A Formative Evaluation of the Whistler 360 Health Collaborative Society

By

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Territorial Acknowledgement

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Executive Summary

Whistler 360 Health Collaborative Society (Whistler 360 Health) is a locally governed charitable organization established in 2022 based on two years of research to address the shortage of primary care providers in Whistler, BC (Whistler 360 Health Collaborative Society, 2023). This evaluation was conducted during the first year of Whistler 360 Health taking over operations of Whistler Medical Clinic in January 2023.

Evaluation Purpose and Questions

This evaluation aims to provide a narrative of Whistler 360 Health during its first year of implementation and operation and identify key areas of success, learning, and recommendations for further implementation. Whistler 360 Health is in the early stages of implementation. As such, the purpose of this formative evaluation is to explore the strengths and challenges experienced to date, the unique strengths of this initiative, and factors relevant to its future sustainability.

The following questions and framework have guided the evaluation:

1. What is unique about Whistler 360 Health?
2. What are the core principles that make this a successful model?
    a. What implementation strategies have contributed to the success?
3. What types of challenges have been encountered to date? How have they been addressed?
4. What are the factors that might influence the sustainability of Whistler 360 Health?

Methodology

The methodology for this evaluation is a formative evaluation to support the ongoing implementation of Whistler 360 Health, gathering data and insights to inform ongoing improvements and sustainability. Qualitative interviews explored participants' experiences, perceptions, and interactions. The evaluation includes a comprehensive review of all program documentation, including the initial community forum, task force research, model development and planning, relevant literature, and meetings with key planning group members and community contributors.

Conclusions

Whistler 360 Health launched a community-driven solution in January 2023 that has seen unpredicted success in retaining primary care providers, recruiting new providers and attaching patients even though almost a million people in British Columbia are currently facing a crisis in accessing primary care. The conclusions drawn from the evaluation findings highlighted that:

- Engaging community members and partnerships beyond those typically involved in the health sector is a key success factor**.**
- Effective communication between the board members and clinic staff supports the successful adaptation to the transition from a private business to a nonprofit charitable model governed by a board of directors.
- At the beginning of implementing change, it is important to have a collaborative culture with a common understanding of the core values, beliefs, and commitment to a respectful working environment.
- Strong, dedicated leadership with business knowledge is crucial for keeping the process focused on a community change initiative and managing the multiple layers of complexity.

Recommendations

Based on the findings and conclusions identified the following recommendations are put forward to support Whistler 360 Health in identifying focus areas in the next implementation phase.

- Focus on implementing team-based care and continuing to focus on team development and culture.
- Develop a framework for ongoing measurement and evaluation to support data-informed care and support community engagement and fundraising.
- Continue to optimize the primary care clinic to support ongoing growth and areas for improvement.
- Create a volunteer engagement and management strategy.

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1. Project Overview

1.1 Project Purpose

In Whistler, British Columbia, two family medical practices have shut down over the past three years, leaving almost 40% of the population without primary care access (Pique, Oct 3, 2021) and more than half of the population of 14,000 without a family physician. In response, in 2019, the Whistler 360 Health Care Collaborative Society (known locally as Whistler 360 Health) was established by the local healthcare foundation, community members, local government officials, and physicians. Their goal was to create a community-governed healthcare centre using a team-based approach to primary care for the residents of Whistler, BC. Community members were instrumental in developing the vision and model of this new collaborative.

This evaluation aims to provide a formative evaluation of Whistler 360 Health during its first year of implementation and operation, focusing on identifying key areas of success and learning and providing recommendations. The evaluation is based on a comprehensive analysis of all program documentation, including the initial community forum summary, task force research, model development and planning, relevant literature, meetings with key planning group members and community contributors, as well as interviews with key members of Whistler 360 Health.

1.2 Community Background and Context

Whistler, BC, is a small municipality located two hours North of Vancouver. It is a popular destination resort with a permanent resident population of approximately 14,000 and approximately 15,000 people with secondary homes in Whistler. Over three million people visit annually (Resort Municipality of Whistler, 2019), with an average of 34,000 daily visitors, rising to 65,000 during the peak holiday season (von der Porten, 2022).

Living in Whistler can be expensive, with the cost of living on average 40% higher than in other areas in British Columbia (Resort Municipality of Whistler, 2019). This high cost of living and expensive commercial rent creates a significant overhead for family physicians who operate as small business owners. In 2017, Whistler had four family physician offices, and by 2022, there

was just one clinic still open in the community. As a result, an estimated 40% of the population does not have access to primary care (Pique, Oct 3, 2021). What is more, over 50% of the population in Whistler BC does not have access to a family physician. Even though six family physicians are currently practicing within the community, according to physician-to-patient ratios (panel size) recommended by the Ministry of Health (2015), it is estimated that the population would need 14 family physicians to meet the community's primary care needs. There is also a large number of transient workers, secondary homeowners and tourists, which further strains the healthcare system.

Recent emergency room data shows that over one month, 1500 people came to the Emergency Room of the local hospital, and based on an assessment of the presenting condition, over fifty percent would have been better served by a family physician (von der Porten, 2022). This adds an additional cost of $300,000 to the healthcare system, compared to the $60,000 it would cost the primary care system to treat these same patients (von der Porten, 2022). It is estimated that an average patient visit to the Emergency Room costs the healthcare system $440, in contrast to the $40 cost of a patient visit to a family physician (Ministry of Health, 2023). Yoon et al. (2015) note that increasing access to longitudinal relationship-based care provided by a primary care provider reduces Emergency visits by 6%, resulting in a significant cost reduction to the healthcare system.

Research aimed at looking at the effects of regular access to a family physician who provides continuity of care over a period of time is associated with better disease management, care coordination, preventative care, reduced hospitalization, improved patient satisfaction and fewer emergency visits (Crooks et al., 2012; Fung et al., 2015; Starfield et al., 2005). While there is no standard panel size for family physicians, calculations are made based on a ratio of supply and demand of appointments, patient complexity, and local context (College of Physicians and Surgeons Canada, 2012; Kivlahan et al., 2017). The Ministry of Health (2015) recommends one physician for 1200 patients. Based on this calculation, Whistler would need an additional six to eight family physicians to meet this target.

1.2 The Whistler 360 Health Collaborative Society

Whistler 360 Health Collaborative Society is a locally governed charitable organization established in 2022 to address the shortage of primary care providers in Whistler, BC (Whistler 360 Health Collaborative Society, 2023). It all started in 2019 when a community forum was held to educate the community about the primary care crisis and to start a conversation about how the community could be involved. The community forum led to creating a task force representing community organizations, community members, and primary care providers, whose aim was to continue the community conversation and develop a healthcare action plan for Whistler. The initial task force spent two years meeting with other communities and clinics that were not traditional private physician-owned businesses, including Community Health Centres and a non-profit clinic in the Saanich Peninsula on Vancouver Island. After two years of research investigating other models, the Whistler 360 Health Collaborative Society was created. The mission for Whistler 360 Health is "to create a team-based, professionally managed, community governed centre of excellence where health care professionals provide patient-focused longitudinal care (Whistler 360 Health Collaborative Society, 2023). Additionally, Whistler 360 Health aims to provide leadership in the community and work in collaboration to improve the social determinants of health (Whistler 360 Health Collaborative, 2023).

The Whistler 360 Health model is based on five core values:

1. Care and Compassion
2. Accessible to All, Equitable and Inclusive
3. Collaborative and Comprehensive
4. Community Driven
5. Innovative- Model of Excellence

In January 2023, Whistler 360 Health, governed through the Society's Board of Directors, assumed operations of the remaining healthcare clinic in Whistler. Whistler 360 Health Collaborative Society has eight board members. At the time of this evaluation and early implementation of Whistler 360 Health assuming operations, the medical clinic consists of seven

primary care providers[1] and seven staff. In the twelve months of operating the clinic, a secondary location has been opened, and as of March 2024, there are thirteen providers and nine staff. Additionally, with the growth of the providers, the clinic has attached 2500 patients (J. Reid, personal communication, March 18, 2024).

1.3 Logic Model for Whistler 360 Health Collaborative Society

A program logic model visually depicts how the program or intervention is intended to work. As such, it helps frame the evaluation, questions, and focus (Harris, 2016). Prior to creating a logic model for Whistler 360 Health, a theory of change was first co-developed with a group of core Whistler volunteers, all of which helped to ensure a common understanding of the initiative's underlying rational, overarching goals, objectives, and activities (Harris, 2016; Reinholz & Andrews, 2020). The original theory of change is included in Appendix A. Subsequently, using the theory of change and an existing logic model provided by Whistler 360 Health, the logic model below was created, reviewed and adopted by the community (see Table 1).

Table 1. Logic Model of Whistler 360 Health

Inputs: Primary Care Providers, Community Foundations, Community Health Service Organizations, Municipal Government, Local Health Authority, Community Volunteers, Division of Family Practice.		
Key Activities	**Outputs**	**Outcomes**
Phase 1 -Engage the community in a primary care forum -Learn about other models in BC -Convene a task force of volunteers -Engage key organizations -Develop a vision for a model for primary care in Whistler -Develop communication strategies for ongoing community engagement	- Diversity/range of attendees - Research findings of other community primary care models - Commitment level of a core group of volunteers (task force) - Level of engagement/range of organizations engaged in supporting the model. - Vision and plan of a model for Whistler	Improved provider experience - Job satisfaction - Work/life balance. - Professional fulfillment Expanded capacity of clinic -new patients attached to the clinic -Providers are not rushed -Workflow/communication is smooth and efficient Increased communication,

[1] Primary care providers refers to either a family physician or nurse practitioner. The provider primarily responsible for the majority of care for a person.

	- Range and type of community strategies	cohesiveness, and collaboration among team and Society Increased recruitment and retention of primary care teams (Family physicians, Nurse Practitioners, Allied Health, Nurses, Medical Office Staff) Increased patient access and experience Increased health outcomes for the community
Phase 2: -Form a non-profit charitable society -Develop a board of directors -Develop an operational model -Take over operations of Whistler Medical Clinic (WMC) -donors/fundraising	- Diversity/# of people on Board - -Level of commitment to the operational model - -Smooth transition of operations of WMC	
Phase 3: -Recruit new providers -Create a system for registering and attaching new patients -Engage staff of WMC with both society activities and WMC -Establish ongoing strategies for learning and improvement -Sustainability plan in place	- Range and diversity of new providers - # of patients engaged and attached to new providers - Increased communication, cohesiveness, and Collaboration among staff/providers - Ongoing regular meetings with clear action items/strategies - Structures in place after initial support of the community that include: - Funding strategies - Operational strategies	

1.4 The BC Healthcare Context

For over fifty years, the Province of British Columbia has delivered primary health care services through family physician-owned and operated clinics (Fritz, 2015). Primary care is the entry point into the health care system and provides accessible, comprehensive, person-centered continual care coordinated among practitioners (World Health Organization, 2023). There is, however, a current crisis in the healthcare system in BC, as one in five people do not have a family physician, a number that is equivalent to almost one million people (BC College of Family Physicians, 2022). Many physicians, pressured to take on more patients with increasingly complex health issues and dealing with the rising costs of doing business in the province, the COVID-19 pandemic, and an ongoing opioid crisis, are experiencing high levels of burnout and stress, causing them to leave family practice (Doctors of BC, 2022).

Until February 2023, BC physicians have largely received compensation through the dominant fee-for-service (FFS) model, where they are reimbursed or bill a fee-for-service for each patient visit or service provided (BC Auditor General, 2017). Under this model, family physicians are considered self-employed small business owners, with overhead costs estimated at 40-50% (College of Family Physicians, 2017). In addition to the FFS compensation model, physicians have had additional incentive fees to care for more patients with more complex issues. While other compensation and primary clinic operating models exist in Canada, BC has had the current FFS model for over 50 years. Given the complexity of this model, many physicians question whether the current model is sustainable, with many physicians also stating that the compensation model, coupled with running a business as a sole business owner, is leading to burnout (Doctors of BC, 2022).

In response to the large number of people in BC without access to primary healthcare services, in the Spring of 2018, the Province of British Columbia launched a *Primary and Community Care Strategy* (Ministry of Health, 2015). The aim of the strategy is to support longitudinal care by creating better access to care and improving attachment to primary care providers. This multi-pronged approach has been implemented in phases since 2018. The strategy addresses the need to reform the dominant FFS model, integrate other healthcare professionals into primary care, and explore alternative models to the traditional private physician-owned clinics. Moreover, since 2018, British Columbia has seen the development of primary care networks (PCNs), a

network of primary care providers in a geographical area (Family Practice Services Committee, 2023). The PCN's primary care clinics have begun integrating other health care providers into their clinics, hoping that patients can access the services of nurses, social workers, and mental health care workers, creating access to physicians for more complex medical needs. The 2018 strategy also outlined the need to explore alternative physician remuneration models, community health centres, and urgent and primary care centres (Ministry of Health, 2019). Since the strategy was released in 2018, the government has gradually implemented payment models for physicians that differ significantly from the dominant FFS. The strategies include contracts for physicians in a group setting, new-to-practice contracts for physicians starting a primary care practice, and in February 2023, the longitudinal family physician (LFP) payment model was introduced (Government of British Columbia, 2023).

Currently, in BC, there are 32 Community Health Centres (CHCs) providing primary care services and a broader range of social support, focusing on helping the social determinants of health (BC Association of Community Health Centres, 2023). In addition to Community Health Centres, Urgent and Primary Care Centres (UPCC), government-funded, health authority-owned and operated, have been created to reduce the number of non-urgent visits to emergency rooms (HealthLink BC, 2023). Some UPCCs also have primary care providers that provide longitudinal patient care. The UPCCs are meant to provide access to non-urgent care within a 12-24 hour period until patients can see their primary care providers. However, many people without a primary care provider in BC are using the UPCCs as their primary source of care, similar to a "walk-in" physician clinic. In addition to CHC and UPCC models, the government has been exploring alternative remuneration models for physicians. Besides government-led strategies, primary care networks, CHCs, UPCCs and alternative payment models, there are also some physician-led efforts to change how primary care is delivered. The most significant example is the Shoreline Medical Society on the Saanich Peninsula, Vancouver Island. Shoreline Medical Society is a nonprofit charitable organization that owns and operates two medical clinics. The Shoreline Medical Society was created by a dedicated group of physicians seeking an alternative to the physician-owned and operated model to reduce the burden of administration involved in running a business. Shoreline Medical Society opened its first clinic in 2016, and in 2019, it opened a second location in Brentwood Bay (Shoreline Medical Society, 2023). While the

Whistler 360 Health model is roughly based on the Shoreline Medical Society model, it has developed its unique healthcare approach.

1.5 Literature Review

1.5.1 Introduction

This project's scope has the potential to be very large as it considers the wide range of contributing factors that necessitate primary care reform in BC. There is vast literature on this topic, and because of this, it was necessary to restrict the literature review to those elements of reform and change pertinent to evaluating Whistler 360 Health. The review is therefore focused on understanding the context of primary care, contributing factors that led to the development of Whistler 360 Health, and literature regarding evaluation and research of community health centres that are the closest models to Whistler 360 Health. This section provides provincial context and examines national efforts to address the primary care crisis. Additionally, the literature review examines evaluations of existing primary care models in Canada and B.C. to establish a relevant and evidence-informed understanding of primary care's historical and current context. The literature review also identifies gaps in the evaluation research related to non-profit primary care models outside the predominant Community Health Centres and privately owned physician clinic models.

A systematic search of grey and published literature was performed for this review. A total of 13 articles and eight pieces of grey literature were identified and selected. Dates of publication varied between 2000 and 2023. Key search terms were selected using the evaluation questions, key concepts, and key concepts in the Whistler 360 Health development model. These terms included: “primary care,” “British Columbia,” “primary care reform,” “evaluation,” “community health centre,” “non-profit primary care,” “physician burnout," and "administrative burden and primary care.” The databases that were searched included PubMed and Google Scholar. Grey literature and leading Canadian medical journals were also searched to complement the scientific database. These included the Canadian Medical Association (CMA), Canadian Medical Protective Association, Doctors of BC, BC Association of Community Health Centres and Canadian Family Physicians were also searched. Journals searched included The Canadian

Medical Journal, BC Medical Journal and Canadian Family Medicine Journal. Only papers written in English focusing on primary care in Canada and BC were included; papers examining primary care related to other medical professionals (e.g., nursing) were excluded.

1.5.2 Context - National and Provincial

In October 2000, the College of Family Physicians of Canada released the report "A Prescription for Renewal," which aimed to guide and inform primary care renewal in the country. The principles that were the basis for the recommendations outlined in the report are still widely supported today (CFPC, 2004). Fundamental principles include universal access to a family physician, comprehensive and continuous care, interdisciplinary team-based models, 24/7 responsiveness, and the integration of information systems.

Hutchison et al. (2011) examined the policy and change efforts in the early 2000s to reform primary care in Canada. These efforts include supporting interprofessional healthcare teams, moving from solo to group practice, networking primary care clinics, patient attachment mechanisms, alternative payment models, quality improvement support, and implementing electronic medical records. Hutchison et al. (2011) conclude that each province has taken varied approaches to primary care reform. Despite not having a genuinely universal national health system, reform is possible but depends on providers' voluntary participation. Although the article is slightly outdated, given the rapidly shifting environment in primary care, Hutchison et al. (2011) acknowledged at the time that there was the beginning of a culture change in some provinces that likely laid the foundation for the current landscape in BC.

McKay et al. (2022) scanned government policy documents from 1998 to 2018 in three provinces: BC, Nova Scotia (NS), and Ontario, which aimed to implement primary care reform in primary care delivery. The article examined how these policies may impact primary care physicians' practice choices, intentions, and patterns. It revealed that the provinces had both similarities and differences in their approach. BC and NS offered alternative models, such as population-based and contract options, as fee-for-service alternatives implemented in the last decade (2013-2023). Ontario has also widely implemented interprofessional team-based models of care, including the implementation of Family Health Teams and the expansion of Community

Health Centre models. Other provinces have experience with team-based models of care, but in BC and NS they are relatively new, apart from the minority model of a CHC in BC. Recruitment and retention efforts were consistent across the policies, particularly in rural and remote communities. The study's strengths are that it highlights the efforts and the need for change to primary care in Canada and the details of the reform efforts in the three provinces. It also acknowledges that the government is limited in using the levers available to them, such as payment models and participation in change efforts being voluntary by physicians. However, the policies are most effective when physicians are engaged in the development. The study's limitations are that it only included three provinces and was restricted by which policy documents were publicly available. Similar to other articles and studies, this was completed in 2018, and by the time it was published in 2022, significantly more change efforts had been attempted.

A research study conducted by Aggarwal, Hutchison, Abdelhalim, Baker (2023) reviewed policy efforts from 2012 to 2021 across 13 provinces and territories addressing the structural components of high-performing primary care. The authors acknowledge that considerable investments have been made to support primary care and build high-performing teams. However, more information is needed about the extent of actual change from implementing programs and policies. There are still substantial variations across the provinces in implementing structural changes to create high-performing primary care teams. The study found significant changes, including adopting electronic medical records, quality improvement training and support, and developing interprofessional teams. However, progress has yet to be made in implementing primary care governance mechanisms, system coordination, patient attachment and enrollment and payment models. The rate of change was slow for patient engagement, leadership development, performance measurement, research capacity and system evaluation of innovation. This study provides a good overview of the efforts up until 2021. The COVID pandemic, since the time of the study and date of publishing, has brought to the forefront the essential role of primary care and, at the same time, created a significant strain on it. Aggarwal et al.’s (2023) study illuminates the need to evaluate and understand the effectiveness of transformation efforts, as developing policy and implementing efforts with accountability for the outcomes of

investment is essential to know where to invest time and resources as we advance in the future with primary care.

The review study by Aggarwal et al. (2023) is optimistic, indicating progress in team-based care and quality improvement, etc. Still, even this most recent study indicates the problem with published literature in an era of rapid change; since their work was completed in 2021, there have been many structural and remuneration changes.

1.5.3 Factors Contributing to the Primary Care Crisis

The literature reveals that a multitude of factors have led to the breakdown of primary care in Canada, leading to shifts that will require a multifaceted approach. Vast demands on the system have accumulated at an unsustainable rate (Lavergne et al., 2023), leaving physicians feeling frustrated, overwhelmed, or burnt out as they struggle with endless administrative workloads and payment models that undervalue their work (Lavergne et al., 2023). A National Physician Health Survey conducted in 2021 by the Canadian Medical Association found that more than 50% of physicians indicated they were experiencing burnout (Canadian Medical Association, 2022). According to Doctors of BC (2022), burnout in physicians has risen to an unprecedented level due to the seemingly insurmountable challenges physicians face in providing care to their patients.

The reasons behind physician burnout are numerous and interrelated and cannot be reduced to singular causes. Extensive research has pointed out that administrative overload, health technology, and growing patient complexity all significantly contribute to physician burnout and frustration (Leiter, 2017). In the last 25 years, primary care practice has become increasingly complex (Lavergne, 2023). This is attributed to the widespread use of the increasing number of clinical guidelines and the fact that patients have more intricate health and social needs that intersect in primary care settings (Lavergne, 2023). Furthermore, there is an increase in diagnostic and pharmacological options, which come with complicated referral procedures and forms (CMA, 2022).

Based on the literature presented and responses generated at engagement events from physician members of Doctors of BC (2022), broad areas contributing to burnout are categorized below

from a thematic analysis of these proceedings and papers. It is important to recognize that all these burden areas are inherently linked and compounded by their interrelatedness.

Technology: This is defined as any information technologies used or required by physicians, such as EMRs, email, texts, telehealth, health apps, and artificial intelligence. Inefficient technology systems or even those products promising to improve physician workload are key factors contributing to the technology burden. However, there is recognition that while technology may currently represent a significant burden to physicians, there are opportunities, if used effectively, to improve physician workflow and the quality of care (Doctors of BC, 2022).

Documentation and Paperwork: There are many issues related to increased time spent managing patient documentation or charting, including EMR systems, forms, and guideline requirements (Doctors of BC, 2022).

Clinical Complexity: There is an increased complexity to providing care. It results from many factors, including advances and rapid growth of medical knowledge, demographic changes (i.e. ageing population), and increased scope of practice for physicians (e.g. the rise of mental health issues, the social and economic determinants of health) (Doctors of BC, 2022).

Patient Expectations: Changing patient attitudes regarding care, treatment options, and timelines have altered the physician-patient relationship. Time pressures and the rise of non-evidence-based medicine are key components of this burden area (Doctors of BC, 2022).

Compensation Models: Compensation models have not kept pace with the changes in care, resulting in challenges or issues for physicians with under-compensation or decreased compensation. There is consistent pressure to maintain a high patient volume to maintain appropriate compensation in the predominant fee-for-service model. This results in physicians not being fairly compensated for the time and costs of meeting the complexity of patient needs, documenting, and supporting the cost of running a business (Doctors of BC, 2022).

Administrative Burden: Physicians are not trained in business operations and human resources. They are navigating increasing overhead costs, Human Resources needs, business requirements and escalating workloads, all contributing to a poor work-life balance (Doctors of BC, 2022).

The effects of physician burnout are wide-ranging, impacting personal, social, organizational, and systemic levels. At the personal level, physicians may experience negative effects on their mental and physical health and may even choose to leave the medical profession altogether. Socially, burnout can lead to strained relationships with colleagues, decreased engagement with patient care, and personal issues in their family or relationships (Ruzycki, 2018; Ghali et al., 2009). Organizational consequences include decreased patient satisfaction, increased medical errors, higher risk of patient mortality, and decreased overall productivity (Card, 2018; Kumar, 2016; Panagioti et al., 2018).

1.5.6 Conclusion

Addressing the primary care crisis in BC presents a multifaceted challenge. As communities and government are rapidly trialing and implementing possible solutions, the literature is not able to keep up to date at the same pace. Some literature is available for the most similar model to Whistler 360 Health, the CHCs; however, they are markedly different in significant ways. Innovative models such as Whistler 360 are arising out of a system in crisis in current time frames. There is no body of literature or conclusive evaluations of these models as the changes in BC are happening rapidly; for example, in just the last few months of 2023 and 2024, remuneration for physicians changed significantly to reduce administration tasks and increase income. The government is rapidly implementing changes to stop a system from crumbling and attempting to build a new, stable, sustainable one that will provide excellence in patient care while supporting physicians to work in a positive and fulfilling environment.

2. Purpose and Scope of the Evaluation

Whistler 360 Health is in the early stages of implementation. As such, this formative evaluation aims to explore their unique strengths and challenges experienced to date, as well as factors relevant to its future sustainability. Additionally, this evaluation aims to identify what makes the

Whistler 360 Health model unique in British Columbia. The findings of this evaluation will be used to establish baseline data for future evaluations.

2.1 Overall Evaluation Approach

This evaluation was collaborative, with participants actively engaged in designing the logic model, providing official documents and pertinent meeting notes, helping with the development of the evaluation questions, and providing input and feedback on findings and recommendations.

2.2 Evaluation Defined

Evaluation is multifaceted, and as such, there is a wide range of definitions available. For the purposes of this evaluation, the definition is informed by the evaluation's purpose, approach and context (Poth et al., 2014). For the present purposes, evaluation is defined as "the systemic assessment of the design, implementation or results of an initiative for the purposes of learning or decision-making" (Canadian Evaluation Society, 2023). Although this definition is broad, it captures this evaluation's formative, improvement-oriented nature and situates evaluation as a systemic process. Given the active engagement of Whistler 360 Board members, this evaluation is also guided by collaborative principles where the evaluator works in partnership with program stakeholders to create evaluation findings (Cousins & Chouinard, 2012).

2.4 Evaluation Questions

As previously noted, the evaluation focused on formative questions concerning the implementation of Whistler 360 Health. The following evaluation framework (Table 2), identifying evaluation questions, indicators, data sources and data collection methods was co-developed and used to guide the evaluation.

Table 2. Evaluation Framework

Evaluation Question	**Indicator**	**Data Source**	**Data Collection Method**

1. What is unique about Whistler 360 Health?	▪ Description of decision points and any significant events ▪ Key principles of effectiveness for model	Board Members Primary Care Providers Medical Director/Emergency Physician Medical Office Assistants Administrative Staff	Document analysis Interviews Review of other models
2. What implementation strategies have contributed to the success? a. What are the core principles that make this a successful model?	▪ Number and type of strengths identified ▪ Range of potential improvements identified ▪ Description of lessons learned, including strengths, opportunities and unintended outcomes	Board Members Primary Care Providers Medical Director/Emergency Physician Medical Office Assistants Administrative Staff	Document analysis Interviews
3. What types of challenges have been encountered to date? How have they been addressed?	▪ Range of challenges ▪ Significance of challenges	Board Members Primary Care Providers Medical Director/Emergency Physician Administrative Staff	Document analysis Interviews
4. What are the factors that might influence the	▪ Structures in place after	Board Members	Interviews

sustainability of Whistler 360 Health?	initial support of from the community ▪ Funding strategies ▪ Operational strategies	Primary Care Providers Medical Director/Emergency Physician Administrative Staff	Document analysis

2.5 Information Needs

Other communities across BC are interested in developing a model similar to the Whistler 360 Health model. This evaluation hopes to help identify core principles, implementation strategies, and key elements of success to share with other communities.

3. Evaluation Method

3.1 Evaluation Design

This evaluation is based on a formative design to support the ongoing implementation of Whistler 360 Health, gathering data and insights to inform ongoing improvements and sustainability.

3.3 Data Collection

The evaluation used two sources of data collection: primary and secondary. The primary data source was collected through interviews. Program documentation provided a secondary source of data.

Interviews

For Whistler 360 Health, interviewees were purposefully selected to provide a diversity of perspectives on the planning and implementation process (Alkin & Vo, 2018). Interviews were semi-structured, which allowed for in-depth discussions that encouraged participants to share their experiences, perceptions, challenges, and suggestions. Interviews were conducted remotely via Zoom and recorded, and subsequently transcribed for analysis. Each interview lasted

approximately 45 minutes, allowing for a thorough exploration of perspectives. The interviewees were informed of the purpose of the evaluation and assured of their anonymity. Participants were also informed of their right to withdraw at any time. All data was kept confidential and stored securely. A total of 10 people were interviewed. Appendix B provides the interview guide.

3.3.a Sampling Strategy

The interview participants were selected using purposeful sampling to provide information-rich sources of data (Patton, 2002), which in this case meant selecting knowledgeable and experienced individuals with knowledge about Whistler 360 Health. In addition to knowledge and experience, Bernard (2002) identifies availability, willingness to participate, and the ability to communicate experience as important.

Four key groups were interviewed for this evaluation:

Board members (n=3). The eight board members represent volunteer community members who supported the planning and implementation of Whistler 360 Health.

Primary Care Providers (n=4). Whistler 360 Health assumed operations of the last medical clinic in January 2023, at that time there was a total of seven primary care providers, consisting of family physicians and nurse practitioners. This required a significant change for the primary care providers from a privately owned partnership business to a nonprofit model with a board of directors.

Medical Office Staff (n=2). Medical office staff runs the day-to-day operations of the care clinic operated by Whistler 360 Health. They are often making decisions that affect the business and the providers. Shifting to a nonprofit model with a board of directors and an executive director significantly changes their human resources model and decision-making pathways.

Emergency Physician (n=1). The Emergency Department in Whistler is the only other option for seeking medical care if patients do not have access to primary care. The perspective of staff and

physicians from the emergency department provides an understanding of the early impacts on the healthcare system.

Documentation

In addition to interviews, relevant documents, including planning documents, agendas, meeting minutes, team charters and newsletters, were collected and reviewed. Table 3 provides a summary of all documentation included in this evaluation. These documents provided valuable context and insights into the design, goals and objectives of Whistler 360 Health. The documents were systematically reviewed to identify alignment between goals, implementation, and emerging challenges. The findings from the document analysis complemented the insights gained from interviews, contributing to a more comprehensive understanding of the implementation of Whistler 360 Health.

Table 3. A Summary of Whistler 360 Health Program Documentation

Documents	**Author(s)**	**Description**
Community Forum planning notes and session notes	Whistler 360 Health	Outline of initial planning notes for session, invitation list and notes from the forum.
Logic Model Whistler 360	Whistler 360 Health	A high level logic model focused on long term outcomes
Research Notes	Whistler 360 Health	Notes from the task force investigating other models in BC- lists of pros/cons
Presentation on Model	Whistler 360 Health	Presentation on overview of the model made a provincial physician meeting in Sept 2022
Minutes from working group on data	Whistler 360 Health	Notes from a working group formed to establish what data Whistler 360 Health should capture
Presentation on Primary Care Crisis from the Emergency Department	Medical Director Whistler	Presentation given by the Medical Director on the Emergency on the effect of the primary care crisis on the ED.

Whistler 6-month workplan January-June 2023	Whistler 360 Health	A review of key projects over the first six months of operating the medical clinic
Whistler 360 Strategic Plan 2023-2025	Whistler 360 Health	Goals and priorities for the next two years.

4.4 Data Analysis and Interpretation

Thematic analysis, a well-established qualitative technique, was employed to analyze the interview data. The analysis process involved several iterative steps, including data familiarization, searching, and reviewing for recurring patterns and themes, and a particular focus on understanding to generate an understanding of key areas of implementation, potential focus areas for future efforts, and the initial impact of Whistler 360 Health. In addition to thematic analysis, document analysis was conducted to complement the interview data. This involved reviewing relevant documents to gain additional insights and triangulate interview findings. The analysis process encompassed several iterative steps, including familiarization of documents, searching and reviewing for themes, and generating a comprehensive understanding of the subject matter. The evaluation questions guided the analysis process, ensuring a thorough exploration of all relevant data sources.

4.5 Ethics Approval and Considerations

This project used a qualitative evaluation methodology and, as such, required the approval of the Human Research Ethics Board (HREB) at the University of Victoria. The HREB approved the project proposal on June 26, 2023.

4.6 Validity and Reliability

Validity was established through data triangulation from interviews, and documents. By attempting to answer the same questions through different methods, we can have greater confidence in the validity of the data. In addition, validity was based on pragmatism, as suggested by Kvale (1996), where the usefulness and relevance of the data to inform practice and policy change was essential.

5. Findings

This section presents the main themes organized by evaluation questions. By organizing the main themes according to the evaluation questions, this section provides an understanding of the multifaceted impact and implications of Whistler 360 Health, grounded in both qualitative data from interviews and insights derived from document analysis. When warranted the evaluation questions have been grouped together in the findings.

Q. 1 What is unique about Whistler 360 Health?

The development of Whistler 360 Health is an innovative approach to mobilizing the entire community to tackle the primary care crisis in Whistler. As interviewees noted, the community inadvertently adopted an asset-based community development approach by utilizing and building on the strengths of individuals, organizations, and institutions. This approach enabled them to unite and establish a multidisciplinary task force and board of directors with the community's commitment to transforming primary care delivery in their community (Tamarack Institute, 2023).

One of Whistler 360 Health's distinctive factors identified by the interviewees is the early engagement of community members and the close collaboration with crucial partners like the Health Authority, Whistler Community Services, and the Municipality. Maximizing the relationships and capacities of individuals, businesses and organizations through robust community ties and engagement, Whistler 360 Health expands the scope of responsibility for delivering healthcare services to the broader community. The community involvement also increased momentum in finding solutions by providing the opportunity for flexibility and adaptability, according to interviewees. Extensive community involvement, particularly the engagement of those from outside the healthcare system and several key decision points during the development and implementation of Whistler 360 Health, is perceived by interviewees as a contributing factor that sets Whistler apart from other healthcare initiatives in the province. One interviewee explained that the volunteers represent the whole community and are well-connected, "spanning the reach to a bunch of different groups we might not have connected with otherwise."

The initial invitation to discuss the primary care crisis was sent to community organizations, citizens, local government, foundations, businesses, and healthcare representatives, allowing all Whistler community members to build awareness and understanding of the crisis and develop a local solution (Whistler 360 Health, 2020). A task group was formed from the community meeting focused on researching models in the province and exploring ideas that would meet the community's needs. Involving diverse task group members, comprised of a cross-sector of community members, not just healthcare policymakers or service providers but representatives from the community and community organizations, is an approach that is unusual from traditional working groups tasked to address primary care challenges in communities as one interviewee explained. The task force enabled a broad perspective on the research gathered and learning from other models, and all aspects were considered, including economic, social and health. There was an effort made from the very beginning to keep the community involved all the way along, and it has helped build a model that the community feels a connection with as one interviewee explained. Keeping the community connected gives them access to resources that may not be available to them. An example provided by an interviewee is when they were deciding to become a nonprofit organization and considering whether to become a charitable organization, a lawyer in Whistler offered their services pro bono. This was a key moment as the lawyer gave advice and guidance on how to become an independent charitable organization without ties to a healthcare foundation or government funding, which is one of the unique factors of Whistler 360 Health. The charitable status makes it easier for the community and municipal government to provide support, donate land, goods, and services, fund capital costs for the current clinic, and raise funds for a new building. Additionally, the connection with the community has made the fundraising easier, according to another interview participant. They described it as “We never have to talk about Whistler 360 Health because it seems like we are never talking to someone in town who has not heard of it. This makes it easier from a fundraising perspective and people willing to donate their services”. Once the model was decided and the nonprofit charity was created, the engagement with the community made it easy to recruit the board of directors. The board consists of volunteers from the community with strong and diverse skill sets. “The depth of knowledge and skills that exist in the community and those people coming forward to help has been such an asset,” one interviewee explained. The board is

described as committed and supportive by interviewees, an indication of the collaborative nature of the relationship.

> We have a really hard-working board, have the right people there, a physician for the medical side, someone experienced in community outreach and connection, and an expert in fundraising. As well as representatives from partner organizations in the community. We also have someone who understands business, who could examine the existing business structure and help navigate transitioning to a nonprofit.

Along the way, the task group and, later, the board of directors kept the community and the clinic's physicians, nurse practitioners, and medical office staff involved. The key features of the model are constant communication, building trust, creating a collaborative culture, and ensuring everyone feels involved in building and developing Whistler 360 Health. Several interviewees spoke of feeling invested in Whistler 360 Health and its success because they were part of it from the beginning, and because of the community engagement, they felt like they were part of something bigger happening in the community than just a different business model for a physician's office. “With this model, we are responsible to the community, we are connected to them, and we strive to do our best,” one interviewee explained.

Q2. What implementation strategies have contributed to the success, and what core principles make this a successful model?

Interview participants identified four main strengths of the Whistler 360 Health implementation: strong community engagement and involvement, organizational support, communication, and collaborative culture. Below is a description of each.

Strong Community Engagement and Involvement

In January 2019, a wide range of community members, organizations, businesses, government, and health authorities were invited to participate in a discussion about primary care. From this engagement event, a group of community volunteers formed a task group to review the data gathered from the session on identified community needs and to investigate possible solutions to the doctor shortage in Whistler. As a result of this meeting, Whistler 360 Health was born. As

evaluation participants state, this community engagement thread has been a strength of Whistler 360 Health since its beginning. Once the model was decided upon and Whistler 360 Health formed, the community continued engaging through volunteer opportunities on committees and participation on the Board. Additionally, the broader community continues to be actively engaged through their involvement with local media, contributing to the website and newsletter.

As a result of significant community involvement, several interview participants felt that the issue of primary care in the community had been strengthened, leading to greater advocacy and stronger partnerships with the Health Authority and the Municipal Government. As one of the participants explained, “Keeping everyone engaged as it went has been really helpful…Vancouver Coastal Health Authority and the Municipality continue to work with us…it feels like a real partnership…and the community gave us a stronger voice.”

The continued involvement of community volunteers has also led to successful fundraising to support purchases of new equipment, conduct renovations, and renew the building lease. In all its activities to date, from the initial forum, developing ongoing engagement opportunities, and communicating with the community, Whistler 360 Health has enhanced awareness of the primary care crisis and involved people who have not typically been involved in supporting health care system change. An interview participant described it as “a buzz in town about Whistler 360 Health [where] the shift in the conversation around primary care feels positive, where it felt desperate before.” Another participant shared, “The amount of capital we have in the community surprised me, with community members not involved in health care wanting to volunteer and help.” The awareness and involvement of the community has also changed from community members complaining about there being no doctors in town to people sharing how to get involved or how to get on a waitlist. As one of the interview participants said, “Everyone in the community is so supportive. Before, you would see people online complaining…saying there were no doctors…to people helping each other get on the waitlist and rallying around us.”

Whistler 360 Health is a nonprofit charitable organization run by community volunteers. The organization aims to meet the community's primary care needs and overall health. Providers, clinic staff, and board members feel that decisions are made based on their accountability to the community rather than the typical primary care clinic's focus on business goals. This shift is significant, as it signals a shift from focusing on meeting the clinic's immediate needs to being

more patient-focused and meeting the needs of the community's well-being. One interviewee explained, “We can focus on taking care of the patients and not have to worry about the business side of things as well.” Another interviewee stated, “People are not focused on making a profit; they are focused on the patients and the community”. This core philosophy, identified during the initial engagement event, has been key to Whistler 360 Health’s initial success. As participants have stated, Whistler 360 Health's focus on community accountability marks a significant departure from traditional clinic models, reflecting its commitment to prioritizing patient needs and community well-being.

Strong Organizational Support

Transitioning from a Business Model to a Nonprofit Society Model

During the initial community engagement process, participants noted that physicians faced ongoing challenges in running a successful and profitable business. The current business model was viewed as no longer viable, as it caused stress and physician burnout, ultimately leading to physicians leaving their practice. It was also noted that physicians and nurse practitioners at the clinic spent significant time on administrative tasks, taking them away from patient care. In response, Whistler 360 Health implemented a different system with human resources support and opportunities for staff development, giving the clinic staff more time to focus on patient needs. As one of the providers put it, “I felt like I was doing fast-food medicine by running a business. But with [Whistler 360 Health] handling much of that operational work, I can now reconnect with my patients and provide them with the care they deserve."

Another interviewee stated, "Before Whistler 360 [Health], I liked taking care of my patients, but I did not like my job. Now I love my job again. We have a deeper connected practice.” Another participant noted, “This has not only brought the joy back into my practice, but I feel proud of what I do. I love going to work.”

Leadership and Management Skills

All interview participants highlighted the value of a knowledgeable and experienced Executive Director (ED), underlining the importance of strong leadership. In its initial implementation, leveraging the strengths of the ED has greatly assisted Whistler 360 Health in setting clear goals and timelines. While the initial focus was fundraising, the attention has since shifted to setting up

the structures needed to take over the medical clinic. According to interviewees, having dedicated leadership has helped to ensure that they stayed on track throughout the process and helped them avoid getting sidetracked by other priorities. In short, strong leadership enabled the clinic and board to focus on their work and helped them establish clear goals and priorities. As one of the providers described, "The leadership has brought stability and support to our administrative staff at the clinic. Before, they were dealing with six different businesses, and now, they can focus on the clinic running smoothly, with the society running the business."

The Importance of Continuous Communication for Enabling Change

Effective communication strategies helped ensure that the volunteers/board members and the clinic team received the same information throughout the planning and implementation process. While the task group initially directed communication toward informing and updating the Board, they soon realized they also needed to communicate with the clinic team. Interview participants stated that over-communicating was necessary, even when there was nothing specific to share. As one of the participants noted:

> We are over communicating with people…through the whole process and continue to do so… making sure everyone knows everything that is going on. We use a weekly email, not just waiting until a monthly meeting, even if there is nothing to put in the email, we send it… this builds trust.

Over communication helped staff and providers feel supported throughout the transition period, with several interview participants noting that being informed throughout the process made the change feel "minimal and manageable." Communication and slow implementation were also thought to contribute to an increase in capacity for change, even for those seen as initially resistant to change. As one provider described, "The change felt smooth and felt good. It has been very thoughtful." As one of the interview participants concluded, "We have never been so communicative and engaged as a team."

Change Management Strategies for Creating a New Collaborative Culture

When Whistler 360 Health first assumed operations of the Whistler Medical Clinic, the team of providers worked with a coaching program to help establish common values, ultimately leading

to the creation of a team charter. While the providers were initially reluctant to participate in the team charter exercise, they all later agreed that it was one of the strengths of their approach. As one of the interviewees explained:

> The time spent developing the team charter gave people space to reflect on key questions that reflected on why we were doing this. What makes you happy at work? What do you not want to lose? What do you want to change? What is your dream scenario?

This exercise also had unexpected benefits as it led to the addition of new providers at the clinic and helped the team navigate communication and conflict challenges that arose during a time of rapid growth. One interview participant stated, "I underestimated how important the team charter was and how often we would use it.". Another participant described the importance of working with the coaching program to make sure the clinic and board were on the same page from the beginning. "I think some people maybe thought it was not really needed to begin with…but the team might have encountered more challenges and had difficulty addressing them if we did not do this at the beginning".

Q. 3 What types of challenges have been encountered to date? How have they been addressed?

As with any project involving multiple partnerships and a system change, Whistler 360 Health experienced several challenges. According to interview participants, challenges included the diversity of perspectives on timelines and priorities and the Health Authority's inability to respond quickly to needs as they arose. While community and volunteer engagement was identified as a strength, it was also noted as a challenge because volunteers did not always share the same initial priorities as the core volunteers working on implementation. Rapid expansion and the addition of new staff were also considered challenging. Additionally, Whistler 360 Health has several goals that have not been met that interview participants felt would be further along in development. While all of these were identified as important, the two main ones mentioned by several interviewees are team-based care and a data-informed approach.

Timelines and Partner Priorities

The Division of Family Practice, the member organization of physicians in the region, faced a challenge in maintaining equitable support for all the Sea to Sky region providers, especially in Whistler, where a small private practice had recently opened. Whistler 360 Health, while waiting for its partners to complete their strategic plans, focused on establishing a strong organizational structure so that it could be ready to move forward when its partners were ready with the next phase of Whistler 360 Health: pursuing a core location for all healthcare services in the community. Several interview participants noted that Whistler 360 Health was able to be responsive due to its structure. However, they often had to wait for their partners, such as the Health Authority and Municipality, to go through their official planning processes, who also needed to incorporate other priorities into their planning processes and address the community's primary care needs.

Rapid Growth

Since January 2023, the administrative staff at the Whistler Medical Clinic has experienced pressure to manage the clinic's needs efficiently and maintain the agreed-upon culture outlined in its charter. According to interview participants, the addition of new staff has caused some interpersonal tension with people not using established communication methods, having side conversations, and not communicating in a way that aligns with the clinic's values. The team charter was used to approach discussions about positive communication and team culture to resolve the issue. As one of the interview participants explained, "Reflecting back, having [the team charter] to reflect on and discuss clinic culture and how people treat each other has been key." The addition of new providers has also meant a lack of space, leading to changes in workflow for the providers who have been at the clinic for a long time and requiring new ways to utilize the existing space.

Community Involvement and Volunteer Management

Whistler 360 Health has successfully engaged the community and its volunteers. Managing a large number of volunteers, however, requires ongoing volunteer support, including a volunteer engagement and management plan. New volunteers have also added stress to the original group of volunteers, sidetracking them or taking them in the wrong direction. As one interview

participant explained, “A lot of people want to be involved, but sometimes it takes us in the wrong direction because they do not have the same understanding of our vision.”

Through the initial community engagement sessions, the community identified multiple needs, including health care, transportation, food security and housing. With such a diversity of perspectives, participants found it challenging to balance meeting the community's needs while staying focused on the priority of Whistler 360 Health, primary care. As one interview participant explained: “We can’t try and fix the housing situation, that’s completely separate…it’s important, but we’ll get distracted…other organizations focus on housing we don’t need to as well.”

Governance and Autonomy

Despite the numerous benefits of the new working model, it has required some adjustments from the providers. While the administrative demands of running a clinic were taking a toll on physicians, the decision to transition to Whistler 360 Health to manage the clinic has been deemed successful. However, the transition to this new practice has caused some discomfort among the providers as they began working on the model. The change in governance has shifted decision-making from individual priorities to the broader priorities of patients/community and the clinic as a whole. As one of the interview participants described:

> Sometimes, I feel like I did lose autonomy. Decisions are made, and we are not consulted, but ultimately, it is society’s decision, not the clinics. The reality is that it is just change. The decisions are based on the good of the community, the patients, and the whole clinic.

With the private business model used prior to Whistler 360 Health, one interviewee perceived that all people’s perspectives were heard in the decision-making process as decisions were made at clinic meetings, and now decisions are made at the board. Now that there is a board structure with one position representing the clinic, some providers feel that their perspectives may get lost in the larger structure of Whistler 360 Health. As one interview participant explained, “Who represents all of the providers’ interests at the board? I am unsure how policy is developed and if both physician and nurse practitioner voices are heard”.

Goals that Remain "In Progress"

These include planning documents (e.g., work plan, strategic plan and interviews) that are still seen as priorities but still need to be achieved.

Data Informed Approach

One of the goals is to incorporate ongoing quality improvement, using data from both the community and the clinic, to create a data-informed approach to Whistler 360 Health. The team has faced challenges in identifying a starting point and determining the best approach to incorporate the clinic community's and clinic's goals. Furthermore, the clinic's decision to change its electronic medical record system has put the question of what data to start with on hold. Interview participants felt "rudderless" due to a lack of training in setting up a data-informed approach for a medical clinic and society, with difficulties translating data from the clinic to the community.

Wellness Collaborative

Although the vision of Whistler 360 Health is to develop a collaborative to address social determinants of health within the community, it is a goal that has yet to be achieved. The focus on creating a strong foundation for the non-profit, clinic operations, fundraising efforts, and rapid clinic expansion has delayed the integration of community services. Initially, people were feeling overwhelmed with where to start, learning about non-profit models, and endeavouring to meet community needs while assuming the operations of the medical clinic. Although interviewees appreciated the community's integration by understanding the needs and connecting the community through a wellness network, they felt that the information was very broad. They needed to figure out what to do with the information and how to get started.

Team-Based Care

The goal of becoming a team-based care model is part of Whistler 360 Health's vision. Most interviewees noted this as an area they want to focus on next, as they felt that they were behind in implementing this aspect of the clinic. However, multiple challenges were identified by

interviewees to enable moving to a team-based model, including funding for additional providers and workspace.

Support Learning/Learners

The strategic plan identifies Whistler 360 Health's aim to foster ongoing learning for existing staff and support learners by providing opportunities for engagement and learning. Whistler 360 Health desires to become a learning center that supports healthcare professionals in learning and developing best practices in medical care, supports ongoing learning for the team and uses it as a catalyst to support recruitment and retention in the future.

Environmental Sustainability

Whistler 360 Health aims to implement environmentally sustainable practices to reflect that a healthy environment underpins healthy people and communities. The board has started reviewing other initiatives in Canada, such as toolkits from the Canadian Association of Physicians for the Environment, to identify actions that they can implement. At the time of this evaluation, they implemented one action, which was to reduce the exam table paper. An interviewee identified this as a key area to focus on next, and the goal is still in the early stages of implementation.

Q.4. What factors might influence the sustainability of Whistler 360 Health?

The majority of interviewees believe that the Whistler 360 Health model is strong enough and well-planned and, as such, will be inherently sustainable. Concerns about sustainability revolve around the loss of highly skilled volunteers, ongoing funding, and the recruitment of future healthcare professionals. Some interview participants also expressed concern about potentially losing the current volunteer Director, worrying that this person would be hard to replace. Others noted the strength of the Board members. As one interviewee explained, “The resources stay in the community even if a provider leaves, and people want to support the society providing primary care, not necessarily private physician businesses, so the interest to continue to support a model that is already proving successful will continue.” Another interviewee worried that the current level of donor support, both financial and in-kind, might not be sustained once the initial buzz of Whistler 360 Health has died down. Others noted the need to consider the level of donor support and fundraising needed in a financial climate of continually rising costs, especially given

that the cost of running a business in Whistler significantly contributed to the previous clinics closing. Others noted that ongoing recruitment poses a challenge, as the cost of living in Whistler directly affects the recruitment of healthcare professionals, including physicians and nurse practitioners. Another was concerned with rising expectations and the possibility of mistakes, potentially challenging the healthcare that could be delivered. Overall, while there were some concerns noted about the sustainability of this approach to top healthcare for Whistler, interview participants remained positive that their approach would prove successful and, hence, ultimately sustainable.

Unintended Outcomes

New Payment Model for Physicians

In every interview, the new payment model in BC was mentioned, even though it was not an initiative of Whistler 360 Health. Participants identified the previous fee-for-service model as unsustainable and saw it as a barrier in the community engagement event. BC launched the new longitudinal family physician (LFP) payment model in February 2023, just one month after Whistler 360 Health assumed the medical clinic operations. The LFP is a significant departure from BC's dominant fee-for-service payment system. It is a blended model that compensates physicians for time spent both interacting with patients and indirect patient care (administration, charting, billing, etc.), as well as an adjusted payment for the complexity of a physician's patients. The physicians not having to operate the business side of the clinic and the timing of the new payment model are viewed as key success factors in recruiting new providers in a short time. Additionally, several interviewed providers described the LFP as lifting a huge burden and making a significant difference in their practice and lives. As one interviewee said, "The system shift and the LFP have made a huge difference in my life." Another interviewee stated, "The combination of Whistler 360 and LFP has brought the joy and pride back to my work. I feel valued again."

Effects on the Local Emergency Room

Emergency Room data within the first few months showed a reduction in inappropriate visits, which could have been addressed through primary care (von der Porten, F. 2022). The emergency room physicians felt that the reduction directly correlated with Whistler 360 Health

assuming medical clinic operations. As the documents shared indicate, there is a correlation, and extenuating circumstances could also contribute to decline (von der Porten, F. 2022). One of the interviewees shared, “Whistler 360 has driven down emergency visits and made the Emergency Room less chaotic.” Since the launch of Whistler 360 Health and the growth in providers, the staff has been able to support patients in finding a primary care provider and ensuring they receive a timely follow-up to their visit to the Emergency. An interviewee explained the shift in the Emergency Room as “the staff are happier, we are seeing fewer people per shift, and we can help people get follow-up. We think this is directly because of Whistler 360.” The reduction in emergency visits has had a direct effect on the staff and data collected by the Emergency Room; it is also a huge cost saving to the system. An interviewee shared that it is hoped that these savings can be redirected into continuing to strengthen care in the community (von der Porten, F, 2022).

6. Limitations

While comprehensive, this evaluation of Whistler 360 Health is not without limitations. First, the sample size of the interviewees only includes half of the primary care providers, half of the clinic's medical office staff, half of the board members and only one of the community partner organizations, which may limit the diversity of perspectives. Furthermore, the evaluation focused on assessing the initial implementation phase of Whistler 360 Health and may not capture longer-term outcomes or sustainability factors. Longitudinal and ongoing evaluation cycles are needed to track the program’s progress over time and determine its lasting impact on primary care delivery and community health outcomes. Despite these limitations, the evaluation provides valuable insights into the implementation process, initial impact and key considerations for the continued success of Whistler 360 Health.

7. Conclusions

In January 2023, Whistler 360 Health introduced a community-driven solution amidst a significant primary care crisis in the community. Despite some challenges, the initiative has achieved unexpected success, evident in its ability to recruit new primary care providers and attach 2500 patients in the first year (J. Read, personal communication, October 28, 2023). Key

factors contributing to this success include robust community engagement, strategic partnerships, a focus on collaborative culture and effective communication both within Whistler 360 Health, and with community partners. Moving forward, maintaining ongoing community engagement and fostering strong partnerships will be essential for sustained success. Additionally, strong leadership with business acumen is necessary for steering the implementation, ensuring realistic goal setting and adherence to the project scope. Despite other pressing community issues, such as affordable housing and cost of living, meaning, a focus on primary care remains paramount for Whistler 360 Health's continued success.

As a community-driven solution, Whistler 360 Health has given the community control over finding a solution distinctive to their circumstances and the provincial primary care crisis. With the community involved, the focus shifted from looking to the government, health authority and providers for a solution to finding it within the community resources and leaders.

In conclusion, Whistler 360 Health's community-driven approach has yielded unexpected success, leveraging social capital and broad community engagement beyond traditional healthcare sectors.

8. Recommendations

The findings and conclusions outlined above led to the emergence of the following recommendations based on the review of current documents, key themes from the interviews and input from Whistler 360 Health. The recommendations are put forward to support Whistler 360 Health in identifying focus areas in the next implementation phase.

Team-Based Care and Team Development

The participants who were interviewed prioritized implementing a team-based model and identified it as one of the key pillars of the Whistler 360 Health model. A team-based model integrates allied health and nurses into the care team. To fully integrate new team members into both clinic culture and day-to-day operations, the clinic can set the groundwork for transitioning to team-based care by 1) developing leadership opportunities within the clinic, 2) creating a process for onboarding, orientation, and team development, 3) providing professional development opportunities and plans for administrative clinic staff, and 4) ensuring that the

governance model includes collaboration and decision-making processes that represent all healthcare professionals.

Measurement and Ongoing Evaluation

Whistler 360 Health aims to use data for ongoing planning and improvement. Participants have identified the need to develop a framework incorporating ongoing measurement and evaluation to achieve this. Establishing a quarterly quality improvement committee to focus on evaluation measures aligned with community and clinic priorities will be key to embedding ongoing quality improvement. The committee could help develop areas for improvement, with an initial focus on access to services for priority populations like seniors, mental health, and children and youth.

Connected Health Services and Wellness Network

The priority focus to date has been stabilizing primary care by recruiting new primary care providers and taking over the operations of the medical clinic. With that established, Whistler 360 Health can begin to broaden its focus to implement the next phase of the vision: to connect health services and develop a wellness network and link with all healthcare services in the community, including the new private primary care clinic.

Volunteer Management and Ongoing Engagement Strategy

With the community's strong interest in Whistler 360 Health to volunteer and support the model, a structured engagement and volunteer management strategy, led by a dedicated position to continue to maintain momentum and offset the roles and responsibilities of core volunteers, is recommended. Additionally, ensuring that ongoing community engagement is inclusive and represents the community's diversity, including marginalized or underrepresented groups, will be important, as some interviewees identified this as a gap in the initial engagement. To support sustainability, Whistler 360 Health should continue to leverage the positive opinion of society to strengthen its brand and ensure it communicates the organization’s mission and initial impact effectively and broadly.

References

Aggarwal, M., Hutchison, B., Abdelhalim, R., & Baker, G. R. (2023). Building high-performing primary care systems: After a decade of policy change, is Canada "walking the talk?" *Milbank Quarterly*, 101(4), 925.

Alkin, M. &Vo, A. (2018). *Evaluation Essentials. From A to Z*. The Guildford Press.

Annie E. Casey Foundation. (2022). *Developing a Theory of Change: Practical Guidance*. https://www.aecf.org/resources/theory-of-change

Baker, R & Denis, J.L. (2011). *A comparative study of three transformative healthcare systems: lessons for Canada.* Canadian Health Services Research Foundation https://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/Baker-Denis-EN.pdf?sfvrsn=0

British Columbia Association of Community Health Centres. (2023). *Strengthening Foundations, 2022-2023 Annual Report*. https://bcachc.org/resources_post/2022-23-annual-report/

BC College of Family Physicians. (2022). *Family Doctors Care. The Role and Value of Family Physicians in BC*. https://bccfp.bc.ca/wp-content/uploads/2022/04/BCCFP_2022_PositionPaper.pdf

Bernard, H.R. (2002). *Research methods in anthropology: Qualitative and quantitative approaches.* 3rd Alta Mira Press.

Canadian Evaluation Society. (2023). https://evaluationcanada.ca/

Canadian Institute for Health Information. (2023). *Physicians*. https://www.cihi.ca/en/physicians

Canadian Medical Association. (2022). *National Physician Health Survey*. https://www.cma.ca/sites/default/files/2022-08/NPHS_final_report_EN.pdf

Card, A. J. (2018). Physician burnout: Resilience training is only part of the solution. *Annals of Family Medicine*, 16(3), 267–270. https://doi.org/10.1370/afm.2223

College of Family Physicians of Canada. (2004). Family medicine in Canada: Vision for the future. http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/FAMILY_MEDICINE_IN_CANADA_English.pdf.

Cousins, B. (1998). Framing participatory evaluation. *New Directions for Evaluation*., 80(114), 5–105. https://doi.org/info:doi/

Cresswell J.W, Plano Clark V.L. (2011). *Designing and conducting mixed method research.* 2nd Sage.

Doctors of BC. (2022). *Advocating Solutions to BC's Health Care Crisis*. https://www.doctorsofbc.ca/advocating-solutions-health-care-crisis#:~:text=BC's%20health%20care%20system%20is,pain%20while%20their%20conditions%20worsen

Doctors of BC. (2022). *The Future of Primary Care: Doctors of BC Member Engagement 2022 Member Feedback Report*. https://www.doctorsofbc.ca/sites/default/files/primary_care_engagement_2022_-_final_report.pdf

Fritz,B. (2015). The Origins of Publicly Funded Medical Care in BC and the BCMA's Contributions. *BCMJ*, 57 (7) 293–295. https://bcmj.org/

General Practice Services Committee (2020). https://gpscbc.ca/what-we-do/system-change/primary-care-networks

Ghali, W. A., Lemaire, J. B., & Wallace, J. E. (2008). Physician wellness: A missing quality indicator. *The Lancet*, 374(9702), 1714-1721. https://doi.org/10.1016/S0140-6736(09)61424-0

Government of British Columbia. (2023). *Healthlink BC Health Services*. https://www.healthlinkbc.ca/health-services/urgent-and-primary-care-centres

Government of British Columbia. (2023). *Longitudinal Family Physician Payment Model.* https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/longitudinal-family-physician-lfp-payment-model

Kneeshaw, D. (2023). One year after it was announced, new pay model for B.C. family physicians showing signs of success. *CFJC Today.* https://cfjctoday.com/2023/11/01/one-year-after-it-was-announced-new-pay-model-for-b-c-family-physicians-showing-signs-of-success/

Harris, M. (2016). *Evaluating Public and Community Health Programs*. John Wiley & Sons, Inc.

Hedden, L., Banihosseini, S., Strydom, N., & McCracken, R. (2021). Family physician perspectives on primary care reform priorities: a cross-sectional survey. *CMAJ Open*, 9(2), E466-E473. https://doi.org/10.9778/cmajo.number_1

Hutchison, B., Levesque, J.-F., Strumpf, E., & Coyle, N. (2011). Primary Health Care in Canada: Systems in Motion. *The Milbank Quarterly*, 89(2), 256-288. https://doi.org/10.1111/j.1468-0009.2011.00628.x

Kvale, S. (1996). *Interviews. An Introduction to Qualitative Research Interviewing*. Sage Publications

Kumar S. (2016). Burnout and Doctors: Prevalence, Prevention and Intervention. *Healthcare (Basel, Switzerland)*, *4*(3), 37. https://doi.org/10.3390/healthcare4030037

Lavergne, M. R., Moravac, C., Scott, I., McCracken, R. K., Hedden, L., Grudniewicz, A., & Marshall, E. G. (2023). *Canadian Family Physician*, 69(8), 524-526. https://www.cfp.ca/

Laycock, A., Bailie, J.& Matthews, V. *et al.* (2019). Using developmental evaluation to support knowledge translation: reflections from a large-scale quality improvement project in Indigenous primary healthcare. *Health Res Policy Sys* **17**, 70. https://doi.org/10.1186/s12961-019-0474-6

Longhurst, A. & Cohen, M. (2019). The importance of community health centres in BC's primary care reforms: What the research tells us. *Policy Note.* https://www.policynote.ca/chcs-in-bc/

Mattessich, P. (1997). *Community Building: What Makes it Work: A Review of Factors Influencing Successful Community Building*. Fieldstone Alliance.

McConnell Foundation. (2010). *A Practitioners' Guide to Developmental Evaluation. International Institute for Child Rights and Development.* https://www.mcconnellfoundation.ca/report/practitioners-guide-developmental-evaluation/

McMurchy, D. (2009). What are the critical attributes and benefits of a high-quality primary healthcare system*? Canadian Health Services Research Foundation= Foundation canadienne de la recherche sur les Services de santé*. https://policycommons.net/artifacts/1228350/what-are-the-critical-attributes-and-benefits-of-a-high-quality-primary-healthcare-system/1781421/

McKay, M., Lavergne, M. R., Lea, A. P., Le, M., Grudniewicz, A., Blackie, D., Goldsmith, L. J., Marshall, E. G., Mathews, M., McCracken, R., McGrail, K., Wong, S., & Rudoler, D. (2022). Government policies targeting primary care physician practice from 1998-2018 in three Canadian provinces: A jurisdictional scan. *Health policy (Amsterdam, Netherlands)*, *126*(6), 565–575. https://doi.org/10.1016/j.healthpol.2022.03.006

McMaster University (2020). Rapid Synthesis: Identifying the Features and Impacts of Community Health Centres 30-day response. McMaster Health Forum. https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/identifying-the-features-and-impacts-of-community-health-centres.pdf?sfvrsn=234559d5_3

Mertens, D. & Wilson, A. (2019). *Program evaluation theory and practice: A comprehensive guide* (2nd ed.). The Guildford Press.

Ministry of Health. (2015). Primary *and Community Care Policy Paper*. https://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf

Ministry of Health. (2019). *A picture of health. Government of BC*. https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/a-picture-of-health

Ministry of Health. (2023). *Medical Services Commission Payment Schedule.* https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msc_payment_schedule_oct_31_2023.pdf

Mitra, G., Grudniewicz, A., Lavergne, M. R., Fernandez, R., & Scott, I. (2021). Alternative payment models: A path forward. *Canadian Family Physician*, 67(11), 805-807. https://doi.org/10.46747/cfp.6711805

Naccarella, L., Southern, D., Furler, J., Scott, A., Prosser, L., Young, D., Swerissen, H. & Waters, E. (2008). Primary care funding and organizational policy options and implications: a narrative review of evidence from five comparator countries. *Medical Journal of Australia*, 188: S73-S76. https://doi.org/10.5694/j.1326-5377.2008.tb01750.x

Nagel, D. A., Keeping-Burke, L., Pyrke, R. J. L., Pyrke, C. L. B., Goudreau, A., Luke, A., Wilbur, K. A., Waycott, L., & Hamilton, C. (2019). Frameworks for evaluation of community health centers' services and outcomes: a scoping review protocol. *JBI database of systematic reviews and implementation reports*, *17*(4), 451–460. https://doi.org/10.11124/JBISRIR-2017-003843

Panagioti, M., Panagopoulou, E., & Bower, P. (2017). Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. *JAMA Internal Medicine*, 177(2), 195–205. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2588814

Patton MQ. (2002) *Qualitative research and evaluation methods.* 3rd Sage Publications.

Patton, M. (2011). *Developmental Evaluation. Applying Complexity Concepts to Enhance Innovation and Use*. The Guildford Press.

Poth, C. Lamarche, M., Yapp, A., Sulla, E. & Chisamore, C. (2014). "Toward a Definition of Evaluation Within the Canadian Context: Who Knew This Would Be So Difficult?" .*Canadian Journal of Program Evaluation*, vol. 29, no. 3. https://doi.org/10.3138/cjpe.29.1.87

Reinholz, D.L., Andrews, T.C. Change theory and theory of change: what's the difference anyway? *IJ STEM Ed* **7**, 2 (2020). https://doi.org/10.1186/s40594-020-0202-3

Resort Municipality of Whistler (2019) *Community Monitoring Dashboard*. https://performance.whistler.ca/

Ruzycki, S. M., & Lemaire, J. B. (2018). Physician burnout. Canadian Medical Association Journal, 190(2), e53. https://doi.org/10.1503/cmaj.170827

Sea to Sky Division of Family Practice (2018). *Patient Medical Home Assessment Results*. General Practice Services Committee.

Starfield, B. (2006). State of the Art in Research on Equity in Health. *Journal of Health Politics, Policy and Law*, 31. 11–32.

Starfield, B. Shi, L. Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. *The Millbank Quarterly*, 83(3).

Whistler 360 Health Collaborative Society. (2020). Summary Documents from Community Forum.

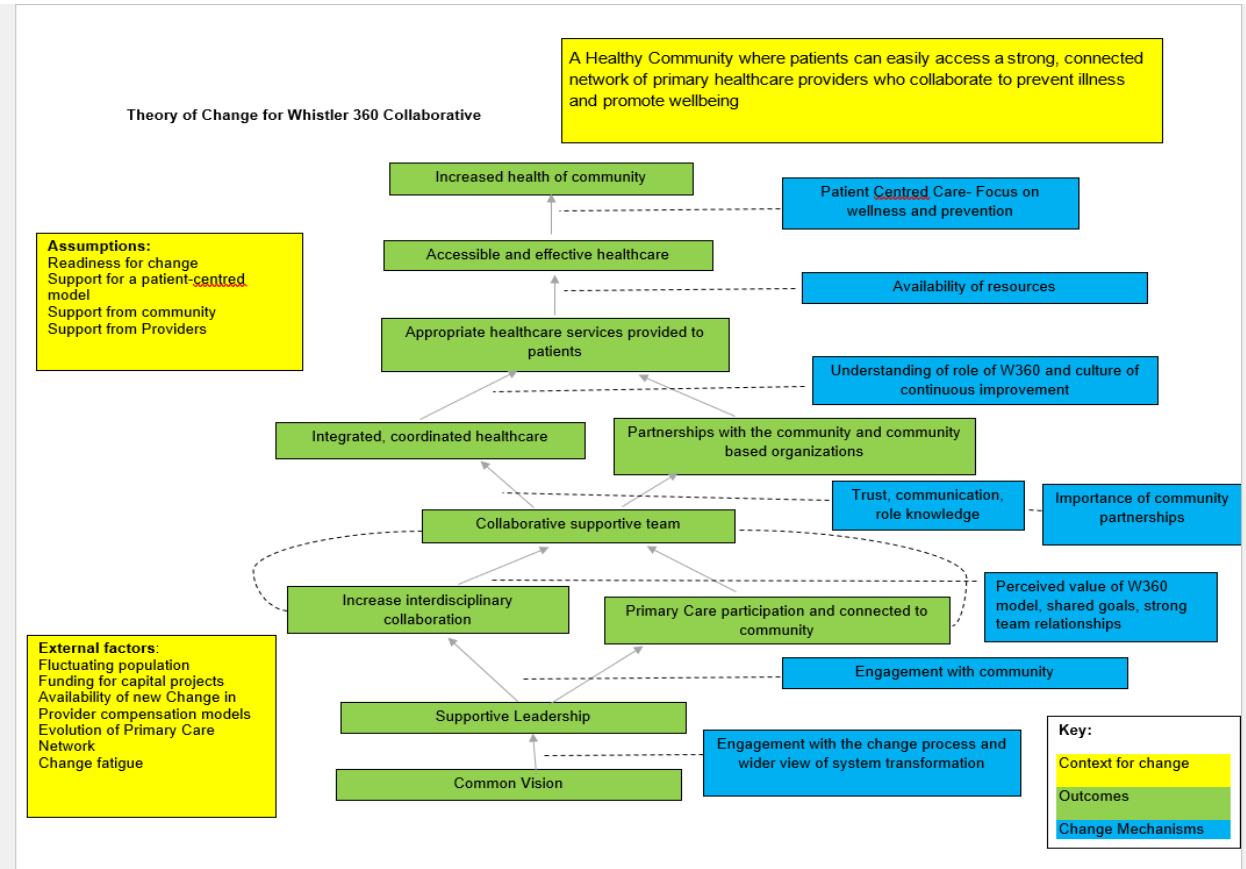
Whistler 360 Health Collaborative Society. (2023) https://www.whistler360health.org/

World Health Organization. (2023) *Integrated Health Services*. https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

von der Porten, F. (2022). The Primary Health Care Crisis in Whistler, the ED Perspective. PowerPoint Presentation at Whistler Community Forum, Whistler BC.

Yoon, J., Cordasco, K. M., Chow, A., & Rubenstein, L. V. (2015). The Relationship between Same-Day Access and Continuity in Primary Care and Emergency Department Visits. *PloS one*, *10*(9), e0135274. https://doi.org/10.1371/journal.pone.0135274

Appendix A. Theory of Change



Appendix B. Interview Questions

Each of the following questions will have follow up prompts, such as: why was this important, what difference did that make, can you give me an example.

1. Can you tell me your involvement in the development of Whistler 360 Health?
2. From your perspective, what are some of the strengths?
3. What have been some of the challenges? Can you provide examples?
4. What are some things that have surprised you so far?
5. What would like to devote more time to if you could?
6. How has Whistler 360 Health changed the way you practice (provider)
7. How would you describe the sustainability of the model? What concerns do you have?
8. Can you think of anything else to add?