Prepared for Doctors of BC

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Evaluation of The Facility Engagement Initiative 2.0

FINAL REPORT

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EXECUTIVE SUMMARY

BACKGROUND

Facility Engagement is an initiative of the Specialist Services Committee (SSC), one of four joint collaborative committees that represent a partnership of the Government of British Columbia (BC) and Doctors of BC. Launched in 2015, the province-wide **Facility Engagement Initiative (FEI) aims to strengthen communication, relationships, and collaboration between facility-based physicians and their health authorities (HAs)**. The goal is to increase meaningful physician consultation and involvement in HA decision-making and planning about their work environment and the delivery of patient care.

FEI activities are overseen and coordinated by MSA or Physician Society physician executives in conjunction with MSA or Physician Society working groups at acute facilities throughout the province. **There are currently 73 MSAs participating in the FEI with 6,506 MSA members across HAs.** In 2020-21, 531 engagement activities were carried out including meetings, quality improvement projects, training, and physician wellness activities. The cost to run the FEI was just over $19M in both 2019-20 and 2020-21.

EVALUATION OVERVIEW

The objectives of the evaluation are to **communicate the impacts of the FEI in relation to the expected outcomes of the program and to identify potential opportunities for improvement**.

A mixed-methods evaluation approach was utilized. Data sources included: administrative and financial data; an online survey with 1,001 MSA members and HA representatives; and 28 virtual interviews with a sample of physicians, HA representatives, Project Managers, Engagement Partners, and external stakeholders to gather stories on FEI activities.

KEY FINDINGS

1. BUILDING RELATIONSHIPS WITH HEALTH AUTHORITIES

- ✓ **The FEI supports foundational relationship building between MSAs and HAs** through its support of MSA governance structures and collaborative meetings, as well as funded projects.
- ✓ **MSA members and HA leaders report improvements in their facility-level relationships,** particularly those more familiar with the FEI.
- ✓ **The response to COVID-19 further supported relationship building between MSA members and HA leaders** through efficient collaboration on response planning and implementation, which was facilitated by the foundational structures and relationships previously established through the FEI.
- ✓ **There are opportunities to support relationships at a regional level** to enable broader communication, collaboration, strategic planning, and the scale and spread of FEI initiatives regionally.

2. ESTABLISHING A COLLECTIVE VOICE AMONG MEDICAL STAFF

- ✓ **Medical staff are being actively engaged in the work of the FEI,** including a 12% increase in MSAs and a 22% increase in MSA members participating in the FEI in 2021-20 compared to 2019-20.
- ✓ **MSAs are developing shared priorities and addressing issues of importance to them,** particularly MSA members more familiar with the FEI.
- ✓ **Almost half of medical staff and HA leaders report improved MSA influence on HA goals and priorities over the past year,** but there are opportunities to continue to enhance influence.
- ✓ **The response to COVID-19 further supported MSAs' influence on HA goals and priorities,** with medical staff participating alongside HA partners in more leadership roles with the support of the FEI.

3. SUPPORTING QUALITY CARE IN BRITISH COLUMBIA

- ✓ **FEI activities address dimensions of quality care,** either directly (e.g., quality improvement projects) or indirectly (e.g., FEI activities that improve work environment and morale, support wellness, and enhance relationships among medical staff).
- ✓ **The response to COVID-19 also addressed dimensions of quality care,** including FEI support for establishing COVID-19 wards within facilities and implementing testing and vaccine clinics.
- ✓ **There are opportunities to improve communications and monitoring for FEI activities** to ensure that stakeholders understand the objectives of the FEI and the impacts of funded activities.

KEY RECOMMENDATIONS

Recommendation 1: Continue focused effort of engaging medical staff and HA leaders in the FEI and building facility-level relationships between MSAs and HAs. Specific actions should include encouraging MSAs and HA leaders to implement FEI activities that involve collaborative strategic planning; providing clearer communications about the FEI to current participants as well as potential new participants; and encouraging MSAs to incorporate equity, diversity, and inclusion into their MSA structure and FEI activities.

Recommendation 2: Identify opportunities to encourage regional MSA and HA engagement activities. Specific actions should include encouraging MSA executives and regional HA leaders to identify and discuss possible regional activities using FEI funding, particularly through sharing regional best practices and lessons learned, and supporting collaboration between MSAs and HAs through regional knowledge sharing platforms and sessions.

Recommendation 3: Create a strong data collection strategy to better track and communicate the impacts of the FEI. Specific actions should include conducting targeted consultations with key stakeholders involved in data collection, including the provincial office, MSA members, MSA Project Managers, and Engagement Partners to collaboratively explore options for how data collection could be more strategic and effective while also efficient.

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ACRONYMS AND ABBREVIATIONS

DoBC	Doctors of BC
EAC	Evaluation Advisory Committee
EDI	Equity, Diversity, and Inclusion
EHR	Electronic Health Record
EPs	Engagement Partners (formerly Facility Engagement Liaisons)
FE	Facility Engagement
FEI	Facility Engagement Initiative
FELs	Facility Engagement Liaisons
FEMS	Facility Engagement Management System
FESC	Facility Engagement Services Company
FHA	Fraser Health Authority
HA	Health Authority
IAP2	Adapted International Association for Public Participation
IHA	Interior Health Authority
IOE	Internal Operating Expenses
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSA	Medical Staff Association
NHA	Northern Health Authority
PHSA	Provincial Health Services Authority
PPE	Personal Protective Equipment
SEAT	Site Engagement Activity Tracker
SRRP	Site Review and Reporting Process
SSC	Specialist Services Committee
SSC FEWG	Specialist Services Committee Facility Engagement Working Group
VCH	Vancouver Coastal Health
VIHA	Island Health Authority

1. EVALUATION OVERVIEW

1.1 OBJECTIVES AND SCOPE

This report presents the findings of the provincial evaluation of the Facility Engagement Initiative (FEI). Facility Engagement is an initiative of the Specialist Services Committee (SSC), one of four joint collaborative committees that represent a partnership of the Government of British Columbia (BC) and Doctors of BC. The objectives of the evaluation are to communicate the impacts of the FEI in relation to the expected outcomes of the program and to identify learnings and potential opportunities for improvement.

The evaluation covers the fiscal years 2019-20 and 2020-21 and explores the following key questions:

- To what extent has the FEI contributed to improved Medical Staff Associations (MSA) and Health Authority (HA) engagement?
- To what extent has the FEI contributed to enhancing MSAs collective voice in health system planning and decision-making?
- To what extent has the FEI enabled MSAs to impact the quality of patient care?

The scope of the evaluation was determined through consultations with the SSC Facility Engagement Working Group (SSC FEWG) and a review of the previous evaluation of the FEI.[1] This final evaluation report also incorporates findings and learnings from the interim evaluation report.[2]

1.2 METHODOLOGY

An evaluation matrix was developed to guide the evaluation and was reviewed by the Evaluation Advisory Committee (EAC), along with associated data collection methods. A simplified version of the evaluation matrix has been included in Appendix A.2, while the data collection methods are described below.

Administrative and Financial Data

A systematic analysis of the financial and administrative data related to the FEI was conducted. The specific data sources utilized for the evaluation are outlined in the table below.

Table 1: FEI Administrative and Financial Data

Type of Data	Description
Facility Engagement Management System (FEMS)	• A business management system used for managing, tracking, and reporting FEI activities and fund usage including sessional payments to practitioners
Site Engagement Activity Tracker (SEAT)	• An online database used to track FEI activities undertaken by MSAs and a knowledge sharing tool to share good ideas, learnings, and collaboration/alignment opportunities

[1] University of British Columbia. 2019. Facility Engagement Initiative: Final Evaluation Report, 2015-2019. https://live-facility-engagement.pantheonsite.io/sites/default/files/FEI%20UBC%202019%20Evaluation_Report__FINAL.pdf

[2] Ference & Company. 2021. Evaluation of the Facility Engagement Initiative 2.0: Interim Evaluation Report. https://live-facility-engagement.pantheonsite.io/sites/default/files/%28FINAL%29%20FEI%20Interim%20Evaluation%20Report%20-%20Feb%2012%202021.pdf

Site Review and Reporting Process (SRRP)	• An annual self-assessment check-in with MSAs, HAs, SSC FEWG to review progress made in support of the FEI outcomes
MSA document review	• A review of MSA documents was conducted to identify specific data points of interest for the evaluation (e.g., number of MSA meetings)
Engagement Partner (EP) data	• Data collected by EPs on specific data points of interest for the evaluation (e.g., number of standing invitations or meetings between MSAs and HAs)

Online Survey

An online province-wide survey of MSA members and HA representatives was conducted between July and August 2021. The survey was distributed to MSA members and HA contacts included in FEMS. In total, 1,001 participants completed the survey, including 746 (75%) medical staff and 255 (22%) HA leaders. The following table provides an overview of the participants' main roles.

Table 2: Characteristics of Province-Wide Survey Participants

Role		Physicians	Non-Physician Medical Staff*	Non-Medical Staff	Total (n)
Medical Staff		708	38	0	746
HA Leaders	Facility	162	3	15	180
	Regional**	56	2	9	67
	Both	6	0	2	8
Total (n)		**932**	**43**	**26**	**1,001**

**Includes midwives, nurse practitioners, and dentists*
***Includes sub-regional HA leaders*

A wide variety of medical staff and HA leaders participated in the survey from a range of HAs, facility sizes, and with varying familiarity with the FEI – a key strength of the survey in terms of representing a range of perspectives. In fact, MSAs and survey participants were encouraged to share the survey widely within their networks to reach colleagues not actively involved in MSA activities. As a result, 61% of participants indicated being familiar or very familiar with the program, while 40% of participants were somewhat familiar or less, and this was fairly consistent across groups (e.g., medical staff and HA leaders).

Telephone Interviews

Telephone interviews were conducted with a sample of physicians, HA representatives, MSA project managers, and EPs to gather stories on FEI activities. In total, 28 key informants participated in the development of stories. The following table provides an overview of the key informants' main roles.

Table 3: Characteristics of Key Informants

Role	Number of Key Informants (n)
Physicians	11
HA Representatives	7
EPs	5

Project Managers (e.g., for MSAs/Physician Societies)	3
External Stakeholders (e.g., consultant)	2
Total (n)	**28**

1.3 LIMITATIONS

The main limitation for this evaluation was the varying availability of data to examine FEI activities (e.g., many SEAT entries were incomplete or provided insufficient information). The FEI funds hundreds of activities ranging from regular engagement events such as standing meetings to quality improvement initiatives such as simulation training. It is therefore challenging to consistently track and monitor these varying activities at an appropriate level. To mitigate this issue, the evaluation used a variety of robust data collection methods to examine the FEI (e.g., province-wide survey) as well as samples of data to conduct a deeper analysis on the available information. However, it is worth noting that not all of the recorded activities during the 2019-20 and 2020-21 fiscal years could be assessed to determine if they were completed successfully and if so, their level of impact. Therefore, the evaluation provides a snapshot of the impacts of the FEI through stakeholder perceptions and examples of activities.

It is also worth noting that experiences vary greatly across the program (e.g., medical staff and HA leaders from different HAs and facility sizes will experience the program differently). While the evaluation represents the key themes resulting from the data collected, these higher-level themes may not be reflective of everyone's experience with the program.

2. DESCRIPTION OF THE FACILITY ENGAGEMENT INITIATIVE

2.1 OBJECTIVES

Meaningful physician engagement is essential to a health care organization's ability to deliver high-quality, cost-effective patient care, but there are ongoing challenges that limit the effective collaboration between BC physicians and health care administration.[3] The FEI was established through the 2014 Physician Master Agreement and officially launched in the fall of 2016 as a BC-wide initiative to strengthen communication, relationships, and collaboration between facility-based physicians and their HAs. The goal is to increase meaningful physician consultation and involvement in HA decision-making and planning about their work environment and the delivery of patient care.

In support of this objective, the FEI aims to achieve three key outcomes, which are described in Table 4 below.

Table 4: FEI Expected Outcomes

Objective	Description
Improved engagement within and amongst MSAs	• MSAs identify collective priorities through well-represented MSA working groups and effective outreach to the MSA membership • At regional, sub-regional or inter-regional levels, MSAs network, share information, and identify shared priorities through forums or meetings
Improved MSA and HA engagement	• MSAs and HA partners build mutual understanding, share information, identify shared priorities and opportunities for engagement (e.g., consultation, collaboration) through local and regional meetings or forums
Enhanced MSA collective voice in health system planning and decision making	• Meaningful MSA consultation into regional and facility-level initiatives and processes that directly affect physicians' work environment and patient care • HA physician engagement strategies with transparent, timely feedback loops and clear points of contact between MSAs and HAs • Alignment between MSAs and existing HA structures (e.g., medical advisory committees)

For additional information regarding FEI objectives, please refer to the Logic Model in Appendix A.1.

2.2 FUNDED ACTIVITIES

FEI activities are overseen and coordinated by MSA or Physician Society physician executives in conjunction with MSA or Physician Society working groups at health care facilities throughout the province (i.e., health care facilities with acute care beds). For the purposes of this report and to support clarity, "MSAs" and "facilities" will be used as the primary terminology.

MSAs are made up of facility-based physicians and also non-physician groups (i.e., notably dentists, nurse practitioners, and midwives) who engage with HAs to collaboratively address health care system challenges and support quality patient care.[4,5] An MSA consists of elected officers (i.e., President, Vice President, and

[3] BC Medical Journal. 2019. Physician Engagement Gains Traction Across BC. https://bcmj.org/ssc/physician-engagement-gains-traction-across-bc

4 Doctors of BC. N.d. Medical Staff Associations. https://www.doctorsofbc.ca/collaboration/medical-staff-associations

5 MSAs and physician societies are the two entities eligible to receive FEI funds. Although somewhat distinct, the term MSA will be used throughout this report for simplicity.

Secretary treasurer) that represents the medical staff to advance the involvement and input of staff in all aspects of hospital life. In addition, MSAs also have a working group, which engages and advises MSA executives on matters of importance to medical staff, their patients, and the HA, as well as oversees FEI activities. There are currently 73 MSAs participating in the FEI with 6,506 MSA members across HAs (i.e., Fraser Health Authority, Interior Health Authority, Northern Health Authority, Provincial Health Services Authority, Vancouver Coastal Health Authority, and Vancouver Island Health Authority).

The intent of the FEI is to support the following types of activities:

- Opportunities for physicians and HA leaders to work together to share knowledge and make informed decisions that improve patient care, the physician experience, and the cost-effectiveness of the health care system;
- Opportunities and support for physicians who work at facilities to develop a meaningful voice and increase involvement in local activities that affect their work and patient care; and
- Funding to support activities that involve physicians in decision-making, to pay for their time in activities, and to hire experts to support them (e.g., a coordinator for administrative support, an MSA project manager to track issues, develop business cases and manage projects, a physician lead to support engagement activities, etc.).

The FEI has maintained flexibility for activities to be tailored to each facility to ensure alignment with and relevance to the needs of each facility, as well as the broader community. Eligible FEI activities are outlined in Table 5 below.

Table 5: Eligible FEI Activities

Activity Type	Description
MSA Governance/ Administration Costs	• Expenses incurred to establish an MSA to act as a representative voice for facility medical staff • Expenses incurred to establish an MSA working group to oversee FEI-funded activities, help identify and prioritize issues of importance for the medical staff, and advance a short-list of priorities to the leadership of the HA through existing avenues such as the Medical Advisory Committee or any other forum dedicated to addressing issues in a facility
Sessional costs	• Compensation of physicians for their time to participate in internal meetings and in meetings with HA/facility representatives in relation to the FEI • Compensation of a physician lead to spearhead engagement initiatives as well as for physicians to participate in activities associated with the initiatives
Consultation Fees	• A capital build project (e.g., construction of a physician lounge, new clinical space, etc.) may need to have physician input on the development of new facilities or the re-design of existing buildings. Funding could support physicians to participate in a consultation process.
Quality Improvement Initiatives	• Physicians may use funding to help support new quality improvement initiatives within their facility (e.g., pilot project to improve local access to maternity care, initiatives to improve clinical management of recurrent ER patients, etc.)
Cross-Departmental Initiatives	• The leadership of a HA or MSA may seek to solve a problem that spans a number of departments (e.g., workplace safety initiatives, facility-based infectious disease prevention strategies, etc.). The issue can be discussed by the MSA for input or advice.
Wellness Activities	• Funds can be used to support activities that address work environment and organizational risks for increasing physician burnout (e.g., reducing administrative burdens on physicians; improving workflows; improving collegiality among and within workgroups such as improving teamwork, communication, and conflict management).
Other	• Other costs contributing to the objectives of the MoU, including for activities related to electronic health record (EHR) training.

Annual funding may not be used for certain activities such as advertising (with the exception of physician recruitment ads), compensation for clinical services, purchase of real estate and vehicles, purchase of clinical equipment, donations to charities or political parties, and meeting attendance that is presently required as part of maintaining privileges. Other ineligible activities are outlined in the FEI Funding Guidelines.[6]

To receive funding, MSAs must have a governance and a decision-making structure (i.e., working group) that will represent the doctors at the facility, the ability to receive, account for, and report on expenditures, and general agreement to proceed with HA representatives at the start of the process. Further, to support the MSAs in establishing themselves as representative structures and carrying out activities, the FEI provincial office provides tools and templates, including job descriptions, contracts, terms of reference, and a constitution and bylaws that can be customized by the facility. Additional administrative supports provided by the provincial office include financial management software (i.e., the Facility Engagement Management System, (FEMS)) for processing financial claims and, for smaller facilities with limited capacity, a third-party financial accounting entity (i.e., the Facility Engagement Services Company, (FESC)) to reduce the administrative costs of the MSA.

Central staff resources are also made available for MSAs, including Engagement Partners (EPs)(formally known as Facility Engagement Liaisons) who support the capacity building and organizational development of MSAs and the relationship development between MSAs and HA partners. Finally, stakeholder consultation and programmatic assessment activities take place at the provincial level in the form of learning and evaluation initiatives (e.g., internal and external evaluations, and sharing best practices and lessons learned for continuous improvement).

2.3 STAKEHOLDERS

Participation in the FEI is open to all HA facilities with acute care beds, and specialists and family physicians with privileges inside BC facilities who are members of the medical staff. Non-physicians such as dentists, nurse practitioners, and midwives may also participate in FE activities such as through projects and working groups. Table 3 below describes the full scope of internal and external program stakeholders.

Table 6: Key FEI Stakeholders

Stakeholder	Description
Internal Stakeholders	
Medical Staff	BC health care providers, including those who engage with the FEI as well as those who do not, are affected by program processes and integral to the effectiveness of activities undertaken.
SSC	As a partnership of Doctors of BC and the BC Government, SSC oversees and monitors the FEI through its Facility Engagement Working Group. As such, they have a direct interest in the success of the program.
SSC FEWG	The SSC FEWG undertakes strategic planning and policy setting in alignment with the MoU and ensures ongoing communication between SSC and FEI key stakeholders. As such, they have a direct interest in the success of the program.
HAs	As part of their commitments to the MOU on Regional and Local Engagement, the HAs are interested in the overall effectiveness and identified impacts of the FEI.
External Stakeholders	

[6]Facility Engagement. 2020. Funding Guidelines. https://facilityengagement.ca/sites/default/files/SSC%20Facility%20Engagement%20Funding%20Guidelines_0.pdf

Patients in BC's Health Care Facilities	Patients in BC's health care facilities are the ultimate beneficiaries of the FEI as one of the key intended impacts of the initiative is to improve the quality of care provided.
Members of the Public	BC residents are directly affected by any identified improvements to population health resulting from the program, and taxpayers are interested to know whether funds allocated to the FEI are well spent.
BC Ministry of Health	The BC Ministry of Health provides funding for the FEI through the Physician Master Agreement and is therefore interested in the accountability of SSC for its stewardship of funding, as well as any impacts towards the Triple Aim.

2.4 GOVERNANCE

Provincial Governance

The broad parameters for the initiative were outlined in a Memorandum of Understanding (MoU) between the Ministry of Health, the six HAs, and Doctors of BC (dated April 1, 2014, and re-signed in 2019).[7] The MoU clearly outlines roles, responsibilities, and accountability mechanisms for these three parties. While the Ministry of Health is responsible for setting broad priorities for the delivery of BC's health care system, both the Ministry and the HAs are expected to be mutually accountable for clarifying and strengthening their relationship with physicians at provincial, regional, and local levels. Meanwhile, HAs and physicians are mutually accountable for the quality of their relationship, with the goal of providing high-quality health care services.

As a partnership of Doctors of BC and the BC Government, the SSC oversees the implementation of the FEI and is responsible for developing payment and other financial support mechanisms, in line with the Joint Clinical Committee Administration Agreement, to enable facility-based medical staff to participate in the engagement process. The SSC FEWG undertakes strategic planning and policy setting in alignment with the MoU and ensures ongoing communication between SSC and key stakeholders, such as the HAs and the BC Ministry of Health.

Facility-Level Governance

MSA executives have the fiduciary responsibilities for governing FEI funds and represent the issues and priorities of the medical staff as the elected officers of the MSA and work with their HA partners to co-develop solutions and provide input before decisions are made. The MSA working group represents the voices of physicians and advises MSA executives and HA partners (if they are part of the working group) on matters of importance to medical staff and their patients. The working group is responsible for reviewing and assessing FEI funding applications to ensure alignment with program guidelines and the strategic goals of the MSA. MSA project managers are available to support the application process and the execution of successfully funded initiatives. The working group, with support from the MSA project managers and the EPs, monitors the financial activities of all funded initiatives.

[7] Ministry of Health, Health Authorities, and Doctors of BC. 2019. Memorandum of Understanding. https://live-facility-engagement.pantheonsite.io/sites/default/files/Memorandum%20of%20Understanding_0.pdf

2.5 RESOURCES

Funding was allocated for the FEI in the 2014 Physician Master Agreement and again in 2019. Annual funding for facilities that participate in the FEI is based on the facility's number of acute care beds and generally ranges from $35,000 (for facilities with 0 to 7 acute care beds) to $500,000 (for facilities with greater than 301 acute care beds). With the exception of Tier 1 facilities, funding is provided in gates (i.e., installments), and the amounts are based on an as-needed basis determined by the actual spend rate on engagement activities during the year. Unspent funds that are already transferred at the beginning of the year can still be carried over, but annual funds that are not yet transferred by the end of the year are forfeited and used to support other FEI provincial initiatives.

Table 7 below outlines the funding tiers for the FEI.[8] In addition, facilities were eligible to access one-time start-up funding ($75,000 for Tiers 4 to 6 and $35,000 for Tiers 1 to 3).

Table 7: FEI Funding Tiers

Funding Tier	# of Acute Care Beds	# of Facilities	Available Full Funding Per Year
Tier 6	301+	15	$500,000*
Tier 5	151 - 300	10	$400,000
Tier 4	101 - 150	5	$300,000
Tier 3	51 - 100	7	$200,000
Tier 2	21 - 50	12	$150,000
Tier 1.3	14 - 20	8	$65,000
Tier 1.2	8 – 13	13	$50,000
Tier 1.1	0 – 7	10	$35,000

*One facility in Vancouver Coastal receives $850,000 per year

The cost to run the FEI was just over $19M in both 2019-20 and 2020-21. The majority of program costs were related to facility-level expenditures on engagement activities (i.e., sessional costs). In 2019-20, each participating provider received an average total of $1,143.67 in sessional payments. Other facility-level expenditures included administrative expenses to support MSA operations (i.e., internal operating expenses, consultants, miscellaneous office and communications expenses, and meals). A smaller proportion of expenses supported the provincial office to operate the FEI, such as staff salaries and benefits, outside help, and training and development. Table 8 below outlines program resources for 2019-20 and 2020-21.

Table 8: FEI Expenditures for 2019-20 and 2020-21

Expenditures	2019-20	2020-21
Facility Expenditures:	**$16,838,145**	**$16,702,444.29**
• Sessional (i.e., engagement)	$7,360,671.85	$9,386,107.89
• Operational (i.e., administration)	$9,477,472.84	$7,316,336.40
Operating Expenditures:	**$2,532,188**	**$2,529,642**
• Salaries	$1,752,551.00	$2,035,049.00
• Employee Benefits	$425,584.00	$461,230.00

[8] Additional funding was made available for facilities in 2020-21 including: 1) COVID-19 Funding through the Ministry of Health, 2) Rate adjustment payments through the Joint Collaborative Committee, and 3) Electronic Health Record funding provided for collaboration with the Health Authority.

• Outside Help	$117,312.00	$31,263.00
• Training and Development	$236,741.00	$2,100.00
Total Facility and Operating Expenditures	**$19,370,333**	**$19,232,086**

3. KEY FINDINGS

3.1 BUILDING RELATIONSHIPS WITH HEALTH AUTHORITIES

The FEI supports relationship building between MSAs and HAs.

Three key factors of the FEI enable relationship building between MSA members and facility-level HA partners:

1. **FEI structures:** MSA governance structures as well as project management and administrative supports enabled 6,506 busy medical staff to carry out 531 engagement activities in 2020-21.

2. **FEI processes:** 86% of MSA working groups extend a standing invitation to the HA to attend their meetings and/or created standing meetings between the MSA Executive and the local HA partners to discuss activities.

3. **FEI-funded projects:** The majority (63%) of funded projects involved HAs in some capacity through consultation (e.g., providing input on proposed solutions or strategies) or collaboration (e.g., working together to identify a preferred solution or strategy) with MSAs.[9]

Further, SRRP self-assessment data from 2020-21 indicate that most HAs are satisfied with the structures and processes in place to support communications (88%) as well as consultation and collaboration (87%) with MSAs.[10]

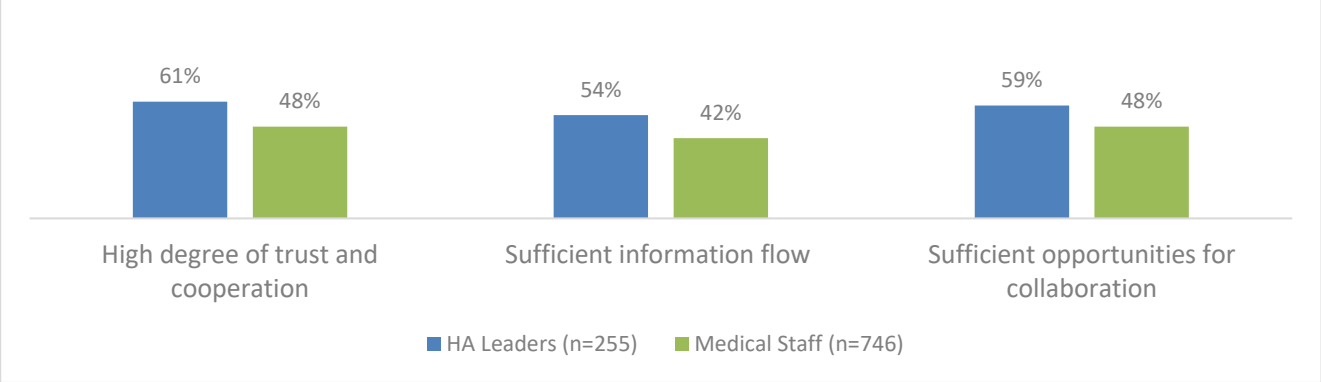
MSA members and HA leaders report improvements in their relationship.

Approximately half of HA leaders and medical staff report trust and cooperation, information flow, and collaboration between MSA members and the facility. HA leaders report slightly better relationships compared to medical staff (as illustrated in Figure 1 survey results). HA leaders and medical staff who work at smaller facilities (e.g., MSA Tier 1) also report slightly better relationships (not depicted in the graph).

[9] Adapted International Association for Public Participation (IAP2): A framework adapted by the FEI and used to assess the level and effectiveness of engagement happening between MSAs and HAs. Available at: Doctors of BC. 2019. Facility Engagement Initiative (FEI) – Planning and Evaluation Toolkit 2019.

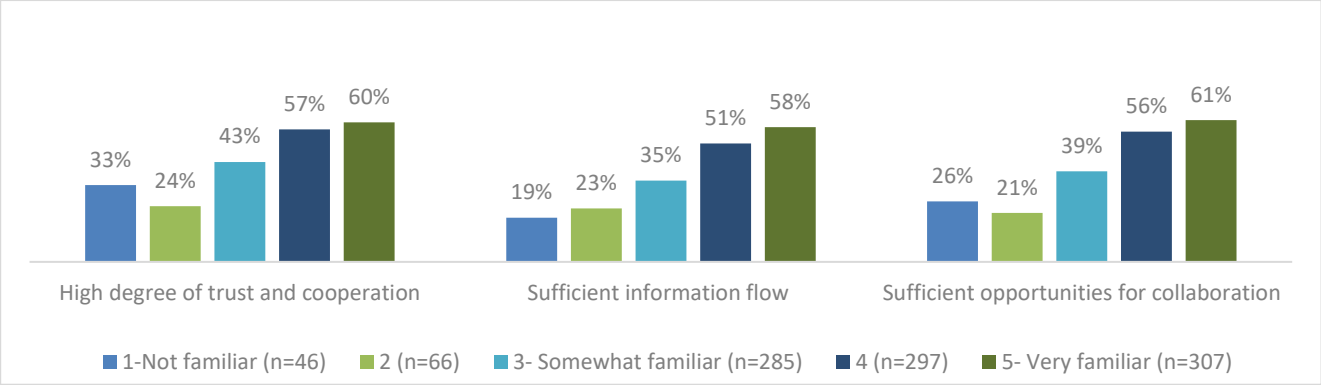
[10] Site Review and Reporting Process (SRRP): An annual self-assessment check-in with MSAs, HAs, and SSC FEWG to review progress made in support of the FEI outcomes.

Figure 1: HA leaders and medical staff who strongly agree or agree with statements about their facility-level relationships



Importantly, HA leaders and medical staff who are more familiar with the FEI (i.e., familiarity scores of 3, 4, or 5) perceive better relationships between MSA members and facility leaders (as illustrated in Figure 2 survey results).

Figure 2: HA leaders and medical staff who strongly agree or agree with statements about their facility-level relationships by familiarity with the FEI



Indeed, most MSAs (87%) and HA (86%) representatives report on their SRRP self-assessments forms that there is improved engagement between MSA members and facility HA staff compared to last year. These results suggest involvement in the FEI has a positive effect on relationships between MSAs and HAs.

The highlight box below provides examples of FEI-funded activities that took place in 2020-21 that demonstrate how the FEI is supporting improved relationships between MSAs and HAs, particularly through collaborative and strategic planning.

FEI Activity Highlight Box – Improving Relationships with HAs

Strategic Planning at St. Paul's – Providence Health Care

Providence Health Care's Physician and Surgeons Society (PASS) developed a strategic approach to FEI to align with the HA's integrated, collaboratively developed 7-year strategic plan ('Mission Forward') and ensure that physicians have a direct link to HA leaders and a meaningful voice in planning and decision-making. Central to the approach are four physician consultant positions that correspond with the four 'strategic pillars' identified in the HA's strategic plan: Quality, People, Learning, and Partnerships. Each physician consultant, referred to as the 'pillar lead', is supported by a Physician Advisory Committee with broad, cross-specialty medical staff representation and the relevant HA VP sponsor, with whom pillar leads meet on a regular basis. Pillar leads are tasked with engaging physicians, supporting two-way communication between physicians and HA leaders (including by attending meetings of HA senior leaders), and identifying and facilitating physician participation in relevant HA projects/initiatives. FEI provides governance, strategic, and operational support as well as sessional and activity/event funding (e.g., for virtual town halls, roadshows), while the HA provides in-kind project management support for pillar leads and their advisory committees. Having structures and support for regular, strategic engagement between HA leaders and physician representatives (i.e., the pillar leads) in shared organizational priority areas has supported relationship-building, improved two-way communication and transparency, and provided opportunities for physicians to have a meaningful voice in planning and decision-making. Both physician and HA leader participants credit the strategic, structured approach to engagement and buy-in among HA leaders as key contributors to success.

Revamping the Forensics Governance Structure - Provincial Health Services Authority

The Forensic Physician Engagement Society Board engaged an external governance consultant to help explore issues, identify shared areas of focus, and facilitate Collaboration committee meetings with PHSA leaders. Both groups share an interest in addressing strained relationships and lack of trust, which had previously resulted in Collaboration Committee meetings being paused. Meetings have since been restarted. Consultant expenses are split between the Physician Engagement Society, supported by FEI funding and the HA. Cost sharing and perceived openness to rethinking engagement have been appreciated by both groups, as has taking a deliberate step back and exploring ways to be more structured and strategic in the approach to communication and engagement (e.g., having meeting co-chairs, developing Terms of Reference). Both groups are optimistic about the direction of the new, supported approach but acknowledge that strengthening the relationship will require continued focus over a matter of years.

"I feel grateful for [the FEI]. I believe it is critical for furthering relationships, trust, effectiveness and efficiency." – Medical Staff (Physician), Island Health

"FE has greatly improved communication and collaboration between physicians and leaders, however, there is still a long way to go…The FE initiative is very valuable, has created much positive change, but is still greatly needed as there is much work still to be done." – Medical Staff (Physician), Interior Health

"…there has been a gradual shift to a greater sense of collective accountability and dedication. While some may think it is not enough, we need to remember that culture change takes time and a deeply imbedded highly dysfunctional culture will take time - but this [the FEI] is the most impressive attempt I have observed in a half-century of observation." – Medical Staff (Physician), Vancouver Coastal Health

Several medical staff and HA leaders also acknowledge in their open-ended survey responses that culture change and developing new ways of working takes time and effort and that the FEI is a promising forum to support improved relationships between MSAs and HAs. Some suggestions to continue to improve relationships between MSAs and HAs include providing greater clarity about the FEI (e.g., objectives of the FEI, FEI's contribution to system change, funding guidelines, best practices for engagement, etc.) as well as ensuring MSAs are inclusive for everyone (e.g., non-physician medical staff, consideration of equity, diversity, and inclusion, etc.).

The response to COVID-19 further supported relationship building between MSA members and HA leaders.

The response to COVID-19 is also consistently noted by MSA members and HA leaders in their open-ended survey responses as a strong example of improved engagement and relationships between medical staff and HA leaders. In total, there were 138 FEI-funded activities related to COVID-19 in 2020-21, with approximately 70% involving the HAs in some capacity through consultation (e.g., providing input on proposed solutions or strategies) or collaboration (e.g., working together to identify a preferred solution or strategy). Examples include collaborative strategic planning exercises such as physician group consultations with facility-level HA leaders, regular meetings with facility-level HA leadership and MSAs, and departmental planning with physicians and HA partners.

Most MSA members and HA leader participants identified through their open-ended surveys responses that FEI structures and processes enabled MSAs to mobilize quickly to respond to the COVID-19 pandemic and effectively share information, communicate openly, and collaborate on response planning and implementation with HAs. Medical staff participants also note the importance of sustaining positive engagement and relationship gains made with HA leadership during COVID-19.

"I think that HA leaders have become more aware of the roles that physicians perform and how they can be utilized to achieve common goals and improve patient care. I think that there has been far more communication and collaboration during and as a result of COVID." – Medical Staff (Physician), PHSA

"There was excellent collaboration between physicians and the health authority leaders with regards to COVID which continues until now." – HA Leader (Physician), Northern Health

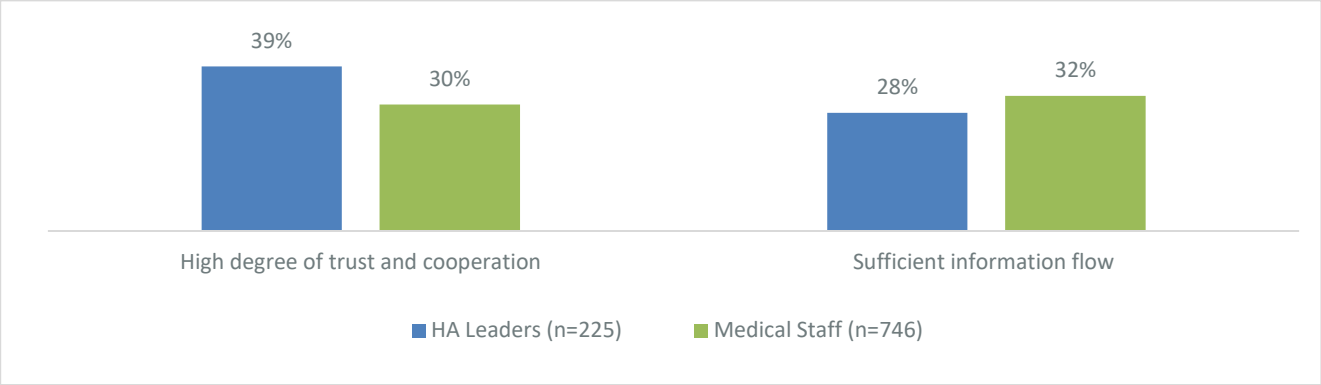
"There has been an incredible level of collaboration and information sharing which has not only strengthened relationships but showed us the opportunities that exist to work in a similar capacity in our post-pandemic era." – HA Leader (Non-Care Provider), Fraser Health

There are opportunities to support relationships at a regional level.

Compared to engagement between MSA members and facility leaders, medical staff and HA leaders report comparatively less agreement that there are effective relationships and engagement between MSA executives and regional HA leaders (as illustrated in Figure 3 survey results). Results were fairly consistent across different groups such as facility size, HA, and familiarity with the FEI (not depicted in the graph). This suggest there are

opportunities to build relationships at a regional level, in addition to continuing to improve facility-level relationships.

Figure 3: HA leaders and medical staff who strongly agree or agree with statements about relationships between MSA executives and leaders at regional levels



However, when asked if regional engagement and relationships improved over the past year, almost half of Island Health participants agreed that trust and cooperation (44%) and information flow (48%) between MSA executives and leaders at regional levels has improved. Other HAs did not report as high of an improvement (ranging from 17% to 35% for trust and cooperation and 17% to 25% for information flow).

The highlight box below provides an example of an FEI funded regional activity that took place in Island Health in 2020-21 that demonstrates how the FEI can support relationship building between MSA executives and leaders at regional levels. In fact, during the interim and final evaluation stages, there was common interest among stakeholders for greater regional engagement to enable broader communication, collaboration, strategic planning, and the scale and spread of FEI initiatives regionally.

FEI Activity Highlight Box – Building Regional Relationships

IHealth Regional Council – Island Health

Island Health is in the process of implementing Electronic Health Records (EHR) across the HA on a site-by-site basis. In response to negative physician experiences with the implementation of EHR at the first site eight years ago, MSAs and HA leaders are now taking a coordinated approach to communication and engagement around EHR roll-out at other sites. Specifically, HA leaders and physician representatives (1-2 per MSA) are jointly participating in the IHealth Regional Council, which has regular, virtual meetings to support open and consistent two-way information-sharing and dialogue among MSAs and HA leaders across the region. FEI provides sessional funding to cover the participation of physician council members as well as ongoing support from Engagement Partners and MSA Project Managers; Island Health funds the time of HA representatives. After the Council's first few meetings, stakeholders identified that it was already starting to create connections and unite voices across MSAs as well as allow MSA representatives to raise and amplify questions and concerns directly with HA leaders and receive follow-up, which MSA representatives can share back to their membership. Early challenges still being addressed include variable engagement/perceived utility among MSA representatives whose sites are not scheduled to receive EHR until later (less pressing) and differences in needs/context between smaller versus larger MSAs/sites.

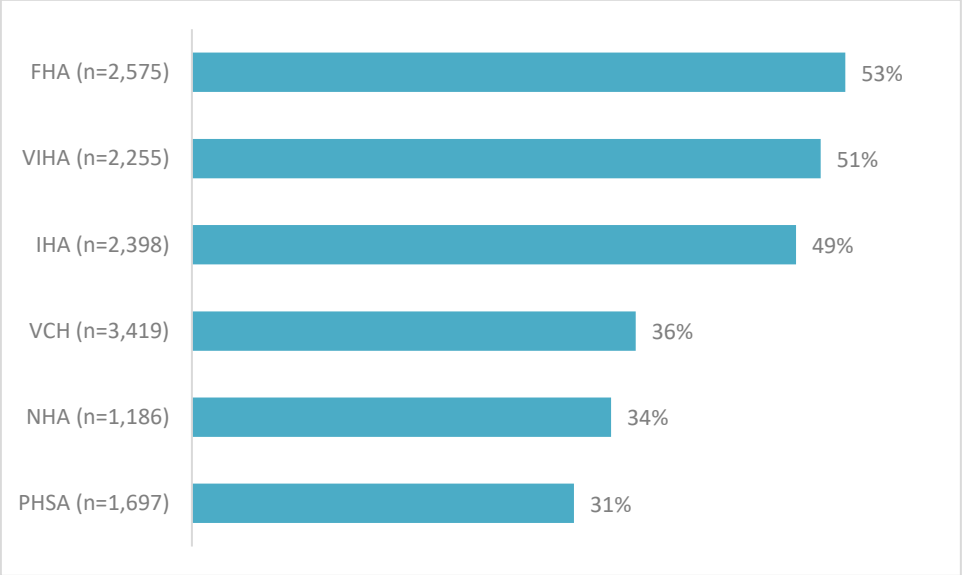
3.2 ESTABLISHING A COLLECTIVE VOICE AMONG MEDICAL STAFF

Medical staff are being actively engaged in the work of the FEI.

There are currently 73 MSAs participating in the FEI with 6,506 MSA members, a 12% increase in MSAs, and a 22% increase in membership compared to 2019-20. The largest number of MSA members are specialist physicians (n=3,403) and family physicians (n=2,457), but there is also participation from other non-physician medical staff such as midwives, nurse practitioners, and dentists as well as non-physician providers such as registered nurses and health science professionals (e.g., dietitian, radiologic technologists, researcher, etc.).[11]

On average, 43% of BC physicians with facility privileges[12] have participated or are currently participating in FEI activities such as quality improvement projects, training, physician wellness activities, as well as other engagement activities. Figure 4 provides a breakdown of physician participation in the FEI by HA. [13] This number suggests that while there is participation, there is also opportunity to increase uptake of the FEI.

Figure 4: Percentage of BC physicians with facility privileges who participate in the FEI by HA



Meetings are one of the primary ways in which medical staff are engaged in MSAs. In 2020-21, MSAs across all facilities met a total of 271 times, with an average of five meetings annually (ranging from zero to 13). Some facilities do not have standalone meetings but use other mechanisms, such as Annual General Meetings.

[11]FEI allows non-physicians to participate in activities. Some are medical staff members (e.g., non-physician medical staff such as midwives, nurse practitioners, and dentists), while others are not medical staff members (e.g., non-physician providers such as nurses and other allied health).

[12] Each HA provided the number of physicians with facility privileges in their HA, which included all privilege types (e.g., including active, provisional, associate, and consulting privileges). As such, some physicians with privileges across HAs may have been double counted.

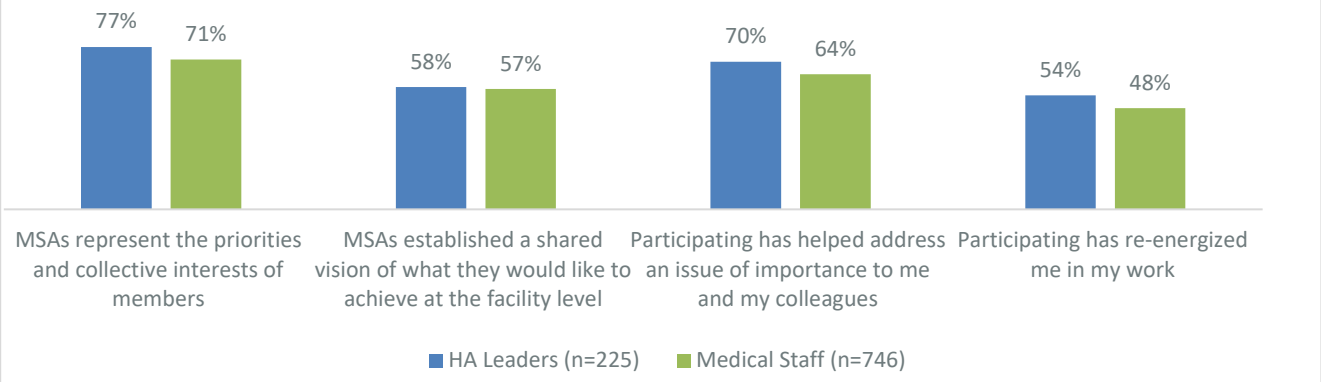
[13]There are five regional HAs in BC that deliver health services within their respective geographic regions (i.e., FHA, VIHA, IHA, and VCH). A sixth HA, PHSA, manages quality, coordination, accessibility and cost of certain province-wide health care programs and services (e.g., BC Cancer Agency, Cardiac Services BC, BC Centre for Disease Control and BC Transplant).

MSAs are developing shared priorities and addressing issues of importance to them.

Most HA leaders and medical staff agree that MSAs represent the priorities of their members and just over half believe MSAs have established a shared vision at the facility level. Further, most HA leaders and medical staff indicate that participating in the work of the MSAs helps to address issues of importance, and approximately half said it re-energizes their work (as illustrated in Figure 5 survey results).

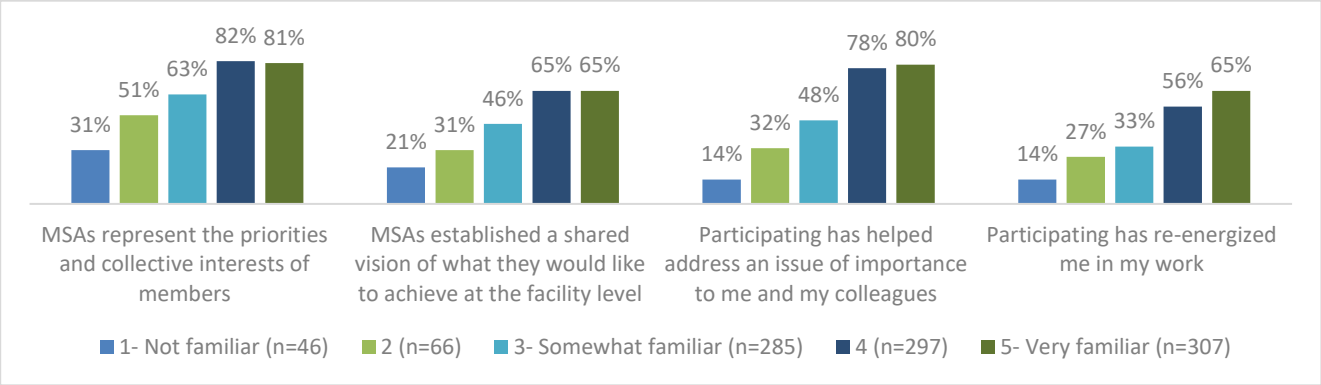
These findings were mostly consistent across the different groups such as facility size and HA. However, similar to findings on relationships between HAs and MSAs, smaller facilities (e.g., MSA Tier 1) had slightly higher agreement on these factors of collective voice compared to larger facilities (not depicted in the graph). This may be due to the nature of smaller facilities, where medical staff likely interact with the same medical staff and HA leaders on a regular basis due to the fewer number of people working in smaller facilities, leading to stronger relationships and collective voice.

Figure 5: HA leaders and medical staff who strongly agree or agree with statements about establishing a collective voice among MSA members



Importantly, HA leaders and medical staff who are more familiar with the FEI (e.g., familiarity ratings of 4 or 5) report greater agreement with factors of collective voice, particularly around MSAs representing their priorities and helping them to address issues of importance (as illustrated in Figure 6 survey results).

Figure 6: HA leaders and medical staff who strongly agree or agree with statements about establishing a collective voice among MSA members by familiarity with the FEI



In fact, a majority of FEI activities are considered to be conceptual in nature (87%),[14] where MSA members work together to establish and communicate ideas and beliefs consistent with intended changes.[15] These results suggest involvement in the FEI has a positive effect on establishing shared priorities and a collective voice among MSAs. Other activities were structural (12%), operational (6%), and relational (2%).

The highlight box below provides an example of an FEI funded activity that took place in 2020-21 that demonstrates how the FEI is supporting MSAs to establish a collective voice in a strategic manner.

FEI Activity Highlight Box – Establishing a Collective Voice

Strategic Planning at Vernon Jubilee Hospital - Interior Health

A sub-regional HA leader engaged an external consultant and approached Department Heads at Vernon Jubilee Hospital to see if they would be interested in developing a departmental strategic plan (1-5 year priorities) with support from the external consultant, local Facility Engagement, and the HA. Some departments had greater initial interest than others, but there has been continual uptake after initial positive experiences and word-of-mouth. All departments were offered support to participate. Once a department elects to participate, the consultant takes a phased approach to engage stakeholders to learn about context and generate buy-in, conduct a current state assessment through 1:1 interviews with every member of the department and a few trusted external voices (e.g., to learn about strengths, challenges, goals and priorities), summarize and share findings, and then facilitate a series of three meetings to support department members to iteratively develop a strategic plan based on their goals and priorities. Both FEI and health system redesign funding supported sessional funding and project costs, including consultant fees. While each plan belongs to the department, the goal is that the plans will ultimately be used widely to support communication, engagement, and collaboration around areas of shared priority across departments and with HA leaders – something that all stakeholder types expressed interest in and that some departments have started doing, with positive results. For instance, one Department Head found that reviewing their strategic plan with HA leaders at monthly meetings has supported the identification of contacts within the HA who could provide support around identified departmental goals.

"Interpersonal relationships with members of other hospital departments have improved, there's much greater collegiality." – Medical Staff (Physician), Vancouver Coastal Health

"I appreciate events put on by FEI to promote relationships and camaraderie between physicians." – Medical Staff (Physician), Fraser Health

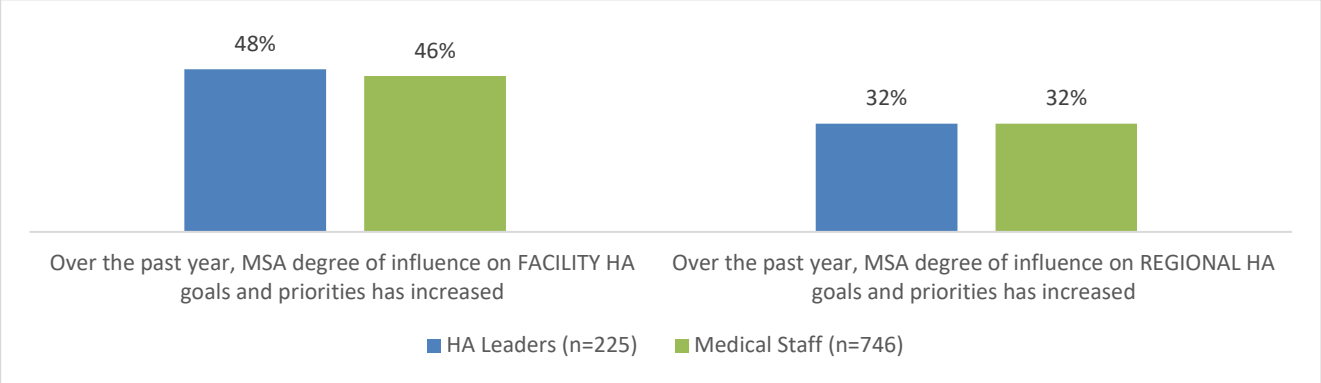
[14]A representative sample of 100 SEAT entries from 2020-21 were randomly selected and categorized based on the Types of Institutional Work framework using the activity descriptions available.

[15]Types of Institutional Work: A framework used to categorize FEI activities by the type of change work occurring (i.e., relational, conceptual, structural, or operational). Available at: Cloutier, C., Denis, J., Langley, A., & Lamothe, L. 2016. Agency at the managerial interface: Public sector reform as institutional work. Journal of Public Administration Research and Theory, 26(2), 259-276. doi:10.1093/jopart/muv009

Medical staff and HA leaders report improved MSA influence on HA goals and priorities.

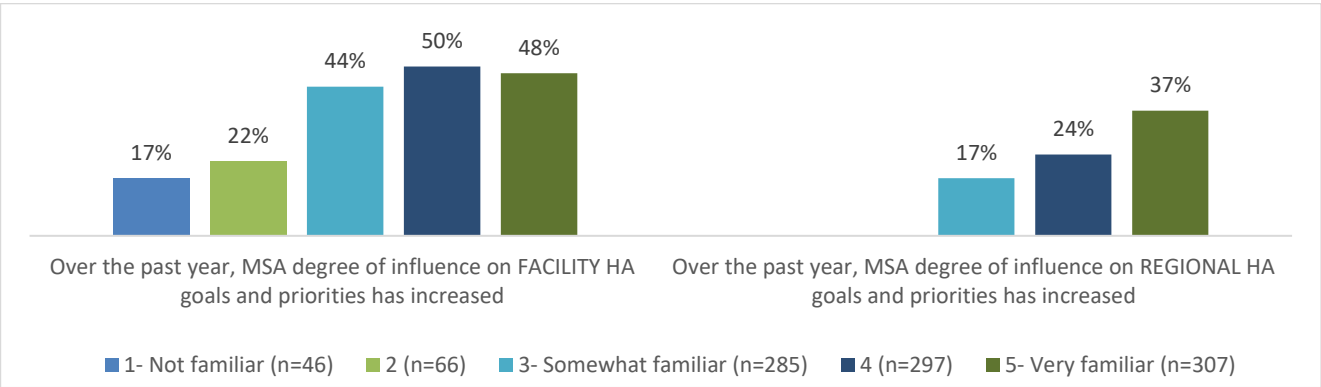
Almost half of HA leaders and medical staff report that the MSA's degree of influence on *facility-level* HA goals and priorities has increased over the past year. However, less than one-third agree that the MSA's degree of influence on *regional* HA goals and priorities has increased (as illustrated in Figure 7 survey results). These findings were fairly consistent across different groups, with the exception that smaller facilities (e.g., MSA Tier 1) perceived even less influence at the regional level (not depicted in the graph).

Figure 7: HA leaders and medical staff who strongly agree or agree with statements about MSA's degree of influence on HA goals and priorities



Similar to previous findings, HA leaders and medical staff more familiar with the FEI (e.g., familiarity ratings of 4 or 5) also report greater agreement that MSA influence over *facility* and *regional* priorities has increased over the past year (as illustrated in Figure 8 survey results).

Figure 8: HA leaders and medical staff who strongly agree or agree with statements about MSA's degree of influence on HA goals and priorities by familiarity with the FEI



To support greater influence, several survey participants identified in their open-ended survey responses the importance of ensuring HAs are willingly and actively engaging with MSAs in a positive manner. This is similar to the interim evaluation findings, where many medical staff encouraged HAs to involve physicians in systems-level discussions and decisions regularly and at the outset. In addition, it was suggested during the interim phase that medical staff need additional support to effectively engage with HAs (e.g., information about roles and responsibilities of HAs and Ministry of Health, how funding decisions are made, best practices for engaging, etc.).

The response to COVID-19 further supported MSA influence on HA goals and priorities.

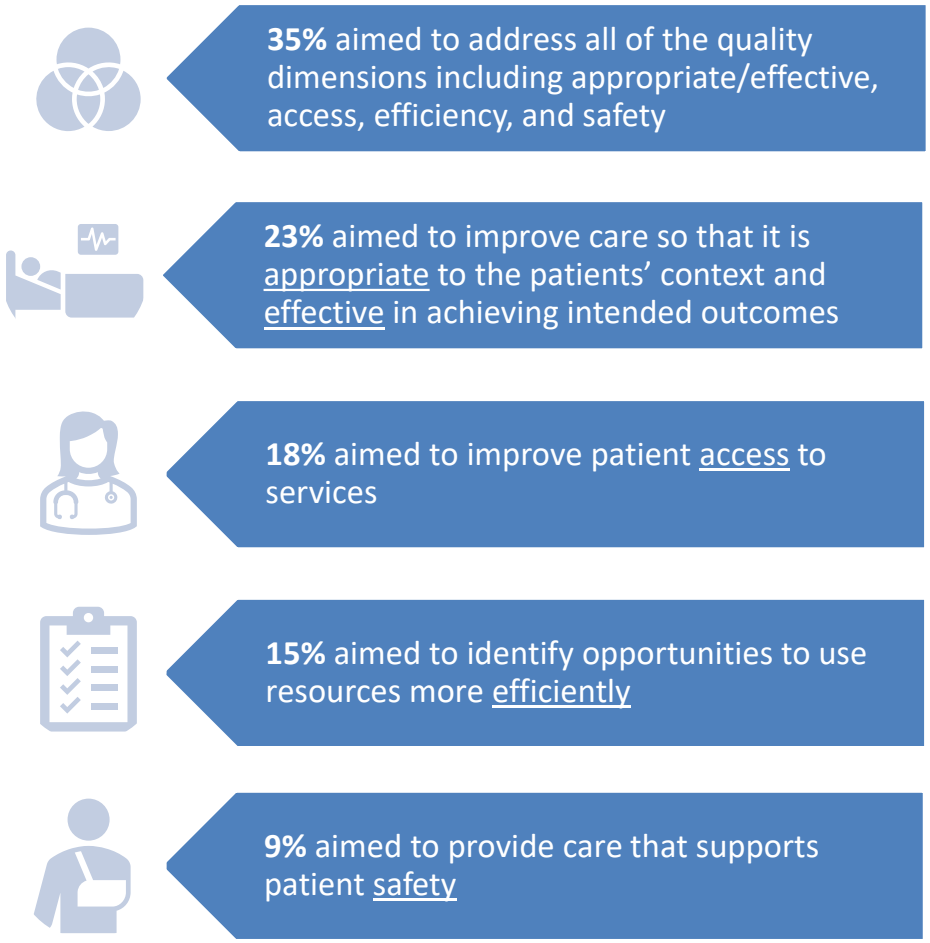
Many HA leaders and medical staff familiar with the FEI indicate that MSA involvement in HA decisions about their work environment and the delivery of patient care increased during the pandemic. With FEI support, medical staff participated alongside HA partners in more leadership roles that had some influence over health system planning and decision making. Key examples include COVID-19 working groups and Emergency Outbreak Committees. Again, medical staff expressed hope that this level of engagement in decision-making continues beyond COVID-19 related activities.

3.3 SUPPORTING QUALITY CARE IN BRITISH COLUMBIA

FEI activities address dimensions of quality care.

Based on a representative sample of 100 SEAT entries, 73% of FEI-funded activities between May 2020 and April 2021 aimed to address at least one quality dimension outlined in the BC Health Quality Matrix (figure 9).[16]

Figure 9: Percentage of FEI-funded activities that address quality dimensions



Most MSA members in their open-ended survey responses agree that the underlying premise of all FEI activities is to support quality of patient care and that this is achieved through both direct and indirect ways:

[16]BC Health Quality Matrix: A matrix used to assess FEI activities by dimensions of quality of patient care (i.e., appropriate/effectiveness, access, efficiency, and safety). Available at: BC Patient Safety and Quality Council. 2020. Dimensions of Quality. https://bcpsqc.ca/what-is-quality/

- **Direct Impacts:** Funded projects and activities that aim to directly address issues and improve the quality of patient care at a specific facility or regionally, such as the activity outlined in the highlight box below

- **Indirect Impacts:** Funded engagement activities that improve work environment and morale, support physician health and wellness, and enhance relationships among providers support medical staff to be able to provide quality care

The highlight box below provides an example of a FEI-funded activity that took place in 2020-21 that demonstrates how the FEI is directly supporting quality care.

FEI Activity Highlight Box – Supporting Quality Care

Collaboration with Indigenous Health Partners in Fort St. James – Northern Health

The MSA at Stuart Lake Hospital in Fort St James, with support from FEI, involves local First Nations leaders, community members, and system partners (including Northern Health and the First Nations Health Authority (FNHA)) in its annual strategic planning to identify opportunities to better serve the community and repair relationships that have been historically strained. Each year, a cultural wellness and physicians retreat is held in the community for stakeholders to come together, establish and strengthen relationships, and identify 4-5 priority areas (e.g., mental health and addictions) that the MSA will focus on throughout the year. For example, in response to an identified priority to improve communication and access to health information, stakeholders were able to work together to provide nurses at local First Nations health centres with access to community Electronic Medical Records (EMR) to enhance communication about patient care. FEI provides sessional funding and administrative support; other funding also supports resulting projects/initiatives, too (e.g., HA funding, grants secured by the local primary care society). Stakeholders credit this approach with helping to build trust and foster better relationships between MSA members and local First Nations. Improvements to patient care have also resulted from learning opportunities provided to medical staff (e.g., about how to provide culturally safe and appropriate care) and projects/initiatives arising through annual strategic planning.

"Physician Engagement has allowed for compensation for physicians who take on non-clinical work through committee and working groups. This has a huge benefit to patient care and having Physicians be at the table for many more decisions than would have been possible in the past." – Medical Staff (Physician), Vancouver Coastal Health

"Facility engagement was critical during COVID. It allowed us to work together and descend from our individual silos. It directly helped people and patient care." – HA Leader (Physician), Fraser Health

"There is increased collaboration to work towards improve patient care and the workplace environment." – HA Leader (Non-Physician Care Provider), Interior Health

The response to COVID-19 also addressed dimensions of quality care.

As noted previously, the FEI enabled rapid development and implementation of projects related to COVID-19, which included measures to address patient and staff safety as well as increase access to continuous and quality care. Examples of FEI-funded quality care activities during the pandemic included providing PPE training, creating airway teams, launching at-home care options (e.g., Hospital at Home), and more recently, establishing COVID-19 wards within facilities and implementing COVID testing and vaccine clinics. Several funded activities also focused on medical staff wellness to support their ability to continue to provide quality patient care (e.g., tokens of appreciation, information on burnout, wellness programs, etc.).

There are opportunities to improve communications and monitoring for FEI activities.

Several medical staff and HA leaders flagged concerns with aspects of FEI activities in their open-ended surveys responses, including a lack of clarity around funded activities, the program's relationship with other initiatives such as the Physician Quality Improvement initiative, and the program's ability to enable sustainable systems changes (e.g., most activities are smaller, facility-level projects). As such, there is an opportunity to improve communication around the FEI initiative in terms of its objectives and expected outcomes (e.g., relationship building and enhancing collective voice) as well as its impacts.

Currently, there is a lack of data collection occurring for FEI-funded quality improvement initiatives (as well as other FEI activities), which makes it challenging to communicate the individual or collective impact of FEI activities to stakeholders. Instead, the evaluation relied primarily on stakeholder perceptions and examples to identify impacts. Therefore, there is an opportunity to improve data collection for FEI-funded activities, which would also support stronger stakeholder communications around the intent and impacts of the FEI.

4. CONCLUSIONS AND KEY RECOMMENDATIONS

4.1 FACILITY LEVEL ENGAGEMENT AND RELATIONSHIP BUILDING

The FEI provides a forum for MSA members and facility-level HA partners to engage with one another and build relationships. The FEI also supports medical staff to build relationships amongst themselves and develop shared priorities and goals; an important step in building a strong collective voice among medical staff. Taken together, these foundational activities of engagement and relationship building are supporting the longer-term goal of MSAs having greater influence over their work environment and the delivery of patient care.

While approximately half of HA leaders and medical staff participants agree there is trust and cooperation, information flow, and collaboration between MSA members and facility leaders, the other half did not agree. Further, less than half of HA leaders and medical staff participants agree with statements around the degree of influence MSAs have over facility-level HA goals and priorities. Encouragingly, participants with greater familiarity with the FEI had more positive views regarding relationships and influence. As such, there is a need to continue to engage medical staff and HA leaders in the work of the FEI at the facility level to improve relationships and the influence of MSAs collective voice. As participants noted, there is still a long way to go to build relationships among medical staff and with the HAs, and the FEI can provide the necessary structure and forum to support this work into the future.

Recommendation 1: Continue focused effort of engaging medical staff and HA leaders in the FEI and building facility-level relationships between MSAs and HAs.

Some options to improve engagement and relationship building identified by the evaluation include:

a) **Encourage MSAs and HAs to implement FEI activities that involve collaborative strategic planning.** Collaborative strategic planning between MSAs and HAs was highlighted as a strong example of relationship building that also supported collective voice among medical staff (both for regular FEI activities and COVID-19 related activities). In particular, these activities highlight the importance of both MSAs and HAs coming to the table in a meaningful way to discuss shared priorities, align planning, and commit to changes. The Collective Story Report will further outline the successes of these activities. Therefore, the provincial office should communicate lessons from these activities (including how the activities were carried out) and encourage MSAs and HAs to look for ways to engage in collaborative and strategic planning activities using FEI funding (beyond the SRRP annual review process). In particular, these lessons indicate that HAs should endeavour to include physicians more regularly at strategic decision-making tables and medical staff should ensure they are demonstrating willingness and productive engagement in these activities. The new Knowledge Sharing Newsletter or the upcoming Engagement Toolkit could be utilized to communicate these learnings as well as other methods such as through the FEI website. Other options could be to host Engagement Partner and/or physician-led webinars to share these learnings with MSA members and HA leaders to encourage the involvement of both parties in collaborative planning, as the MOU intended.[17]

[17]MOU for Regional and Local Engagement. 2019. Available at: https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/mou-2019-regional-local-engagement.pdf

b) **Provide clearer communications about the FEI to current participants as well as potential new participants.** Many medical staff and HA leaders express ongoing confusion around the FEI program, which may impact engagement in the program. In particular, stakeholders need clearer information on the objectives of the FEI and the funding process, how it contributes to system change, and best practices for engaging with the program and with HAs. The provincial office has recently released and/or is creating reference materials to support better information about the program and best practices for engagement (e.g., website improvements, Knowledge Sharing Newsletter, Engagement Toolkit, etc.). It will be important for the provincial office to evaluate stakeholder satisfaction with these materials. As well, determine if additional materials are needed to communicate the purpose of the program at a higher level, such as an educational/promotional campaign to those less familiar with the FEI (particularly in relation to other SSC funding opportunities such as the Physician Quality Improvement initiative). The HA may also have a role to play in providing clearer communications around the FEI, such as promoting awareness of the FEI and alignment between the HA and medical staff (e.g., information on how to get involved and engage with MSAs and the work of the FEI).

c) **Encourage MSAs to incorporate equity, diversity, and inclusion (EDI) into their MSA structures and FEI activities.** Some medical staff and HA leaders identify that there could be greater attention to EDI factors in the work of MSAs and FEI-funded activities. This may encourage greater engagement of MSA members, non-physician medical staff, HAs, and others. The provincial office could support these efforts by releasing information about EDI specific to the FEI and suggestions for how it may be incorporated into FEI structures and activities. There is current work underway at the broader Doctors of BC level which could be leveraged to support this recommendation.[18] In particular, Doctors of BC is making efforts to increase the diversity and inclusion of their governance bodies – the Board, Representative Assembly, and Committees – while also working to ensure that all members have an equal opportunity to participate in these bodies. The provincial office should explore this current work and determine what lessons and actions can be brought forward into MSAs' structures and FEI-funded activities.

4.2 REGIONAL ENGAGEMENT AND RELATIONSHIP BUILDING

Compared to engagement between MSA members and facility leaders, medical staff and HA leaders report comparatively less agreement that there are effective relationships and engagement between MSA executives and regional HA leaders. As the HAs operate at a regional level, there was common interest among stakeholders for greater regional engagement to enable broader communication, collaboration, strategic planning, and the scale and spread of FEI initiatives regionally. As such, there is a need to encourage greater regional engagement and relationship-building between MSA executives and regional HA leaders. It's important to note that regional engagement would be in addition to the important relationship building efforts occurring at the facility-level, and not a replacement of the facility-level work.

[18] Doctors of BC. 2021. Equity, Diversity, and Inclusion. Available at: https://www.doctorsofbc.ca/about-us/equity-diversity-inclusion#quickset-equity_diversity_and_inclusion_w=1

Recommendation 2: Identify opportunities to encourage regional MSA and HA engagement activities.

There are some examples of regional FEI activities from both the interim and final evaluation stages that highlight how FEI funding can be used toward successful regional engagement. The Collective Story Report will further outline the successes of these activities. Similar to facility-level relationships, the provincial office should communicate lessons from these activities (including how the activities were carried out) and encourage MSA executives and HA leaders to look for ways to engage in their own regional-level activities using FEI funding. The Knowledge Sharing Newsletter, the Engagement Toolkit, and the FEI website could be utilized to communicate these learnings.

Another option could be to engage MSA Executives and HA leaders directly in presentations and discussions to brainstorm types of regional activities that could be supported by FEI funding. For example, the provincial office could hold a regional 'lessons learned' webinar and/or roundtable with MSA executives and regional HA leaders to explore options for regional FEI activities (e.g., showcasing of successful regional projects, lessons from current regional activities, possible regional activities that could be funded, etc.). The session could be facilitated by EPs and include time for collaboration and discussion among HA leaders and MSA executives. If attendance and interest is good, this could become a regular engagement session (e.g., annual) to reinforce the opportunities around regional FEI activities. It will be important for both HA leaders and MSA executives to actively engage in these sessions as well as to commit to working on regional activities together to ensure the sessions are useful and impactful.

4.3 MONITORING AND DATA COLLECTION

The FEI currently uses a combination of administrative data (e.g., FEMS and SEAT) as well as stakeholder review processes (e.g., SRRP and information from EPs) to monitor its program. Further, the provincial office provides resource material such as an activity intake form for MSAs to track their activities. However, these systems produce minimal information (e.g., number and types of activities, expected impacts, etc.) and do not collect consistent data on outcomes to indicate whether the activities were completed successfully and/or if the activities achieved intended outcomes. It is worth noting that the FEI funds hundreds of activities ranging from smaller engagement events to quality improvement initiatives. As such, more intensive tracking may be less important for smaller engagement activities (e.g., medical staff lunches), but more important for funded projects that aim to improve quality of patient care. Regardless, there is a need to collect better data so that the program is able to successfully and efficiently track and report on the impacts of FEI activities. This will also support stronger communication around the FEI and better evaluation processes.

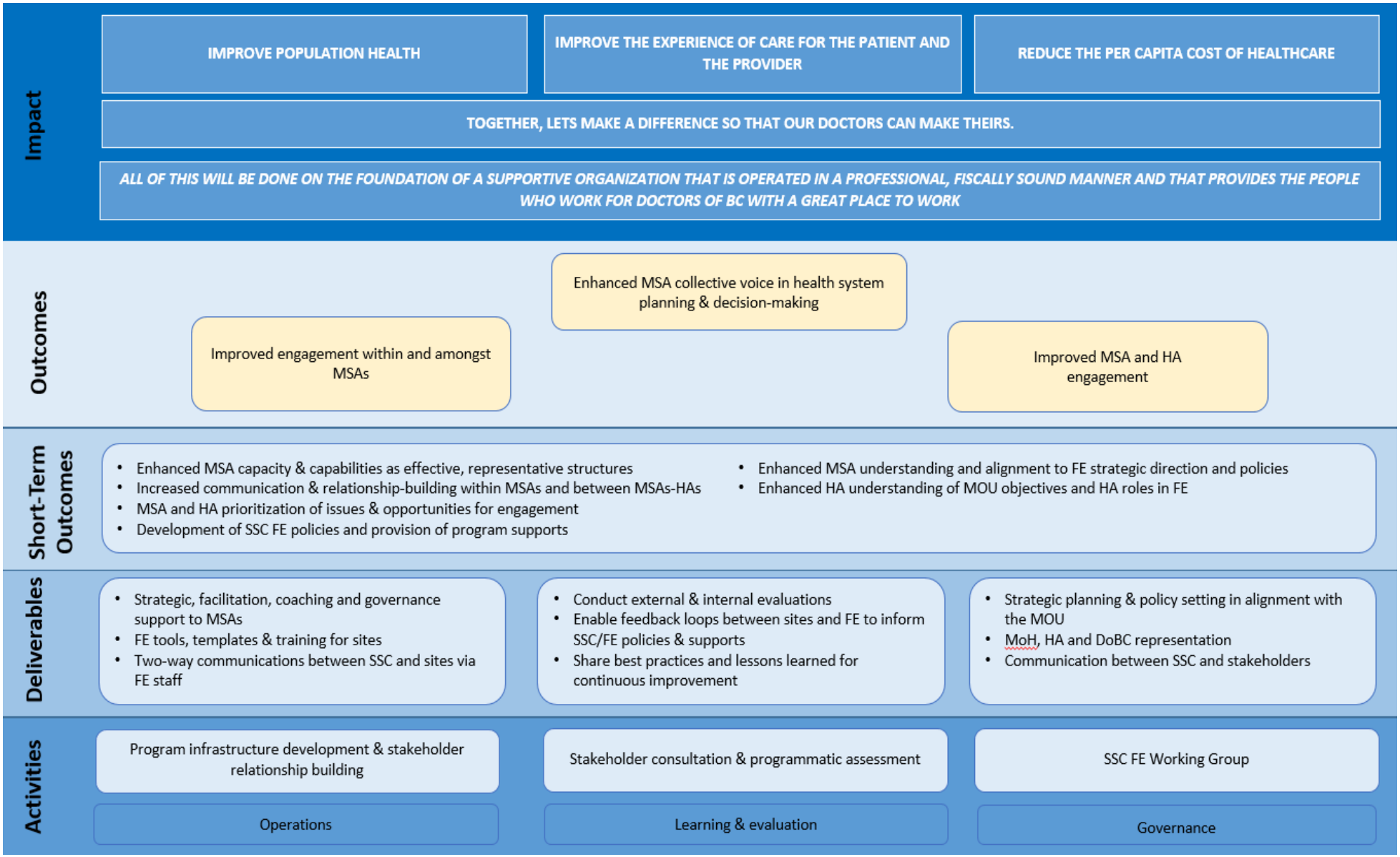
Recommendation 3: Create a strong data collection strategy to better track and communicate the impacts of the FEI.

The provincial office is currently integrating their FEMS and SEAT databases to improve the user experience and produce better quality data. This is an opportune time to ensure a strong and strategic data collection approach is created alongside this work which outlines success indicators, data sources, timing of data collection, and data collection responsibilities to track the impacts of the FEI. Both direct (e.g., impacts of quality improvement initiatives) and indirect (e.g., impacts of physician wellness activities on quality of care) impacts of the FEI will need to be examined.

The strategy will need to consider the audience (e.g., MSA members, MSA project managers, etc.) and ensure that data collection does not become too onerous as to deter participation. Therefore, in order to create an effective data collection strategy for the FEI, targeted consultations will be needed with key stakeholders involved in data collection including the provincial office, MSA members, MSA project managers, and EPs. Consultations can occur in a variety of formats but some of the more common methods include roundtables, one-on-one interviews, or engagement surveys. The goal of these consultations will be to collaboratively explore with key stakeholders what data is being collected now, whether that data is useful, and what data is available to communicate the impacts of the FEI (both direct and indirect impacts). As opposed to simply adding additional data requirements, the consultations will aim to identify efficiencies for data collection such as ways to optimize current data collection as well as leverage existing data collection at Doctors of BC and the HAs. Importantly, having a collaboratively created data collection strategy that is strategic and efficient can create buy-in and stronger data collection among relevant stakeholders.

APPENDICES

A.1 FEI LOGIC MODEL



A.2 FEI EVALUATION MATRIX*

FE Outcomes	Evaluation Question	Data Sources	Indicators
Enhanced MSA capacity and capabilities as effective, representative structures	To what extent has FE contributed to increased MSA capacity and capabilities as effective, representative structures?	Qualitative Interviews	• Qualitative interviews with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on increased MSA capacity/capabilities and effectiveness/representativeness (also relating to COVID-19)
		FEMS	• # of MSAs • # of MSA members in FEMS (i.e., by site; by type; by medical practice type; by year)
		SRRP	• # and % with high score on MSA Working Group Effectiveness • # and % with high score on MSA Executive Structure Effectiveness • # and % with high score on Appropriateness of Support Staff Resources • # and % with high score on Use of Assessment/Evaluation Measures • Questions related to COVID-19
		MSA Document Review	• # and % of MSA that have a representative WG • # and % of sites with succession planning documents
		SEAT	• # and % of project SEAT tags (e.g., wellness project, COVID-19 activities, etc.)
Improved engagement within and amongst MSAs	To what extent has FE contributed to improved engagement within MSAs (e.g., increased communication and relationships within MSAs)?	Qualitative Interviews and Stories	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on improved engagement within MSAs (also relating to COVID-19)
		Province-Wide Survey	• Surveys with physicians and health authority representatives to examine improved engagement within MSAs (also relating to COVID-19)
		SRRP	• # and % of sites who agree or strongly agree that: "There was improved engagement among MSA members over the last year"
		FEMS	• Claims: by dollar amounts of sessionals (hours); of expenses • IOE overhead: financial database ($ spent on engagement versus supports) • # of MSA members in FEMS by site; by type; by Department; by year
		MSA Document Review	• Average # of MSA meetings per MSA per year • # and % of MSAs who meet at least 4 times a year
	To what extent has FE contributed to improved engagement amongst MSAs?	Qualitative Interviews and Stories	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on improved engagement amongst MSAs (also relating to COVID-19)
		Province-Wide Survey	• Surveys with physicians and health authority representatives to examine improved engagement amongst MSAs (also relating to COVID-19)
		SRRP	• # and % of sites indicating improved engagement among MSA members over last year

FE Process	Evaluation Question	Data Sources	Indicators
Improved MSA and health authority engagement	To what extent has FE contributed to improved MSA and HA (local and regional) engagement (e.g. increased communication and relationships between MSAs and HAs; increased MSA and HA prioritization of issues and opportunities for engagement)?	Qualitative Interviews and Stories	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on engagement between MSA and HA (also relating to COVID-19)
		Province-Wide Survey	• Surveys with physicians and health authority representatives to examine engagement between MSA and HA (also relating to COVID-19)
		SRRP	• # and % with high score on Consultation with HA on proposed activities • # and % of sites indicating improved engagement between MSA and HA over last year • # and % high score on HA structures and processes effective for the MSA and HA to consult and collaborate on priorities • # and % of high score on HA provides appropriate and timely information to allow for more effective engagement and consultation between the MSA and HA • # and % of high score on HA processes provide appropriate opportunities for MSA contributions to the development and achievement of HA plans and initiatives that directly impact MSA members at the facility • Questions related to COVID-19
		SEAT	• % of FE activities with HA involvement, including COVID-19 related activities
		FELs	• Total # of MSAs where the Working Groups extends a standing invitation to the HA to attend OR there is a standing meeting between the MSA Executive and the HA local partners to discuss activities
Enhanced MSA collective voice in health system planning & decision making	To what extent has FE contributed to enhancing MSA collective voice in health system planning & decision-making?	Qualitative Interviews and Stories	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on collective voice (also relating to COVID-19)
		Province-Wide Survey	• Surveys with physicians and health authority representatives to examine collective voice
Improve the experience of care for the patient	To what extent has FE enabled MSAs to impact quality of patient care?	Qualitative Interviews and Stories	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on impact quality of patient care
		Province-Wide Survey	• Surveys with physicians and health authority representatives to examine impact on quality of patient care
		SEAT	• # and % of activities which address quality dimensions (BC Health Quality Matrix)

Satisfaction with program elements	How satisfied are stakeholders with the investments made into key program elements?	Qualitative Interviews	• Qualitative interviews and stories with MSA leaders, physicians, MSA project coordinators, HA reps and FELS with a theme on satisfaction with FELS, Program Supports, SSC FE Working Group as well as a theme on satisfaction with roles, events, and processes created to improve physician engagement with health authorities
Cost of the program	What was the cost to implement the program?	FEMS	• By sites: Provincial total; Amount/site; % spent of received funds; What $ was spent on, Average $ of sessional claims / facility; Average and median # claimants/facility; Average amount $ claimed/physician; Estimated mean MSA size; Spend rate; Spending/HA: total spending; % of FEI spent accounted for by sites in each HA

**The FEI Evaluation Matrix includes methodologies from both the interim evaluation and final evaluation stages. Some methodologies noted above were not included in this final evaluation report.*