accessibility
- Team Capacity

TBPCC Foundations

Features of the team, community and supporting organizations that enable effective team-based primary and community care (TBPCC). It includes both micro (i.e. clinic level) and macro (i.e. jurisdictional level) foundational aspects. It relies on opportunities for interdisciplinary education, strategies to support workforce capacity, provision of clinic level infrastructure and appropriate funding for equipment, supplies, facilities and information systems.[3,5,7–11,18] Additionally, it requires strong connections across the health system to provide optimal service level coordination of care between primary care and other secondary services.[3,5–11,18]

TBPCC Foundations Aspects:

- Care Coordination
- Clinical Infrastructure
- Education
- Funding
- Workforce Capacity

Governance & Accountability

Includes the development of a shared long-term vision that facilitates the alignment of evidence-based policy planning to support and strengthen primary care services.[8] It relies on appropriate leadership and management structures, as well as evidence-based research and evaluation to track progress, engage stakeholders, inform policy and focus investment to achieve desired health outcomes.[8–11,18]

Governance & Accountability Aspects:

- Evidence Based Decision Making
- Monitoring and Evaluation
- Stakeholder Engagement
- System Leadership and Management

Health of the Population

Focuses on the population of people served by the team and includes the assessment of broader health systems utilization measures, determinants of health and health outcomes for that population, whether care is accessed or not.[6,8,10,16] As it is focused on the health of the population served by the team, it includes attachment,[5,6,9,18] as well as the extent to which services are responsive to the needs of the community that the team is intended to serve.[3,9] In comparison, population health in the Quadruple Aim focuses on longer term health outcomes at a societal level.[16]

Health of the Population Aspects:

- Attachment
- Community Responsive Services
- Health Outcomes

Healthcare Costs

The tracking and analysis of costs associated with individual patients as well as broader, systems level costs that are influenced by the move to TBPCC. It reflects total healthcare spending per person and includes facility and operational costs, direct service costs, medication costs and both hospital and ED utilization rates and costs.[7,8,10,11] It is a component of the Quadruple Aim,[16] with a focus on achieving desired results with the most cost-effective use of resources.[9,16]

Healthcare Costs Aspects:

- Care Cost Effectiveness

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